

NHS 24

**Minutes of the Meeting of the
NHS 24 Clinical Governance Committee
held on Thursday 6 November 2025 at 10.30am
Boardroom, Lumina/MS Teams**

PRESENT

Mr Martin Togneri (in the Chair)
Ms Anne Gibson
Dr Martin Cheyne
Ms Liz Mallinson
Ms Abeer Macintyre

IN ATTENDANCE

Mr Jim Miller	Chief Executive Officer
Mr Patrick Rafferty	Director of Nursing & Care
Dr Ron Cook	Medical Director
Ms Jo Edwards	Director of Service Delivery
Mr John Gebbie	Director of Finance
Dr John McAnaw	Associate Clinical Director
Mr Martin MacGregor	Partnership Forum Nominated Staff Representative
Ms Laura Neil	Lead AHP/Interim Head of Clinical Governance and Quality Improvement
Ms Steph Phillips	Director of Transformation, Strategy, Planning & Performance
Ms Maureen Burns (For Item 8.1)	Lead Nurse Public Protection/Child Health Commissioner
Ms Kerry Foley (For Item 6.1)	Lead Nurse Quality Assurance and Standards
Ms Fenella Hynes (For Items 7.1, 7.6)	Clinical Governance Manager
Ms Geraldine Mathew	Corporate Governance Manager
Mrs Ann Campbell (Minute)	

01. WELCOME, APOLOGIES AND INTRODUCTIONS

The Chair welcomed members present to the November 2025 meeting of the Clinical Governance Committee. Apologies were intimated on the behalf of Jacqui Hepburn, Dawn Orr, Linda Robertson and Jennifer Rodgers.

NOTED

02. DECLARATIONS OF INTEREST

The Chair invited members to declare any interests in any of the items being discussed. There were no declarations made.

NOTED

03. MINUTES OF PREVIOUS MEETINGS

a) Minutes Of Previous Meeting held 7 August 2025

The Committee considered the minute of the previous meeting held on 7 August 2025 [Paper No. 03] and were content to approve the minute.

APPROVED

04. MATTERS ARISING

a) Rolling Actions Log

The Committee considered the Rolling Actions Log [Paper No. 4a] and were content to accept the recommendation that 4 actions were closed.

There was concern about closing action 42 before it was fully completed as the wording indicated that the communication plan was in progress. It was explained that the specific parts of the action, in relation to the public sharing of survey elements, had been completed. The group agreed that the reference to the communication plan in progress was considered irrelevant to the closure of this action.

APPROVED

05. REPORT OF THE CLINICAL DIRECTORS

The Committee considered the paper 'Report of the Clinical Directors' [Paper No. 5] presented by Dr Ron Cook, Medical Director and Mr Patrick Rafferty, Executive Director for Nursing & Care. The paper provided an overview of activities and developments in the Medical and Nursing & Care Directorates.

Dr Cook highlighted the points below:

- The ongoing success of the Advanced Nurse Practitioner programme, especially in its contribution to advancing video consultation capabilities, which were considered vital for wider service transformation.
- National leadership in the promotion of flow navigation was noted, with the primary care toolkit identified as a crucial resource for clarifying service boundaries and benefits to patients, as well as supporting future primary care interactions.
- Notable progress had been achieved in mental health, highlighted by the appointment of a new head of clinical services for mental health and the positive impact of Alison Sharp, the head of psychology, who had provided organisational leadership and made significant contributions to the development of the "held in mind" service.

Mr Rafferty highlighted the points below:

- NHS 24 was well represented at the recent NHS Research Scotland mental health annual scientific meeting, three posters were presented, including two on collaborative projects. Feedback from the event was awaited to inform future activities.
- The staff flu vaccination programme was launched across centres, with a focus on improving uptake compared to the previous year, and it was noted that COVID vaccines would not be provided this year in line with national guidance.

The Chair thanked Dr Cook and Mr Rafferty for the updates and invited comments and questions from members.

