

**Minutes of NHS Shetland Clinical Governance Committee (CGC)
Held on Tuesday 17 March 2026
09:30 – 13:00 via TEAMS**

PRESENT

Mr Joe Higgins - (Chair) & Non-Executive Member of the Board	Mrs Kathy Hubbard - Non-Executive Member of the Board
Mr Bruce McCulloch - Non-Executive Member of the Board & Chair of Area Partnership Forum (APF)	Mr Colin Campbell - Non-Executive Member of the Board

IN ATTENDANCE

Prof Kathleen Carolan – Director of Nursing and Acute Services & Joint Executive Lead	Ms Edna Mary Watson – Chief Nurse Corporate
Mr Colin Marsland – Director of Finance	Susan Laidlaw - Director of Public Health
Mrs Mary Marsland – Minute Taker & CGC Admin Support	Jo Robinson – Director of Health & Social Care
Mr Antony McDavitt - Director of Pharmacy and Interim Depute Chief Officer	

CONTRIBUTING TO AGENDA

Ms Carolyn Hand – Corporate Services Manager (<i>Agenda Item 15</i>)	
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1. Welcome and Apologies

The Chair commenced the meeting, outlining the committee’s primary objectives. It was noted the agenda does not include any guests or items requiring policy approval. The committee were informed it had been originally planned to have a focus on sub-national planning, however, as there has been an extraordinary Board meeting called on this subject, and after reviewing the executive summary, it had been decided not to proceed with that agenda item at today’s meeting.

Updates regarding material from Health Care Improvement Scotland on the definitions of Best Care will be addressed towards the end of the meeting.

Apologies were received from Kirsty Brightwell, Joint Executive Lead & Medical

Director, and Ms Michelle Hankin, Clinical Governance & Risk Team

2. **Declaration(s) of Interest**

There were no declarations of interest raised.

3. **Approval of the CGC 09 December 2025 Minutes**

The Chair thanked Mary Marsland, Committee Administrator for the excellent meeting notes.

The minutes were approved as an accurate reflection of the previous meeting.

4. **Matters arising from the minutes**

There were no matters arising.

5. **Review of Action Tracker**

The outstanding open actions from the previous meeting were reviewed and discussed:

- **The current situation re the Independent Market Street Dental Practice:**

It was noted the provisional practice certificate is still in place

A forthcoming inspection is planned for June. Although progress has been made, certain concerns persist. It is recognised that not all required improvements have been sustained, therefore, these areas remain a priority, with appropriate resources allocated to support sustained progress.

Ms Laidlaw updated the committee on the recent Infection Control issue and measures taken to address this

It was agreed this item remains open, due to the live Infection Control issue.

Open

- **The Chair requested a specific session on lessons learned and implemented via adverse events at the December meeting to identify themes and gain assurance of implementation.**

The committee had previously agreed to postpone this initiative until the new framework has been fully implemented and integrated. Once complete, the

committee will undertake an in-depth examination. Edna Mary Watson to notify when appropriate to proceed, meanwhile this item remains as open within the

action tracker to ensure it remains a holding status.

Open

- **Quality Update Report - Health Services delivered under the Partnership**

Although documentation was presented late yesterday, the action as written from the September CGC meeting remains. When addressed further within the agenda the committee is expected to identify the specific requirements for the CGC data set.

This item is to remain as open and will be revisited once addressed further on within the agenda.

Open

- **Feedback and Complaints 2024 – 2025 Annual Report**

Ms Watson was to meet with Ms Hand to review complaint outcomes and the new adverse event framework, aiming for closer collaboration, using the lessons learned template for tracking insight.

This task had not been completed due to time constraints; however, it is anticipated that it will be finished prior to the next meeting.

Open

- **Whistleblowing Cases (Stage 2) Governance of Clinical Action Plans and Lessons Learned**

This action focussed specifically on the approaching 18-month period. In light of this, there is now a need to establish target closure dates for outstanding actions. The paper that has been produced for this meeting addresses this requirement, reflecting current status and proposed timelines. Therefore, this item can be closed.

Equally the outstanding INWO Oral Maxillofacial Service Whistleblowing case can also be closed due to an update further on within the agenda

Close

- **Recommendations to Audit Committee for proposed IA activity**

In regard to the current mental health plan being a suitable suggestion, Jo Robinson informed the committee that she would value continued oversight of the mental health team and requested further time to determine the most suitable approach.

The Chair noted that an update was still required from Prof Carolan on whether maternity and obstetrics should be proposed as a potential future audit area. He also confirmed that a previous action for Ms Marsland to circulate earlier audit reports had been completed and closed.

Close

6. **Operational Clinical Governance Group (OCGG) 18th February 2026 Decision Note**

Ms Watson presented the key updates, highlighting the main areas of discussion, progress and assurance.

Key discussions focussed on:

- Professional assurance frameworks across different professional groups, which was seen as positive development.
- Annual review of the OCGG Terms of Reference which will be brought to the June CGC meeting for final approval.

