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	**7 May 2026 – 9.00am (via MS Teams)**

Present

Joanne McCoy, Vice Chair and Non-Executive Director – Chaired the meeting
Karen Leach, Chair
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
Dr Boyd Peters, Board Medical Director
Katherine Sutton, Chief Officer, Acute
Arlene Johnstone, Chief Officer, HSCP
Neil Wright, Non-Executive Director

In attendance

Rebecca Helliwell, Deputy Medical Director (A&B)
Heather Richardson, Head of Operations
Leah Smith, Complaints Manager
Allyson Turnbull-Jukes, Director of Psychology
Dominic Watson, Head of Corporate Governance
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
Mirian Morrison, Clinical Governance Development Manager
Bryan McKellar, Whole System Transformation Manager
James Mullins Associate Nurse Director, A&B
Elizabeth Drummond, Lead Nurse
Katy Styles, Associate Director of Planning, Strategy and Transformation

1.1 WELCOME AND APOLOGIES

Formal apologies were received from Emily Austin, Linda Currie, Elaine Henry, Evelyn Gray, Jill Mitchell and Gavin Smith.

1.2 DECLARATIONS OF INTEREST

No members declared any interests.

1.3 MINUTE OF MEETING FRIDAY 6 MARCH 2026, ROLLING ACTION PLAN AND COMMITTEE WORKPLAN 2026/2027

The Minute of Meeting held on 6 March 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 2 July 2026.

L Bussell advised that this work is dependent on ongoing engagement with Highland Council and therefore could not be finalised in time for this meeting. A revised and realistic timescale will be agreed once the joint work is sufficiently progressed.

A&B 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 A&B. It was agreed that the paper should first be reviewed through local A&B governance structures before being presented to the Clinical Governance Committee at the next meeting on 2 July 2026.

L Bussell advised that the report was not achieved, as the paper has not yet completed local governance processes. It was confirmed that the paper is in development, with delays due to data availability and quality issues. The update is expected to progress through A&B SLT and Clinical Governance and be brought to the next Clinical Governance Committee for consideration.

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 CAMHS / PT Update

H Richardson spoke to the circulated report highlighting CAMHS RTT performance was reported at 90% overall, with the most recent weekly data showing 100% compliance in both North Highland and A&B. The combined waiting list stood at 120 patients (82 in North Highland). Performance is monitored weekly, with three-weekly reviews with the Chief Executive. The service is on track for de-escalation, subject to maintaining performance over two consecutive quarters.

It was confirmed the Highland Council has withdrawn funding for the Care Experienced Young People service following a review of historical commissioning arrangements dating back to 2019. Heather advised the notification was received in March and that a nine-month transition period is underway, during which NHS Highland is working with Highland Council on alternative arrangements. Heather emphasised that this was not related to service quality, and that direct clinical CAMHS provision for care-experienced young people would continue, with the decommissioning affecting primarily preventative and relational elements of support.
M Cockburn highlighted the scale and significance of the change, noting the vulnerability of the group affected, and asked whether further updates could be provided to the Committee to monitor impact.

G Illsley sought clarity on the transition arrangements and mitigations, expressing concern that some of the work being lost could fall to existing CAMHS staff who are already under pressure, and requested further detail on how workforce impact would be managed.

J Mullins reinforced these concerns by asking specifically about staff wellbeing, acknowledging the cumulative effect of commissioning uncertainty, workforce pressures and sustained performance expectations on CAMHS teams.

G O'Brien queried whether the decommissioning represented a full cessation of services or whether Highland Council intended to commission alternative provision. Heather explained that some elements may be provided by third-sector or external organisations, but that the clinical team believed not all aspects—particularly preventative support—were easily replaceable. Gerard also asked whether the decision was financially driven; Heather responded cautiously, noting changes in commissioning models and potential duplication, rather than deficiencies in service delivery.

L Bussell added that the decision was not one NHS Highland would have chosen, describing it as something that had happened to us rather than with us, and stressed that work was now focused on rebuilding constructive partnership arrangements with Highland Council during the transition.