A question was raised regarding the evaluation of learning from the second phase of the collaboration with SAS, specifically noting that the monthly uptake of the pathway had remained constant at 51 referrals. There was curiosity about whether this outcome was anticipated and surprise that the number had not varied, with a request for feedback on the matter. It was noted that there had been a recent

evening visit to review service elements, focusing on the referral pathway into NHS 24, which showed promising uptake. It was acknowledged that promoting this pathway, particularly from the SAS perspective, could be beneficial. Discussions with SAS emphasised the value of the pathway, noting successful adoption in some regions, while highlighting areas for improvement in others. Ongoing discussions with SAS were planned to further promote the pathway and encourage greater uptake.

In response to a question about how GPs have reacted to the Primary Care Toolkit, Dr Cook explained that the toolkit is regarded as having significant potential. It has already been collaboratively trialled in both Tayside and Greater Glasgow & Clyde. National engagement is being led by Kerri Neylon, Associate Medical Director for the West, who will consult the Scottish General Practice Committee to guide further engagement. The toolkit was seen as essential for clearly defining the boundaries of services, highlighting the benefits for patients, and supporting the development of a framework for ongoing collaboration with primary care.

A question was raised regarding whether there had been any feedback or response from the government about the reduction in repeat calls and the impact of the initiatives implemented. In response, it was clarified that the combined efforts, including the Advanced Nurse Practitioner model, Prof to Prof, and the Flow Navigation Centre, had attracted national interest. These initiatives were highlighted positively in the annual review, and the team had received favourable feedback, indicating that the work was recognised and on the government's radar at a national level.

In response to a question about how NHS 24 planned to sustainably scale up the advanced nurse practitioner (ANP) model—while ensuring there is a sufficiently skilled workforce to meet demand across all boards—it was explained that a targeted approach was being used. This involved identifying which patient groups were most appropriate for the ANP video programme, recognising that not every clinical triage situation is suitable for this format. The programme had been broadened to include specific age ranges and medical conditions where it was most effective, and its benefit as a clinical tool had been emphasised. Expansion was being managed gradually, with ongoing engagement and consultation with staff and relevant professional bodies. These efforts were expected to help retain staff and support the ongoing development of skills over time.

Clarification was provided that "call levelling" referred to a process where, if a clinician was uncertain during a patient interaction, they could consult a clinical supervisor for advice by sharing the patient's situation and seeking input to confirm the clinical decision. This approach was used to ensure quality and safety by involving another clinician when needed.

NOTED

ITEMS FOR ENDORSEMENT

6.1 PATIENT EXPERIENCE AND SERVICE USER FEEDBACK ANNUAL REPORT 2024/25

The Committee considered the revised paper 'Patient Experience and Service User Feedback Annual Report 2024/25' [Paper No. 6.1] presented by Mr Rafferty, Executive Director for Nursing & Care

The revised Patient Experience and Service User Feedback Annual Report was presented following revision to incorporate feedback from both the Clinical Governance Committee and the Board, focused particularly on content and styling. The report had been updated and circulated recently, with the key figures and national reporting remaining consistent. The new version had been deemed more appropriate for public use, and several minor amendments were identified for correction prior to final Board approval. Specifically, the group noted:

- On page 4, incorrect figure on the infographic was to be corrected
- On page 5, a double negative ("unrelated to non-NHS 24") was to be corrected

- On page 6, the phrase "always where possible" was to be revised

Further layout and wording issues had been highlighted for the graphic designer, all changes were to be made before submission of the report for final Board approval.

The group acknowledged improvements and discussed that the statistics presented on pages 13 and 14 of the annual report lacked benchmarking against previous years, which made it challenging to assess trends or progress. It was noted that while the annual report provided a yearly snapshot, more detailed trend analysis was available in the quarterly committee reports and that ongoing data monitoring was part of regular committee cycles. There was consensus that including more comparative context, especially for public-facing documents, would better demonstrate achievements and continuous improvement.

One Correction was noted - On page 11, 2 references to 'woman' were to be corrected to 'women'.

Action: Mr Rafferty

The Committee were content to endorse submission of the report to the NHS 24 Board for approval of publication on the NHS 24 public website and submission to the Scottish Government.

ENDORSED

ITEMS FOR ASSURANCE

7.1 NATIONAL QUARTERLY HEALTHCARE QUALITY REPORT Q2 (Jul-Sep 2025)

The Committee considered the paper 'National Quarterly Healthcare Quality Report Q2 (Jul-Sep 2025)' [Paper No. 7.1] presented by Ms Laura Neil, Lead AHP/Interim Head of Clinical Governance and Quality Improvement. The paper provided an update on the key activities and developments in relation to clinical governance and quality improvement for the period July to September 2025. Ms Neil provided an overview of the key activities outlined in the report and the below points were highlighted.