ACTION EMW

- Clinical Guidelines were discussed which were heavily maternity focussed. It was noted this reflected the continuing attention and scrutiny on maternity services and the ongoing work to strengthen clinical practice through updated guidance. These were subsequently approved at the Joint Governance Group (JGG).
- Four flashcard reports were considered. An additional key update was the first report from the newly appointed team leader for children and young people's occupational therapy and physiotherapy services, which is now being managed under a single structure.
- Regular updates included, the Council Lead Team, Obstetrics & Gynaecology (Obs & Gynae) presented by Jackie Whitaker and the Hospital Transfusion Committee by Prof Carolan.
- Hot topics and emerging issues included concerns around cold body storage capacity before the Christmas period, leading to a temporary arrangement for both the hospital and local undertakers within the Gilbert Bain. A more sustained solution will be forthcoming shortly.
The group identified both existing and new risks related to specialist service capacities, highlighting challenges with some of the services we rely on. This promoted a productive discussion, where support was expressed for escalating these concerns within the organisation.
- Prof Carolan indicated plans to review local safeguarding and public protection services, recognising the need to further strengthen our approach to those areas. The Chair proposed that the CGC receive an update on progress of this work at its June meeting.

ACTION Prof Carolan

The Chair noted the flashcard updates provide a useful insight, highlighting both positive aspects and genuine challenges encountered in daily operations. These meetings facilitate constructive dialogue regarding current realities and strategies for addressing various obstacles, which is further observed through CGC walk-rounds.

The committee agreed to a Comprehensive Level of Assurance

7. **Joint Governance Group (JGG) 05th March 2026**

Ms Watson updated the committee on the main highlights from the meeting, these were:

- Several projects are currently being overseen, including the Hospital Electronic Prescribing and Medicines Administration (HEPMA) and Immediate Discharge Letters (IDL) updates, with concerns raised around timescales and completeness of the rollout. Work, in collaboration with Grampian staff to implement Core Document Development is in progress, however, NHS Grampian has not provided a clear timeframe, which increases risk for our organisation. The issue is being escalated, and advice on anticipated progress is being sought as the risk remains open.
- A short life working group has been established to develop a Neurodevelopmental Pathway. Recruitment for a neurodevelopment nurse is underway, with limited

interest initially, however several candidates expressed an interest as the deadline approached. Follow up conversations are to take place.

- The Accelerated National Innovation Adoption (ANIA) which is an innovation project received an update on the gene sequencing for stroke management with a plan to go LIVE at the end of April with the appropriate testing of drug administration following that. Another ANIA project focuses on diabetes and weight management for individuals with type 2.
- The Healthcare Improvement Scotland (HIS) National Adverse Event Framework has already been highlighted. Efforts are ongoing to implement this locally, with the objective of presenting it at the CGC meeting in June for final approval.

ACTION – EMW

The Chair enquired if the dental risk was being presented at the upcoming Risk Management Group (RMG).

Ms Watson noted due to the number of issues for discussion within the meeting, this was to be delayed but would be presented at the following RMG meeting in May.

The committee agreed to a Comprehensive Level of Assurance

8. CGC Annual Work Plan – 2025 – 2026 Year End Review

Ms Watson noted the work plan covers the areas of safe, effective, person-centered, population health and assurance, which is core to this committee. Examples from each area were:

- Safe: Ongoing risk management activity and oversight of whistleblowing cases, including complex investigations.
- Effective: Regular review of OCGG/JGG outputs, national audit participation, and dissemination of national guidance.
- Person-Centered: Patient feedback gathered via surveys and Care Opinion, with consistently positive experiences reported.
- Population Health: Routine monitoring of infection control, screening, immunization and wider public health activity.
- Assurance: Established governance processes maintained through work plan reviews, committee reporting and annual assurance.

It was noted most workplan objectives for 2025 – 2026 had been achieved, with outstanding items to be carried forward into 2026 – 2027.

The Chair noted that essential topics were reviewed and new items added as needed throughout the year. This approach helps the committee stay aware of changes in the organization and ensures our governance adapts accordingly, which has been done effectively.

After examining the agendas of similar committees from other Boards, the Chair conducted a comprehensive review and did not find any items indicating a major gap within this committee's current activities, which is reassuring. On reflection from a

strategic perspective, the committee appears to be overly focused on immediate objectives rather than longer term Horizons 2 and 3 planning so the Committee should keep this open for review to include Horizon 2 and 3 objectives as appropriate.

The committee agreed to a Moderate Level of Assurance

9. CGC Annual Work Plan – 2026 – 2027 Year Ahead

Ms Watson noted that the format and headers are consistent with those used in previous years as these are the key areas of assurance that this committee seeks to be sighted on.

The risk management strategy for items under “Safe” will be adjusted as the new risk strategy is completed, including developing the board’s risk appetite statement. Healthcare Guardian has indicated that the timeline for this initiative has been revised, with implementation now scheduled for 2026 - 2027.

It was noted self-assessment on HIS Essentials of Safe Care and clinical standards for effective practice are being reviewed which will be covered further within the agenda.

Furthermore, the committee will stay informed of the assurances that will be received from the Strategic Change Oversight Board, as well as those emerging from the sub-national planning agenda.

In terms of person-centered, there is a need to refresh the patient’s experience engagement strategies and to continue learning from feedback and complaints.

Colin Campbell praised the excellent work, confirming the format was effective in terms of a work plan.

He noted when considering the sub-national strategy, the person-centered section – ensuring participation, patient and service user rights, and feedback, it is increasingly necessary and important as we progress into Horizon two and eventually Horizon three.

Ms Watson informed the committee that she intends to discuss Care Opinion with Carolyn Hand as rates of participation remain low.

Mr McDavitt added that national work on rural and island patient engagement, including community impact assessment and strategic needs assessment approaches, may provide useful opportunities for local applications. It was also noted that Shetland is well linked into this work through sub-national planning arrangements.

The Chair welcomed the points raised and noted that rural and island issues were reflected in the paper for Board consideration, with further details expected to be covered within the full meeting pack.

The committee did not propose any additional amendments to the plan.