M Cockburn then asked directly whether the Committee was comfortable with the level of risk. Heather advised that risk could not yet be fully quantified until there was greater clarity around what alternative providers would deliver but identified the principal risk as the loss of flexibility and preventative capacity. She committed to bringing back a more detailed briefing paper, including an updated risk assessment, once transition plans were clearer.

In conclusion, the Chair summarised that the Committee acknowledged the significance of the service change and ongoing uncertainty, requested a further update covering transition planning, mitigations and workforce impact.

The closure of specialist inpatient beds at Skye House (Glasgow) has increased system pressures and contributed to delays in securing inpatient placements. CAMHS is working system-wide, including with adult mental health services, to identify alternative solutions and improve patient flow.

The service has experienced unplanned nursing leave, creating short-term capacity challenges. Mitigations include additional hours, resource reallocation, and redeployment from other areas. Staff wellbeing and psychological safety were highlighted as key concerns, with support being provided via the People and Change network.

The overall assurance level for CAMHS was assessed as Moderate. Risks relate primarily to the loss of flexibility, workforce fragility, and uncertainty around replacement provision for CEYP support. The Committee requested a further update at a future meeting, including transition plans, mitigations, workforce impact, and quantified risk once third-party provision is clearer.

The Committee accepted **Moderate** assurance on the CAMHS report.

The Committee gave **Moderate Assurance**, noting improved RTT performance with strong oversight, but recognising ongoing risks relating to workforce fragility, system pressures, inpatient bed availability and uncertainty following the decommissioning of preventative elements of the Care Experienced Young People service.

2.2 Cancer Services – SACT

Dr B Peters advised the Cancer Services SACT report was deferred, with it confirmed that the paper will be submitted on behalf of Acute Services, as responsibility for SACT sits within that portfolio. Ongoing work is underway to stabilise and improve any areas requiring action, and the Committee

was advised that an update is expected to be brought to one of the next one to two meetings for consideration.

2.3 Healthcare Improvement Scotland (HIS) - Clinical Governance Standards

M Morrison provided an update on the circulated report advising the newly published Healthcare Improvement Scotland (HIS) Clinical Governance Standards, which align closely with previous governance frameworks but bring together multiple strands into a single, unified reference. Work has commenced to develop a self-assessment against the seven standards, supported by the HIS toolkit, with an approach that will assess performance at Board, organisational and service/team levels. A bespoke template is being developed to map evidence against each standard and identify gaps and improvement actions.

The Chair noted that while Healthcare Improvement Scotland has provided a toolkit, it appears high-level and generic, and questioned whether it offers sufficient structure to support a meaningful self-assessment. She asked for clarity on timescales for completion and sought to understand what happens after the self-assessment, including how the work will be structured, reviewed and taken forward once an initial position is established.

Members noted this represents a significant piece of work that will link closely with the Quality Strategy and Quality Management System and is expected to generate ongoing improvement priorities rather than a one-off exercise. No external timescale has been set by HIS, with the focus currently on establishing a baseline position.

G Illsley noted how extensive and far-reaching the HIS Clinical Governance Standards are and questioned whether, given their scope, they should be considered by other committees as well as Clinical Governance—particularly the Staff Governance Committee, as many of the standards appeared directly relevant to workforce and staff-related matters.

M Morrison confirmed that this had already been discussed by the team. She acknowledged that the standards are far-reaching and apply across the whole organisation and advised that they will be referred to and considered by the appropriate committees, including Staff Governance, as and when relevant, rather than being owned solely by the Clinical Governance Committee.

A further progress report is expected in due course.

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

The Committee noted the update and accepted **Moderate Assurance** with assurance reflecting that self-assessment has commenced, with further work required to complete assessment and identify gaps and improvement actions across the organisation. A further progress report expected in due course.

2.4 Psychological Therapy Update

L Bussell provided an update on Psychological Therapy noting that NHS Highland has been one of the top three mainland boards during 2025–26, reflecting strong overall performance. Members were advised of a recent performance wobble, particularly in A&B, linked to workforce fragility within small teams, where the loss of even a single staff member has a disproportionate impact on capacity and RTT performance.

Mitigations include recent recruitment, leadership and structural work, development of professional assurance frameworks, and continued improvement in data quality in collaboration with eHealth and primary care mental health teams. Performance over the rolling 12-month period remained above national average.