It was noted that patient data from Ayrshire and Arran was excluded from the report due to their involvement in the first phase of the digital transformation programme, assurance was provided that the missing data would be incorporated once work on the data warehouse permitted it. Delays in finalising adverse event reports were attributed to both the digital transformation programme and service delivery capacity. Improvements were observed in the complaints process, particularly in categorising stage 1 and stage 2 complaints, with slight progress noted and further improvement anticipated. It was reported that individual learning actions had met the overall target since July, although priority learning had not yet reached its target but was showing improvement. The group then discussed the report in detail, discussion is summarised below

Learning Actions Target: The target for overall individual learning actions was being met or exceeded. It would be reviewed and raised if sustained improvement above the target continues. A review date had already been set.

Adverse Event Reporting: Clarification was sought on the statement about adverse event completion rates, specifically regarding what "remains high" signifies and the standard for comparison. It was explained that the rise in adverse event activity is attributed to enhanced reporting processes. The group noted that more contacts might also lead to a higher number of reported events and suggested that measuring rates, rather than just counts, is being considered. Overall, the higher reporting rate was viewed positively, indicating a cultural move towards better reporting, and is likely to be the new norm.

Adverse Event Report Completion: Completion times for adverse event reports have decreased over the past year, attributed to increased activity and changes in the review processes, including the introduction

Level 2 and 3 reviews with defined timetables. Embedding these changes, particularly for Level 3, has taken time, but efforts such as upskilling senior charge nurses to conduct local reviews aim to improve completion rates. It was recommended that future reports provide commentary on the impact of these changes.

KPI 2 Suspension: It was asked why KPI 2 in complaints was suspended and when it would resume. The response was that a national directive was awaited, and resumption was beyond local control.

Clinical Investigation Timescales: Questions were raised regarding delays in clinical investigation timescales and their potential impact on patient safety, highlighting concerns that delayed learning could lead to repeated issues. The delays were attributed to the ongoing digital transformation programme and reduced capacity, though monitoring and efforts to address overdue cases continue. It was emphasised that future reports should include commentary on actions being taken to address these delays, as timely investigations are important for organisational assurance of clinical safety. Additionally, complaint categorisation is being adjusted to align with other boards (it was explained that too many complaints were previously logged as stage 1, which is inconsistent with how other boards handle stage 1 complaints), which should help improve response times, though statistics for priority learning remain below target and continue to be a concern.

Priority Learning Metric: The metric remained below the 90% target due to the digital transformation programme. The trend was upward, with no decline, and staff are being encouraged to use the process, including requesting extensions when learners are unavailable, making reporting more accurate. It was agreed that more reassurance and clarity on when targets will be met is needed for the Board, as this is a potential patient safety issue.

Organisational Recommendations: There were 55 open recommendations; 19 lacked closure dates. Efforts were underway to improve date-setting and clarify owner expectations. This issue is recognised as a priority and efforts were being made to enhance communication and management of organisational recommendations. The national patient safety group monitored progress, and future reports would include closure dates for all items.

SAS Referrals: A reduction in referrals from SAS to the NHS 24 Mental Health Hub was highlighted, possibly due to leadership changes within the ambulance service, resulting in a lag in engagement, efforts are underway to re-engage with the service and Scottish Government to address the issue. Efforts to re-engage the service and government were ongoing. The availability of additional funding for mental health and Breathing Space was noted, with recruitment underway to improve KPIs in these areas

Cancer Treatment Helpline Licences: It was agreed a licensing question in relation to replacing the Sugar system would be taken offline.

Action: Ms Edwards

Pharmacy Clinical Support Sampling: A concern was raised about a significant decline in the achievement of appropriate outcomes within Pharmacy Clinical Support line, with the drop attributed to the use of a very small sample size meaning the percentage variability can be dramatic. It was clarified that this limited sampling has distorted the figures. The Digital Transformation Programme (DTP) will not address this problem, as the review process remains manual and resource intensive. Efforts are underway to enhance the review process.

eLearning Compliance: It was confirmed the overall eLearning compliance target was being met with no further issues to report.