The Chair noted the committees purpose remains unchanged and that the 2026 – 2027 work plan carries forward core priorities, updated to reflect Scottish Government requirements and sub-national planning.

The committee approved the year-ahead work plan

10. **Draft CGC 2025 – 2026 Annual Report & Certificate of Assurance for Approval**

The Chair reminded the committee that as a standing committee of the Board, it is required to produce an annual report to inform the governance section of the Annual Report and Accounts.

It was advised that the annual draft report had been updated following feedback from the non-executive members and provides a factual account of the committee's business and conclusions against relevant governance requirements. It was noted that no significant areas of concern for escalation had been identified for inclusion within the governance statement.

It was noted the Certificate of Assurance would be finalized and dated on or after 3rd April 2026, subject to any matters arising before the end of March.

The committee approved the 2025 – 2026 Annual Report

11. **Whistleblowing Cases (Stage2) Governance of Clinical Action Plans and Lessons Learnt - Update on progress against the Action Plan Part A**

Jo Robinson noted the Mental Health Team, in collaboration with colleagues across the organisation, have continued to make progress on these actions.

The committee were informed a pragmatic approach had been taken to focus on actions that add value to service delivery, patient safety and quality.

It was noted of the remaining actions, six were complete with three on track, with the Service Specification for Mental Health in draft form and is awaiting sign off.

Of the remaining fifty-five actions, thirty-four are now complete, with a small number proposed for closure where they were no longer considered critical or had been addressed through other means.

It was noted that recruitment to substantive consultant psychiatry post remains challenging; however, current postholders are providing committed leadership and was not considered to present a current clinical risk. Of the remaining fourteen actions, nine are on track, two are yet to be started and two need to be followed up with a bit more detail.

Overall good progress was reported, and the service was described as significantly improved.

Kathy Hubbard wanted to formally express her deep appreciation for the immense challenges faced by the overburdened Mental Health Team. Their diligence and determination in tackling this issue has been remarkable. The effort and commitment involved is fully recognised and appreciation was conveyed for all they have done.

Bruce McCulloch echoed Ms Hubbard's sentiment, noting this improvement and is reflected in increased staff engagement through iMatter.

Mr Campbell agreed with his colleague's comments, highlighting that the Mental Health Team is now managed effectively. He supports the systematic approach, acknowledging the need to carefully evaluate remaining tasks and set priorities. This method strikes a sensible balanced tone, and he fully supports following this direction.

Ms Watson recommended adding completion dates in the next version, as most items are either nearly finished or are already complete. This would clarify when each task is completed and would serve as a useful metric.

Ms Watson noted that six actions were cancelled after evaluating their impact on the Mental Health Service. However, whistleblowing aims to promote organisational learning. Issues unrelated to Mental Health Services should be confirmed as addressed elsewhere to ensure concerns are not overlooked and the organisation continues to act and learn.

Ms Robinson emphasized the importance of directing efforts towards objectives that are closely aligned with our strategic priorities.

Prof Carolan expressed that some actions aren't well suited to the current reality. While hospital liaison generally works well with community mental health teams, there are issues with out of hours, especially with complex cases. It may help to bring this to OCGG, clarify the problem statement, and work backwards as we did with the neurodevelopmental pathways. Although not fully captured in this plan, more work is needed, and this process could be a way for full system engagement if agreeable.

Ms Robinson was in agreement and thanked Prof Carolan for her suggestion.

The Chair considered the phrasing "cancelled" be amended to reflect the truer picture of the work that has been done elsewhere to render the action void and to avoid accepting actions which are not within the organisation's control to close.

The Chair sought assurance that the Mental Health Service is now more stable and that improvements arising from the action plan will be sustained.

Ms Robinson advised that strengthened management and governance arrangements, improved communication and clearer early warning signs provide greater confidence in the service's ongoing stability, although some challenges remain. It was also noted that learning from the action plan should inform future work by ensuring actions are realistic, achievable and allocated to the appropriate part of the system.

The committee agreed to continue receiving updates until the plan is fully closed.

The committee noted the report

Part B

Ms Watson advised the committee that there was minimal progress to report concerning the Dental & Oral Maxillofacial Service Action Plan, which had initially been presented at the committee's December. The whistleblower subsequently referred the case to INWO and we await their response at this time.

The Chair observed the action plan shared in December indicated most actions were completed. A revised action plan will be provided to the committee following the decision from INWO.

12. **Topics of Emerging Concern – Anything emerging from any area that has specific relevance to this committee**

The Chair informed the committee up until yesterday it had been the intention to discuss updates on sub-national work streams however, as this topic is scheduled for discussion at tomorrow's Extraordinary Board meeting, it was deemed appropriate for the Board to address the matter first.

The work streams will be central and relevant to this committee; therefore, it was proposed these updates be added as a standing CGC agenda item until decided otherwise.

ACTION: The committee agreed to add the updates as a standing agenda item

Previous updates have indicated that the Winter Plan is not yet available. A review of this will be conducted when complete.

13. **Population Screening Q3 01st October – 31st December 2025 Report**

Ms Laidlaw informed the committee the new part-time Public Health Consultant, Dr Karandeep Nandra has now fully assumed the lead public health consultant role for screening, previously held by screening coordinators. This should increase capacity and accelerate progress. He also leads health protection and will soon be chair of the Control of Infection Committee. Due to his part time schedule and unavailability on Tuesday mornings Ms Laidlaw will continue presenting reports to this committee.