Members noted that the Psychological Therapies report demonstrated strong governance, highlighting its transparency, effective use of data, and clear articulation of both pressures and performance. J Mullins noted that the paper provided a good example of early escalation and early warning and suggested it illustrated how robust governance should operate in practice. He also observed that the PT update, alongside the CAMHS paper, could serve as a useful example when considering the HIS Clinical Governance Standards, potentially as a pilot for demonstrating how services meet governance expectations.

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

The Committee noted the update and accepted **Substantial Assurance** highlighting strong overall performance, with workforce risks mitigated through recruitment, leadership and strengthened governance.

3 EMERGING ISSUES/EXECUTIVE AND PROFESSIONAL LEADS REPORTS BY EXCEPTION

Dr B Peters advised of a developing regional issue affecting availability of hepatopancreatic biliary (HPB) surgery, which has knock-on implications for gynaecological oncology surgery. This relates to changes within NHS Grampian, including cessation of aspects of its HPB service, with consequent impacts on boards that traditionally outsource care to Grampian. Interim workarounds are in place for the next 1–2 months with some patients being supported via NHS Lothian. However, Lothian's capacity is limited and does not fully cover all gynaecological oncology requirements. The Committee was assured that there is currently no cessation of service for NHS Highland patients, but challenges are anticipated later in the year. It was noted that HPB surgery is a highly specialised service, typically provided on a population basis of 1–3 million, and that there may need to be national or regional re-planning of provision in Scotland. NHS Highland will participate in any such regional or national discussions. Updates will be brought back to Committee if a significant service change or patient impact arises.

The Chair thanked Boyd for the update and sought clarification on capacity and sustainability, specifically asking whether NHS Lothian has sufficient capacity in the short term and whether NHS Grampian was likely to come back online. B Peters advised that capacity is managed through mutual aid arrangements, with NHS Highland able to access support from larger Boards when required. He explained that where services are not locally sustainable, larger Boards (e.g. NHS Lothian-type arrangements) can provide support that Highland cannot deliver due to small service size. In other cases, pressures are short-term (e.g. recruitment gaps or staff illness) and external support is used temporarily until local capacity is restored. The Chair acknowledged the explanation that interim arrangements are in place but accepted that future provision remains uncertain and may require further discussion if circumstances change. The Chair confirmed that the Committee was content to note the issue at this stage, with the expectation that it would return to the Committee only if there is a material change, such as a cessation of service or significant impact on patients.

L Bussell highlighted the potential clinical governance implications of sub-national working, highlighting the need for close alignment of governance arrangements as this work progresses. This was noted for awareness rather than detailed discussion at this stage.

In response to Louise's point, the Chair also noted the potential clinical governance implications of sub-national working, agreeing this should be kept under review, but not requiring detailed discussion at this point.

The Committee Noted the reported position.

4 PATIENT EXPERIENCE AND FEEDBACK – Complaints and Compliments Case Studies

M Morrison spoke to the circulated report on Care Opinion activity, noting a recent increase in postings, with 42 Care Opinion submissions in the most recent month. This was highlighted as a positive indicator of increased patient and public engagement. The Committee was advised that a dedicated member of the Feedback Team is now in place to ensure timely responses to Care Opinion posts, recognising that response times can be challenging. Ongoing work was noted to review and clarify responsibility for responding to Care Opinion feedback, with the aim of embedding this more consistently across services and encouraging wider use of the platform. No questions were raised by members, and the Committee acknowledged the value of regular patient experience reporting in providing assurance and organisational learning.

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**.

5 CLINICAL GOVERNANCE AND PERFORMANCE DATA

M Morrison spoke to the circulated report where a slight improvement was reported in compliance with the 20-working-day response target. While the overall number of formal complaints remains relatively high, assurance was provided and that responses are being issued more promptly. Increased activity from the Scottish Public Services Ombudsman (SPSO) was noted, with reassurance that most cases reviewed were not taken forward, indicating appropriate complaint handling. Thirteen SCRs were reported as exceeding the 36-week timescale. These are being closely monitored through Quality and Patient Safety (QPS) arrangements. An increase in SCR declarations over time was noted, and it was confirmed that around 40 staff have recently been trained to act as lead reviewers, strengthening organisational capacity. Run chart data was presented. Members queried whether inpatient falls data could also be shown as a rate or percentage, to better reflect fluctuating inpatient populations. It was agreed that this would be explored in future reports. It was confirmed data is drawn from the DATIX reporting system, including reports from NHS Highland services and some partner services.