The main key points from the quarter three report were highlighted as follows:

- No major national updates on programme activity or uptake this quarter. The first Abdominal Aortic Aneurysm (AAA) screening at Grantfield vaccination centre went smoothly, allowing some to receive both screening and vaccination during one visit. Future AAA sessions will remain at the centre to support prevention activity.
- Bowel screening uptake in Shetland remains high at 75%, above Scotland's average of 66%. National data show lower participation among some minority ethnic groups, but local analysis is limited. A governance meeting on bowel screening is being planned.
- National breast screening is being modernised, with a shift towards a unified national service instead of six regional centres. The effect on Shetland remains uncertain, for now NHS Grampian and the mobile unit continue local delivery on a three-year cycle. Final uptake data from the latest round is still pending.
- Cervical screening uptake has declined both nationally and locally, though Shetland still ranks among Scotland's top areas. This drop is due to post-pandemic impacts and the shift from three-to-five-year screening intervals, affecting current measurement, rates are expected to stabilise over time.
- Lerwick Health Centre is working to increase cervical screening among women who haven't attended, including offering alternative appointments like extra

Saturday clinics. Short-term national funding has enabled extra clinics, and primary care is exploring ways to make these sustainable. Successful strategies may be adopted by other practices.

- New national standards have been published for diabetic eye screening. A governance review meeting is planned for later in the year to consider the programme in more detail and determine whether regular oversight meetings are required.
- A review of governance arrangements for pregnancy and newborn screening is planned for the latter half of the year to confirm if a one-off review will provide sufficient assurance or whether regular meetings are required. It was also noted that changes to heel prick testing standards will need to be reflected locally.

In summary, these are the main assurance matters for this committee. Local cervical screening initiatives are conducted, while breast and AAA screening programmes are managed by Grampian. Meetings will address assurance and governance for pregnancy, newborn, diabetic eye, and bowel screening. The aim is to improve current moderate assurance rating. With Karandeep in the role, there is now greater capacity to advance pending tasks.

The Chair expressed appreciation to Ms Laidlaw for her comprehensive update, noting the planned steps to improve the assurance rating.

Ms Hubbard conveyed her concerns regarding the proposed National Breast Screening programme, expressing the hope that any decision made will consider the unique challenges faced by rural and island health authorities. She further expressed the desire for the continuation of the visiting service in some form.

Ms Laidlaw noted it was unclear whether the east-west sub-national regional factors would have an impact. Any further updates will be provided as developments occur.

Mr Campbell referenced section 2.3.11-Equality and Diversity including health inequalities on page seven of the report, where it mentions and action plan for screening inequalities. Does the Board currently have such a plan in place, and how is success measured? Are there established Key Performance Indicators (KPIs)?

Ms Laidlaw advised that there are currently no specific KPIs for the screening inequalities action plan, which is brief and focused mainly on cervical screening work at the Lerwick Health Centre and improving access to information for people whose first language is not English. It was noted that local inequalities work is primarily shaped by rural and access issues, with learning also shared through national screening networks.

The Chair observed that, as a committee, it can take good assurance on the information presented, along with the potential to progress from a moderate to a comprehensive assurance rating.

The committee agreed to a Moderate Level of Assurance

14. **Control of Infection Committee Q3 01st October – 31st December 2025**

Ms Laidlaw noted the Control of Infection Committee (CoIC) key points:

- The winter infection prevention activity focused on respiratory viruses, including flu, COVID-19 and Respiratory Syncytial Virus (RSV). The hospital experienced outbreaks of COVID-19 and RSV on the wards and flu in the renal unit. Staff were commended for their prompt management of cases through early identification, screening of contacts and use of antivirals where appropriate. Ongoing challenges were noted in relation to bed capacity and limited availability of single rooms during periods of high demand.
- There was a significant flu outbreak within the North Haven Care Home between December and January, during which five residents contracted flu. A formal debrief has been undertaken. While the outbreak was generally managed well, learning was identified in relation to earlier case identification, timely testing and vaccination timing. Positive practice was noted in the outbreak response, including infection control measures and timely access to antivirals. If available, the report into this outbreak will be presented at the next CGC meeting in June.
- A new immunisation dashboard has been developed for the CoIC, providing an interactive view of vaccine uptake across programmes. The dashboard enables comparison of local uptake with national figures, which shows Shetland achieved higher uptake across most COVID-19 cohorts and performed particularly well for children's flu vaccination. It was further noted that the dashboard will continue to be refined and will provide a more accessible overview of immunisation data than traditional reports.
- High Consequence Infectious Disease (HCID) planning and protocols have remained a standing agenda item at recent CoIC meetings, with work progressing nationally and locally. A recent suspected case of Middle East Respiratory Syndrome (MERS) provided a live test of protocol, although High Consequence Infectious Disease (HCID) was ruled out, the incident highlighted areas for improvement, particularly in relation to community presentation pathways and staff familiarity with the protocol. A formal multi-agency debrief is planned to review the incident and inform further refinements.

National work on HCID is ongoing, particularly in relation to Boards with limited capacity to manage patients locally for any extended period. Local challenges were highlighted in relation to suitable facilities and off-island patient transfer arrangements. The recent incident also identified learning in relation to ambulance involvement, with further national guidance anticipated. If available, the multi-agency debrief report on the suspected HCID incident will be presented at the next CGC meeting in June.

A report on the dental infection control issue will be presented to the CoIC and subsequently reported to the CGC, including final figures and outcomes.

- The revision of the Communicable Disease Control policy remains outstanding. Additional capacity is now available to progress this work, with the intention that the revised policy will be brought to the next CGC for approval.
- The CoIC is considering how best to strengthen lay and community engagement, including potential lay representation or alternative approaches. Ongoing visits to primary care practices were also noted to be supporting engagement and improving communication on infection communicable disease matters.

Ms Laidlaw noted current arrangements provide moderate to comprehensive assurance. Further improvement is expected once the revised policy and associated terms of reference are in place. It was noted chairing responsibilities are expected to transfer to Karandeeep.

The Chair thanked Ms Laidlaw for the comprehensive update and noted that the immunisation dashboard provided clear and helpful assurance on vaccine uptake. It was further noted that, while outbreaks are expected to occur, the committee was assured by the response arrangements and the update provided.

The Chair asked whether the recent meningitis outbreak reported nationally would fall within HCID arrangements and whether any proactive local response was required.

Ms Laidlaw noted meningococcal meningitis is not classified as a HCID. Assurance was provided in that prevention and management arrangements are in place, including vaccination, public awareness of symptoms, early identification and prompt antibiotic treatment.

Narrative from within the Chat function

Antony McDvitt (NHS Shetland) – We have chemoprophylaxis and treatments as well as part of contingency planning too.

Kathleen Carolan (NHS Shetland) – We would need to make some of the same constraints for patients admitted with meningitis and we have had patients previously.

The Chair noted the Board is prepared as it waits to see if there are any specific instruction received regarding this matter.

The committee agreed to a Moderate to Comprehensive Level of Assurance

15. NHS Complaints & Feedback Monitoring Report Q3 01st October – 31st December 2025

Ms Hand advised that the quarter three report showed a broadly consistent position in relation to complaint volumes and response performance against stage one and stage two timescales. It was noted that quarter four had been significantly busier, with increase complaints, concerns and Member of Scottish Parliament (MSP) correspondence. An increase in follow-up queries on complaint responses was also reported, alongside emerging themes relating to access to care, partner board issues, particularly NHS Grampian, and delays in responding to subject access requests, although improvement in the latter was noted.

Positive progress was reported on implementation of the new reporting system, with further work underway to confirm deliverable timescales and review the complaints module. It was further noted that a second cohort of staff are due to undertake Scottish Public Services Ombudsman (SPSO) investigation training shortly.

The committee noted ongoing capacity pressures in relation to complaint investigations and follow-up reviews. Ms Hand advised that staff nominated for SPSO investigation training had been identified by Directors and teams based on local need, although no direct correlation had been taken between training uptake and areas of highest complaint volume. It was further noted that capacity within the complaints team remains challenging, with delays in progressing investigator reports, despite additional funding capacity.

Prof Carolan noted that a growing proportion of complaints related to access to, and engagement with, other NHS providers, particularly NHS Grampian. This is placing additional pressure on NHS Shetland, which is frequently acting as an intermediary for patients. The ongoing high number of complaint and concerns is expected to persist, creating considerable strain on staff. A recommended strategy for handling this workload should be devised and presented to the committee to help ensure a sustainable solution.

Ms Robinson noted that a number of complaints relate to concerns that conditions, particularly cancer, should have been identified earlier. In many cases, review indicates that care had been managed appropriately. Clearer communication with patients throughout care was required.

Mr McDavitt noted complex complaints often require longer timescales to ensure appropriate engagement across all teams involved and to support a thorough response. Positive feedback was reported following recent complaints training, which had been targeted through a local training needs exercise. Complaint handling continues to require support across services to help manage uneven workload distribution.

Ms Laidlaw noted that learning from complaints should focus, where possible, on preventing complaints arising in the first instance. Cleaner communication with patients throughout care pathways, using language that is easy to understand, was identified as an important factor in reducing misunderstandings and supporting earlier local resolution. Staff who have undertaken investigation training may be able to provide support to other teams where appropriate.

The Chair invited Mr Chitticks reflections on the range of pressures affecting complaints handling, including circumstances where NHS Shetland is the visible point of contact despite not being the provider, associated workforce pressures, and whether national discussion or shared learning may help inform local approaches.

Mr Chittick noted that further discussion was required at Executive Management Team (EMT), and also including engagement with NHS Grampian at the appropriate senior level. He also highlighted the need to support patients through complex pathways in a person-centred way, address the current backlog, and recognise the impact of wider information governance pressures, including FOI demand and reduced senior medical capacity, on complaints handling.

Mr Chittick noted that current complaints pressures reflect wider system demand, patient expectations and challenges in supporting people through complex pathways in a person-centred way. He also noted a likely link with increased information governance requests, including access to notes, and advised that a focused session would be helpful to review the end-to-end patient pathway, complaints handling arrangements and options for improvement.

Narrative from within the Chat function

Antony McDvitt (NHS Shetland) – The internal learning for external providers where it is care shared across organisations is also a potential weakness in how the learning is then implemented within the other organisation.

Kathleen Carolan (NHS Shetland) – There is also some need to support look at how we can support patients to use digital access though telehealth etc as that can sometimes be a feature of concerns raised linked to communication theme

Susan Laidlaw (NHS Shetland) – Yes, I think that is really important as we move towards more digital access

Antony McDavitt (NHS Shetland) - <https://link.springer.com/article/10.1186/s12910-020-0459-6>
Hopefully an opportunity for DFD direction to be influenced by the internal business of delivery organisations into the products that would support good care and good experience of care

Kathleen Carolan (NHS Shetland) - Do we have space to do this on Wednesday at EMT to start the conversation?

The Chair agreed that a focused session would be valuable and emphasised the importance of using available resources to address the underlying causes of complaints, rather than simply expanding complaints team capacity.