S McMillan queried the presentation of inpatient falls as absolute numbers, noting that this makes interpretation difficult given fluctuating inpatient populations. He asked whether future reports could present falls data as a rate or percentage, to allow more meaningful comparison over time. He clarified that this was not a request for immediate change, but a suggestion for future reporting, which was acknowledged and agreed to be explored by officers.

M Cockburn asked whether the falls data presented captures information from all services, including services commissioned both internally and externally, rather than only directly provided NHS Highland services. She highlighted an ongoing concern about whether all relevant risk is being identified and recorded, particularly where services are delivered outside core NHS settings, and emphasised the importance of assurance that risks are being appropriately captured to support oversight and improvement.

L Bussell explained that the falls data currently reported is labelled as inpatient falls and acknowledged the importance of improving understanding of where falls are occurring, including care homes and community settings, where reporting can be more challenging. She advised that work is underway to make better sense of the data, including breaking it down by setting (e.g. inpatient, care homes, care at home), recognising that community data is harder to capture but that all known incidents should be recorded. Louise confirmed that this forms part of wider work to strengthen data quality and interpretation, ensuring the Committee has clearer assurance on risk across different care environments.

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**, acknowledging areas of improvement, ongoing monitoring arrangements, and planned actions to address identified risks and enhance 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 advising there were no additional critical issues beyond those outlined in the paper but provided clarification on two appendices included for context.
Members were advised that one appendix contained notes from the Clinical and Care Governance Group, which operates below Committee level as a senior operational forum addressing complex, cross-service issues. It was acknowledged that these notes were included in error, but they nonetheless provided helpful insight into ongoing system pressures. A second appendix (SBAR) highlighted significant challenges within community paediatrics in Argyll & Bute, arising from multiple staffing vacancies across very small multidisciplinary teams. These gaps have resulted in a fragile service with associated clinical risk, particularly in relation to timely review and continuity of care. Recruitment efforts have been unsuccessful to date. The issues in community paediatrics have been escalated through the Infant, Children and Young People's Clinical Governance Group. Work is underway to seek support from NHS Highland North and NHS Greater Glasgow & Clyde, recognising increasing subspecialisation and the difficulty of sustaining services locally. During discussion, members noted that recurrent staffing challenges, particularly in small and highly specialised services reliant on other boards, are a persistent risk theme for Argyll & Bute. It was recognised that these issues often sit within Staff Governance, though they have clear implications for clinical governance and service sustainability.

S McMillan observed that staffing shortages and recruitment difficulties appear to be a recurring and significant theme, particularly within the issues highlighted in the A&B exception reporting. He queried whether it would be helpful for the Committee to receive a broader overview of recruitment practices and workforce challenges, including consideration of potential mitigations such as accommodation, incentives, or alternative approaches to recruitment and retention. He acknowledged that this may sit primarily within Staff Governance but highlighted that the impact of workforce fragility is clearly reflected in clinical governance risks and exceptions being reported to the Committee.

L Henderson asked to be included in any follow-up discussion or meeting arising from Seamus's comments on workforce and recruitment, noting she would find this helpful for her own understanding. She supported Seamus's point and suggested it would be useful to explore whether there is a clear correlation between staffing challenges and the clinical governance issues and exceptions being reported. Liz proposed that a dashboard or overview showing the relationship between workforce pressures and governance risks across services might help the Committee better understand whether resolving staffing issues would mitigate a significant proportion of the risks being escalated through clinical governance.

The Chair acknowledged the recurring workforce and recruitment challenges highlighted in the discussion and agreed that a broader overview would be helpful to understand the issue more fully. She confirmed that workforce matters primarily sit within Staff Governance but recognised their clear impact on clinical governance risks and exceptions being reported.

Action: The Chair proposed that the issue be taken forward offline, indicating she would discuss next steps with B Peters, L Bussell and K Leach to consider how best to progress the request and whether it should return as a future discussion item.

The Committee welcomed the approach of splitting assurance ratings by service area. Assurance levels were agreed as follows:

- Quality and Patient Care: **Moderate** assurance
- Primary Care: **Moderate** assurance
- Children, Families and Justice: **Limited** assurance, reflecting community paediatric pressures
- Acute and Complex Care: **Moderate** assurance
- Rural General Hospital (Lorn & Islands): **Moderate** assurance

After discussion, the Committee:

Noted the content of the circulated report and **Agreed** to the **varying levels** of **assurance**.

6.2 Highland Health and Social Care Partnership

Dr C Copeland spoke to the circulated report, advising that the paper followed the usual assurance structure. It was noted that the risk register section was still in draft, and this would be corrected and re-circulated. The report provided assurance across a range of areas, with particular reference to quality dashboards, including falls, tissue viability, infection control, stress and distress (violence and aggression), and learning from adverse events. Ongoing thematic analysis and linkage to wider organisational quality work were highlighted. Workforce fragility was identified as a recurring theme impacting service resilience, particularly within primary care and pharmacy, and was reflected in exception reporting and assurance recommendations. Members discussed mandatory and statutory training (StatMan) compliance, including cyber security training. It was explained that lower compliance partly reflects the recent introduction of the cyber security module, with expectations that completion rates will improve over coming months. The report demonstrated ongoing focus on learning from Significant Case Reviews and other reviews, with efforts to strengthen thematic learning alongside individual case actions.

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**.

6.3 Acute Services

E Drummond spoke to the circulated report, who outlined current pressures, escalations and mitigation actions across acute services. A new vascular consultant has been appointed on a two-year fixed-term contract, working alongside a locum consultant to improve clinic access and repatriation protocols. Significant pressures were reported across Raigmore Hospital, including periods where the elective programme was stepped down for a total of four weeks due to high numbers of risk-assessed patients. A co-ordinated Incident Management Team (IMT) has been in place since mid-February to stabilise flow and reduce patient and staff risk. Work is ongoing to reduce risk-assessed beds to zero by 1 June 2026, with limited assurance currently noted for this area.

Diagnostics and specialist services:

- Diabetes: High referral volumes were reported, with Inverness patients allocated clinic appointments and work progressing in other areas.
- Breast services: Ongoing pressures were highlighted due to staffing shortages. Mutual aid is in place for breast screening until the end of July, and reduced capacity within breast symptomatic services was noted due to reliance on a single consultant radiologist. Discussions are underway to secure additional support.
- Oncology: Continued reliance on mutual aid was reported, with gaps across consultant, advanced nurse, pharmacy and radiographer roles.

An update was provided on the planned go-live of a new system scheduled for 15 June, with work ongoing. Improvement work was noted in relation to urgent and unscheduled care assurance, with progress being made. The Maternity Care Standards, launched in March 2026, are expected to be fully implemented within six months. Assurance will be provided through governance structures and external inspection. Members discussed the increasing reliance on mutual aid, the importance of clinician-to-patient communication, and the need for clarity where assurance differs within sections of the report. It was agreed that future reports would split assurance where appropriate to reflect areas of limited assurance more clearly.

L Henderson queried the implementation of the Maternity Care Standards, noting that these were introduced in March 2026 with an expectation of full implementation within six months. She asked whether this would require formal Board-level assurance and suggested that an update should return to the Clinical Governance Committee, potentially in September, to provide assurance that the standards have been implemented.

E Drummond agreed that the Maternity Care Standards should return to the Clinical Governance Committee for assurance and invited Heather Richardson, as service lead, to respond. H Richardson confirmed that work is currently underway to assess how existing maternity service provision aligns with the new standards, and that a first-pass assessment has already been completed, with further work in progress. She advised that, once this work is sufficiently developed, it will be progressed through the appropriate governance structures, including returning to the Clinical Governance Committee, and via the Chief Executive, before any external submission or formal assurance is provided.

N Wright asked how the effectiveness and risks of the Discharge to Assess approach are being assessed, particularly in relation to patient safety and the potential risks associated with progressing this as a system-wide strategy. He sought assurance that the risks involved in accelerating discharge were being properly understood and managed, given the pressures within acute services.