The committee agreed to a Moderate Level of Assurance

16. Leadership Walkrounds Q3 01st October – 31st December 2025

Ms Watson noted that the leadership walkrounds undertaken between October to December 2025 included visits to the Community Nursing Team in Lerwick, Specialist Nurses at the Gilbert Bain Hospital and the Vaccination Centre.

Positive culture, staff engagement, peer support and patient focus were highlighted across all teams.

Challenges were noted in relation to communication between acute and community services, complex discharge planning, workforce pressures and succession planning in small teams.

Digital systems were also identified as a key theme, with the move to an electronic patient record expected to support community nursing.

The vaccination centre model was noted to be working well, supporting delivery both centrally and in local communities.

It was further noted that walkrounds were paused in quarter four to allow review of the format, with relaunch planned towards the end of quarter one.

The Chair noted the committee receives updates regularly, and it is clear everyone recognises their value across multiple areas. Whilst the decision to pause them is understood, it is hoped the interruption will be limited to the current quarter and that updates will resume promptly thereafter.

The Chair sought assurance regarding public toilet provision at the vaccination centre. Mr Chittick advised that building consent and planning arrangements are being processed.

The committee agreed to a Comprehensive Level of Assurance

17. Quality Score Card incorporating the QMPLE Report

Ms Watson presented the regular report, noting that of the forty-six KPIs, twenty-six were rated green, three amber and nine red, with eight awaiting update due to reporting timescales.

Key points noteworthy were:

- There were no still births, neonatal deaths or cardiac arrests reported within the quarter
- A new postpartum haemorrhage measure has been added to the scorecard, with one case reported within the last quarter
- Falls increased, reflecting patient complexity and wider service pressures
- One hospital-acquired pressure ulcer was reported and is subject to detailed review
- Deep Vein Thrombosis (DVT) risk assessment and review have improved, although recording of discussion with patients on Hospital Electronic Prescribing and Medicines Administration (HEPMA) requires further improvement
- Catheter usage reduced during the quarter, supported by input from infection prevention and control nurses
- Excellence in Care measures continue to be collected, with the range of measures expanded and further new measures under consideration
- There is an ongoing aim to strengthen patient feedback and Care Opinion engagement
- Surgical site infection surveillance remains paused and there is no indication it will restart
- Hospital at Home data has been added to the score card.

- Student placement satisfaction reduced slightly overall, although feedback on person-centred care and team support remained very positive, including where reasonable adjustments were required

Mr Campbell welcomed the inclusion of Hospital at Home data and noted the positive impact of ninety-five patients being treated in the community rather than in hospital.

Mr McCulloch also noted the positive impact of Hospital at Home and commended the staff providing the support.

The Chair also welcomed the inclusion of Hospital at Home data and noted the report provided a broad and stable overview of performance, with action being taken where improvement was required.

The committee agreed to a Comprehensive Level of Assurance

18. **Quality Update Report - Health Services delivered under the Partnership - Quarterly Progress Update**

Mr McDavitt apologised for the late paper and noted that the purpose is to develop a consistent reporting methodology for partnership services delivered under the NHS, enabling the committee to agree the volume, relevance and format of future assurance reporting. This builds on earlier discussions with partnership, planning and primary care colleagues, and further development work will continue to refine the approach and identify any additional areas the committee may wish to include.

The Chair noted that the existing outstanding action stands and that future work is required to develop a report that meets the needs of both CGC. He suggested that it is likely that the CGC reporting requirements would form a subset of the IJB report, and asked Ms Watson to lead further discussion with relevant colleagues to agree the most appropriate data set and reporting approach.

Mr Campbell welcomed the report as a helpful overview of IJB activity and thanked Mr McDavitt and colleagues for their work involved. He noted, however, that the report may contain more detail than required for CGC and supported future refinement to focus it on the committee's assurance needs.

Ms Watson invited members to provide feedback and contribute to discussions on shaping the information to be drawn from wider IJB reporting for future CGC reports.

Mr Chittick welcomed the whole-system view and asked that future reporting place greater emphasis on the impact, timescales and outcomes of improvement work. He noted the need to combine the right quantitative data with qualitative evidence and to reflect wider system changes, including psychological therapies, delayed discharge and Hospital at Home, rather than relying on headline measures alone.

The Chair noted that a wide range of metrics and supporting information may be of value, but emphasised the need for the committee to specify more clearly the data and evidence it most wishes to receive, including case studies, patient surveys and quality improvement work.

Mr McDavitt asked the committee to support further discussion on prioritising assurance and scrutiny activity within finite resources, noting the additional reporting requirements may require trade-offs elsewhere. He highlighted the need to shape CGC and IJB reporting around measures that demonstrate improvement in performance, experience and outcomes over time, and noted that some data remain manually collected and resource-intensive for staff.

Ms Robinson emphasised that reporting to CGC should remain focused on matters within the committee's clinical governance remit, with broader contextual information provided through other appropriate forums were helpful.

Prof Carolan highlighted the whole-system assurance work being undertaken through the Care Home Assurance Group, including qualitative, quality, safe and access measures. She noted that full oversight of this work would sit more appropriately through JGG, but that relevant information could be shared with CGC were helpful and within existing capacity.

The Chair agreed that existing information should first be reviewed and its relevance assessed before deciding what should be included.

Ms Laidlaw advised that further work is underway to strengthen the use of data through a health intelligence approach, drawing on wider resources such as Public Health Scotland. She noted that the aim is to provide more targeted, triangulated information for the right audience and to present a clearer picture of performance and outcomes, rather than relying on large volumes of standalone measures.