K Sutton explained that Discharge to Assess is being led by Paul Chapman, Professional Lead for AHPs, with responsibility across both acute services and the Health and Social Care Partnership. She confirmed that Discharge to Assess is being implemented in line with national standards, with an initial pilot model tested in the Invergordon area to ensure safety and consistency before wider rollout. The model is now better understood and will be rolled out more broadly, forming part of the wider Discharge Without Delay programme, supported by national expertise and with a strong focus on patient-centred care.

B Peters added that Discharge to Assess reflects a national direction of travel and emphasised that hospitals themselves carry inherent risks. He noted that professional practice and behaviour need to adapt to new models of care that are already well established in other boards. He cautioned against allowing risk aversion to prevent change, highlighting that the current system also contains risk, and stressed the importance of benchmarking against other boards to ensure NHS Highland keeps pace with best practice.

The Committee noted the report and agreed a **Moderate** level of assurance noting ongoing service pressures, mitigations in place (including IMTs and mutual aid), and the request to improve clarity by splitting assurance where specific areas carry limited assurance in future reports.

After discussion, the Committee Noted the content of the circulated report and **Agreed** to take **Moderate assurance**, noting ongoing service pressures, mitigations in place (including IMTs and mutual aid), and the request to improve clarity by splitting assurance where specific areas carry limited assurance in future reports.

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. An update was provided on the implementation of the new Child Health System, covering five digital components. A previously planned go-live in December was deferred due to system issues. A further planned go-live was scheduled for the following week but had again been paused due to outstanding system bugs, particularly relating to vaccination safety. A revised go-live date was anticipated, subject to final clinical assurance, with Louise confirming she holds responsibility for clinical sign-off. CAMHS and Psychological Therapies performance updates were noted, including ongoing monitoring of RTT performance and service pressures, consistent with earlier agenda items. The report highlighted significant concerns in A&B community paediatrics, reflecting workforce fragility and capacity challenges. These issues were noted as being escalated through the Infant, Children and Young People's governance structures, aligning with the limited assurance position reported elsewhere.

S McMillan asked for clarification on the extension of services for care-experienced young people up to age 26, noting that this extends well into adulthood. He queried the rationale for this extension and whether it could have any impact on capacity or availability of services for younger children and young people.

L Bussell confirmed that extending support for care-experienced young people up to age 26 relates to very small numbers and is intended to provide additional support to a particularly vulnerable group, without significant impact on wider service capacity.

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**, while recognising ongoing risks associated with digital system implementation and workforce pressures within children's services.

7 INFECTION PREVENTION AND CONTROL REPORT

L Bussell spoke to the circulated report noting ongoing monitoring of infection prevention and control indicators, including assurance arrangements relating to outbreaks, environmental controls and water safety. An exception was highlighted in relation to water safety assurance, specifically noting that the report referenced a meeting where Estates and Water Safety Group representation had not been present. It was confirmed during discussion that this lack of representation was not routine and represented an exception rather than normal practice. Officers advised that follow-up action would be taken, with the Chair of the Infection Control Committee asked to ensure appropriate representation and oversight. Further work was noted to clarify and strengthen governance arrangements for water safety, including clearer reporting and assurance routes.

The Committee noted the report and agreed **Moderate** assurance within the overall quality and performance framework.

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.

8 OPERATIONAL IMPROVEMENT PLAN UPDATE

B McKellar presented an update on the Operational Improvement Plan, providing an overview of progress against Scottish Government priorities and key deliverables. He reported that, as at 19 February, approximately half of OIP deliverables were on track, with a number at amber risk and a small number significantly delayed, notably 62-day cancer waiting times, particularly within breast cancer pathways; and implementation of the OpenEyes system for the community glaucoma

service, which had rolled into the new financial year. Bryan explained that delayed deliverables have mitigation and action plans in place and remained within active oversight rather than escalation. He clarified the reporting and assurance route for the OIP, explaining that the OIP is initially reported through the Executive Directors Group (EDG), then to the Finance, Resources and Performance Committee (FRPC), and subsequently to the Clinical Governance Committee, before onward reporting to the NHS Board. He highlighted the challenge this creates in maintaining timely data by the point of Board assurance.