The Chair asked members to review the current report pack and provide feedback to Ms Watson in inform further developments of the reporting approach, with an update to be brought back to the June meeting.

ACTION: Members to review the report and provide feedback ahead of June meeting

19. **Clinical Effectiveness Quarterly Report as shared with Joint Governance Group (JGG) Q3 01st October – 31st December 2025**

Ms Watson informed the committee included within the pack is the latest audit and service improvement grid which highlights ongoing audits and anything that is new.

Highlights from the last quarter were:

- Anaesthetic charts reviewed, updates provided on hand injuries and medical handovers
- Positive patient feedback reported for clinical nurse specialist services
- Guidance and Learning Bulletin continues to be issued monthly
- Clinical governance afternoons remain challenging, with two sessions cancelled due to staffing pressures

- Mental health governance session was well received, though attendance was limited
- Governance groups to consider options to improve attendance and sustainability of governance afternoons
- Surgical governance session shared learning from breast surgery, gastrointestinal endoscopy and a complex case review
- Multidisciplinary governance meetings are established and progressing well
- Participation in national audits, including hip fracture and stroke, continues
- Annual stroke review was more positive than in previous years
- Scottish Patient Safety Programme (SPSP) work continues, with a focus on falls
- Adverse event and risk management training is strengthening incident review and learning
- Datix training requirement is improving analysis and lessons learned
- Work to align local documents with the national Adverse Events framework continues
- Ongoing clinical governance advice, information and project support continues

The Chair noted the extensive clinical governance activity outlined provides strong assurance to the committee. Confirmation was sought regarding team capacity and resourcing for the next quarter.

Ms Watson advised that team capacity remains pressured due to staff leave and vacancies, although some backfill has been secured. Recruitment is planned to strengthen the team, but current staffing remains limited.

The committee agreed to a Comprehensive Level of Assurance

20. Whistleblowing Quarterly Report Q3 01st October – 31st December 2025

Ms Watson reported four new whistleblowing contacts in quarter three, with two stage 2 externally commissioned investigations currently underway.

Whistleblowing support arrangements remain in place, with interim Executive Lead cover, a new confidential contact inducted, and ongoing promotion of training and speaking up support across the organisation.

Prof Carolan asked whether local guidance or a policy is now in place to support managers in applying whistleblowing training in practice, noting that the training modules are helpful but generic and may not provide sufficient support for managing specific circumstances within teams or departments.

Ms Watson advised that the local whistleblowing policy remains in draft and is being progressed through governance routes, informed by work from the short life working group and examples from other Boards. It was noted the support for managers is available through the existing managers guide, Executive Lead advice, and confidential contact support where required.

Ms Laidlaw asked whether reports are available to show completion of non-mandatory whistleblowing training across teams or directorates.

Ms Watson advised that while this information is not directly available through the system, training data is received through the quarterly Staff Development report and can be shared with Directors by area if required.

The Chair advised that a letter had been received from the Cabinet Secretary seeking a response by 16th April 2026 on whistleblowing arrangements and supporting evidence. It was noted that a response would be prepared with support from Ms Watson, and that a similar request was expected to be issued to Chief Executives.

Prof Carolan suggested that the response should include the potential value of a more detailed Once for Scotland whistleblowing policy, noting that this could reduce duplication across Boards and support greater consistency in the investigation of whistleblowing concerns.

The Chair agreed that the response would include the value of a more detailed Once for Scotland whistleblowing policy, noting the current lack of consistent national templates and the variation in local approaches.

Narrative from within the Chat function

Brian Chittick (NHS Shetland) – My letter was received on 05th March with a return date of 16th April

The committee agreed to a Moderate Level of Assurance

21. Health and Care Staffing Programme

Ms Watson advised that implementation of SafeCare and e-rostering continues to progress, supported by monthly reporting to Directors and targeted one-to-one support. It was noted that the Allocate system is now in place across almost 92% of the organisation, workforce pressures continue to affect rollout, and a nil return continues to be reported against 150% agency staffing. Two Healthcare Improvement Scotland review calls were completed for in-year, with the same review cycle confirmed for 2026 – 2027, and the annual report is now being prepared for Board approval in April.

The Chair noted the report provides comprehensive detail, adding that it was reassuring NHS Shetland is being recognised nationally as meeting expected requirements.

Colin Marsland noted that the current 150% staffing cost measure applies only to agency staff and does not capture comparable bank usage and is therefore an incomplete indicator of overall staffing cost pressures. He advised that this limitation has been raised with the Scottish Government.

Ms Watson noted while the ask is to report on the 150% agency, additional information is also being requested on bank usage across areas such as finance, nursing, and AHPs, however no equivalent cost figure is currently attached to the data

The Chair sought feedback on user experience of SafeCare, including whether staff found the system straightforward to use in practice.

Ms Watson advised that staff experience had been mixed. While some teams are now using the system effectively, others have required further support and implementation remains ongoing. It was noted that SafeCare is providing useful aggregated staffing information to support operational oversight, and work continues to extend this approach into primary care, although the planned April go-live will not now be achieved.

Narrative from within the Chat function

Kathleen Carolan (NHS Shetland) – It takes time to set up so the data are meaningful for teams to record real time staffing. This is the initial barrier - but not difficult to use in day-to-day practice

Ms Robinson noted that SafeCare requires time to embed and is not fully aligned to some community-based workflows. While this can affect its practical usefulness for some staff groups, work is ongoing to identify pragmatic local solutions and support effective implementation.

The committee agreed to a Moderate Level of Assurance

22. **Adverse Event Report Q3 01st October – 31st December 2025**

Ms Watson reported that two hundred adverse events were recorded within the quarter, with one hundred and twenty-eight case closed, showing improvement on the previous quarter. Most events resulted in negligible or minor harm. Within the quarter there were no new level one reviews, duty of candour cases, category one events, reportable incidents or child deaths.

Progress continues in recording lessons learned, with one hundred and twenty-three recorded in the quarter, reflecting the benefit of training.

Timeliness remains a challenge, with some reviews significantly delayed, limiting learning opportunities.

Ms Hubbard queried whether delays in closing older adverse events may limit the organisation's ability to capture and apply learning.

Ms Watson advised that the most significant adverse events are subject to greater oversight and formal review where required. She acknowledged that delays in closing lower-level events can reduce opportunities for timely learning, although improvements are being seen in the recording of lessons learned and service changes, including updates to shared operating procedures.

Ms Hubbard further queried whether staff feedback about limitations in the system reflected system constraints or user difficulties, and whether action could be taken in response.

Ms Watson advised that staff feedback mainly related to system usability, including navigation and save requirements, rather than user error. She noted these limitations

could not be resolved within the current system, and that the move to Healthcare Guardian would provide an opportunity to simplify forms while retaining essential information.

The Chair noted that adverse event reporting reflects similar resource pressures to complaints handling, although overall performance remains stable. He welcomed the one-page summary and noted that, once the new framework is in place, the committee will undertake a fuller review of adverse events to strengthen organisational learning.

The committee agreed to a Comprehensive Level of Assurance

23. CGC Aligned Strategic Risk Report

Ms Watson noted that the strategic risks aligned to the CGC had shown very little change, consistent with the position reported across most committees. It was reported risk ratings for SR21 and SR22 had reduced to reflect the improved financial position. Estates-related risks remain under review due to their potential impact on clinical services, and a new risk relating to lifts at the Gilbert Bain Hospital is being progressed through the ARMG.

The committee was invited to consider whether future reports should continue to include all aligned risks or only those scored fifteen and above.

Following discussion, the Chair proposed that all aligned risks should continue to be reported, with committee discussion focused on the highest net score pending further consideration of risk appetite through the ARMG.

The committee agreed to a Moderate Level of Assurance

24. Approval of the Approved Medical Practitioners (AMP) List Mental Health Act

The Chair noted that the names on the list remain unchanged from the previous approval. The only substantive change is the introduction of a new list manager role to provide national oversight of training and compliance.

The Chair requested that the cover paper be updated to reflect the change.

The committee was assured that the names remain unchanged from the previous approved list, that those listed continued to hold the required competence, and that the new list manager role provided an additional control which was welcomed.

The committee approved the report and agreed to a Comprehensive Level of Assurance

25. Service Change Governance – Updates from the Strategic Change Oversight Group 25 February 2026

The Chair noted that no formal update had been received from the Strategic Change Oversight Group (SCOG) for this meeting. He reminded members that, at the December meeting the committee had agreed the assurance it expected from SCOG in relation to strategic change governance, including confirmation that clinical quality

and safety standards are being met across projects, that associated risks are being identified and mitigated, and that developments remain aligned with the Care and Clinical strategy. It was anticipated that by the June meeting, SCOG would be sufficiently established to provide the committee with the agreed style of update and assurance.

26. New Clinical Governance Standards Consultation Update

Ms Watson advised that the refreshed national clinical governance standards were launched at the end of February 2026, following a review of the previous standards. She noted that the standards cover seven domains:

- Leadership and Staffing
- Quality Management and Continuous Improvement
- Clinical Effectiveness
- Clinical Safety and Risk
- Education and Training
- Service User
- Patient Involvement
- Data and Information

It was agreed through the JGG that the Board would undertake an organisational self-assessment against each standard, using the national assessment tool and series of focussed sessions. Ms Watson will lead this work, supported by colleagues from the JGG, with a full update and improvement plan expected by December 2026, or earlier if available.

Ms Hubbard welcomed the refreshed clinical governance standards but expressed concern about the potential additional reporting burden and possible duplication with existing arrangements.

Ms Watson advised that the refreshed standards should not create a significant additional burden beyond the planned self-assessment but would provide a timely opportunity to review assurance arrangements across the domains, identify any gaps or blind spots, and test existing evidence against national expectations.

The Chair noted that a gap analysis would be undertaken and that the findings would be reported back to this committee whenever the results are available.

27. “Essentials of Safe Care” Refresh

Ms Watson advised that the “Essentials of Safe Care” had recently been refreshed and now provided a change package across four areas of practice, supported by driver diagrams to aid self-assessment. She noted that, while the framework could be used to review current practice, comprehensive implementation would require significant work across team, department and organisational levels. Further consideration is therefore needed on whether this should be progressed as a formal workstream or used more flexibly within existing engagement with teams.

Prof Carolan suggested that the refreshed standards should initially be considered as part of the work into on developing the professional assurance frameworks to identify any gaps, with professional leads asked to take this forward through their framework review and development work before reporting back through OCGG.

Ms Watson agreed that mapping the refreshed standards against existing assurance frameworks would provide a practical starting point and help ensure the work remains manageable while supporting compliance.

The Chair agreed this should be taken forward as the initial step and asked Ms Watson to keep the committee updated on progress.

28. Next scheduled Development Session

It was noted that the next development session will focus on adult protection services and review of the current delivery model, the date of which will be confirmed in due course.

29. Date of Next Meeting - TEAMS - Tuesday 09th June 2026 @ 09:30

The Chair conveyed thanks to the committee for their contribution.