J Mullins asked how the patient voice and lived experience are being captured and reflected within the Operational Improvement Plan, noting that much of the reporting focuses on delivery metrics and milestones. He queried whether there were opportunities to strengthen the visibility of patient experience within OIP assurance, for example by demonstrating how improvement actions align with what matters to patients, rather than performance data alone.

B McKellar acknowledged the need to strengthen this within OIP reporting and discussed ongoing work with colleagues to better integrate patient experience and feedback, draw on staff survey outputs, and develop improved approaches for future OIP updates. He agreed that future reporting should provide clearer narrative and assurance.

The committee noted:
After discussion, the Committee **Agreed** on **Moderate assurance**, noting the progress against deliverables, recognition of ongoing risks (including delayed cancer waiting times and the community glaucoma service), and confirmation that mitigation plans and oversight arrangements are in place.

9 SIX MONTHLY UPDATES BY EXCEPTION

9.1 Women's Services (Maternity, Neonates and Gynaecology) Updates

I Barton and H Richardson spoke to the circulated report covering maternity, neonatal and gynaecology services, including quality, workforce, and governance arrangements. Recent Healthcare Improvement Scotland (HIS) inspections were noted, alongside the publication of new national Maternity Care Standards.

A gap analysis has been undertaken to assess current compliance, identifying key areas for focus including triage, workforce capacity, safety, and family experience. Work is ongoing to prepare for formal assurance against the standards within the six-month implementation period.

Significant workforce challenges were highlighted, particularly within scanning and screening services, with vacancy levels impacting service resilience. Actions underway include local and national recruitment approaches, international recruitment, and targeted stabilisation work, including in Caithness.

A comprehensive review of maternity, neonatal and gynaecology services is in progress, covering medical, midwifery and scanning functions. This includes review of models of care, workforce, culture and leadership, and alignment with national expectations.

Progress was reported in reducing long-wait gynaecology pathways, including a reduction in patients waiting over 52 weeks. Robotic-assisted surgery remains paused pending completion of an external review of adverse outcomes, with this being managed through established medical governance routes.

Strong governance arrangements were described, including cluster reviews, large-scale thematic reviews, and learning from adverse events. Ongoing benchmarking against national reviews (including Ockenden) was referenced, alongside engagement with Highland Maternity Voices and use of Care Opinion feedback to inform improvement.

M Cockburn acknowledged the quality of the report and highlighted the significant pressures and strain on staff, particularly within community teams in North Highland. She drew specific attention to sickness absence, noting that reporting absence as percentages alone does not fully convey the impact on services. Muriel asked that future reports include sickness absence expressed as total hours lost, as this would more clearly illustrate the scale of workforce pressure and support more informed reflection on where additional support might be required.

J Mullins acknowledged the scale and complexity of the workforce challenges across Women's Services, particularly within maternity and related services. He emphasised the importance of understanding assurance in context, noting that the Moderate assurance being proposed reflected robust governance, escalation and mitigation arrangements, rather than the absence of risk. James highlighted the value of benchmarking and external reference points, including learning from national reviews and inspections, to support confidence in the improvement approach. He supported the narrative that assurance should be grounded in process maturity and oversight, even where workforce pressures remain significant.

The Committee noted the report and agreed **Moderate** levels of assurance, reflecting the robustness of governance and improvement activity, while recognising ongoing workforce risks and inspection-related pressures.

After discussion, the Committee Agreed on **Moderate assurance**.

9.2 Organ & Tissue Donation Committee Update

This item has been deferred and will be presented at the next meeting.

10 COMMITTEE ADMINISTRATION

The Chair asked if there was any Committee administration to be discussed. A Chisholm highlighted that the Work Plan is still in development will be brought to a future meeting.

11 CALENDAR OF MEETING DATES

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

2 July 2026
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. She noted, however, that themes such as workforce fragility and reliance on mutual aid would be highlighted through routine feedback, even though they did not warrant escalation as specific agenda items.

13 ANY OTHER COMPETENT BUSINESS

The Committee did not have any other competent business.

14 DATE OF NEXT MEETING

The Chair advised the Members the next meeting would take place on **Thursday, 2 July 2026** at 9.00am.

The meeting closed at 11.30am