Mental Health Hub Response Times: A question was raised about erratic statistics for calls answered within 5 minutes. The inconsistency was attributed to staff shortages, which had since improved as recruitment progressed.

Finally, a query was raised regarding the process for reviewing low-demand services, specifically the health and social care helpline, and whether such services might be discontinued. It was clarified that the helpline was introduced as a COVID-19 measure and, due to the very low number of calls, discussions were ongoing with the Scottish Government about potentially ceasing the service. Positive remarks were also made about the increased resources for breathing space. The response was acknowledged.

The Committee were content to note the paper.

NOTED

7.2. RISK MANAGEMENT UPDATE

The Committee considered the paper 'Risk Management Update' [Paper No. 7.2] presented by Mr John Gebbie, Director of Finance. The paper provided an update on all primary and secondary category clinical risks to the organisation as of 2025.

A new risk RI-0037580 had been added regarding access needs of the population and addressing health inequalities. It replaced a similar closed risk and was redefined for clarity. The risk was assigned an existing score of 12, with a target score of 6 and a target date for mitigation actions set for April 2027.

It was agreed that this new risk should be overseen by the Clinical Governance Committee, as its remit more suitably covers issues of inequality, rather than the Staff Governance Committee.

Concern was raised regarding the absence of clear, measurable deliverables for the mitigation actions, resulting in uncertainty as to how the risk score would be halved. In response, it was explained that progress would be evaluated through ongoing engagement and established metrics, with mitigation decisions informed by evidence of active participation and transformation efforts. The committee agreed to ensure that this assessment process is communicated more transparently in the future.

When asked about the pace of mitigations for ICT cyber risk and sector comparisons. It was confirmed that the organisation is well positioned, holding a high cyber security score and working towards further certification, with timelines consistent with sector standards. Cyber risk remains dynamic and ongoing.

The Committee were content to note the paper.

NOTED

7.3 WHISTLEBLOWING UPDATE

The Committee considered the paper 'Whistleblowing Update – Quarter 2 2025-26' [Paper No. 7.3] introduced by Dr Cook, Medical Director who noted that whistleblowing had been covered in the discussion of the previous item. He confirmed there were no new whistleblowing incidents for the current quarter.

Both training and communication plans to highlight the importance of Whistleblowing were ongoing. It was noted that a complex, outstanding concern had been closed, with all related actions completed.

Whistleblowing training performance was previously higher (around 74% currently) and the hope that performance would return to previous levels was expressed, attributing the dip to organizational pressures affecting training completion.

No further comments or questions were raised on this topic.

The Committee were content to note the paper.

NOTED

7.4 HEALTHCARE STAFFING ACT UPDATE

The Committee considered the paper 'Health and Care (Staffing) (Scotland) Act 2019 Quarter 2 2025-26' [Paper No. 7.4] introduced by Mr Rafferty, Director of Nursing and Care.

Mr Rafferty confirmed that the organisation had remained compliant with the legislation throughout the period, noting that all assurance standards were green. No formal concerns or escalations were reported, and it was noted that the staffing establishment had been achieved, supporting both clinical performance and additional activities. The organisation continued to gather evidence of good practice and was recognised as being in a strong position nationally regarding compliance.

A question was raised regarding NHS 24's exemption from the common staffing method, seeking clarification on the alternative model used and how effective, safe service delivery and staffing were measured. It was explained that the common staffing tool was developed for clinical inpatient settings and is not suitable for NHS 24's large contact centre model. Instead, NHS 24 utilised the Verint Workforce Management (WFM) system to align staffing with demand in 15-minute intervals, alongside monitoring sickness absence and receiving national support. Assurance was provided through external audit and review, confirming that NHS 24's approach could not be improved upon given the service's complexity. It was also clarified that the common staffing tool is intended for inpatient wards and emergency departments, with boards required to interpret its local application, and NHS 24's approach had satisfied those providing external scrutiny.

The Committee were content to note the paper.

NOTED

7.5 REALISTIC MEDICINE UPDATE

The Committee considered the paper 'Realistic Medicine Update October 2025' [Paper No. 7.5] presented by Dr McAnaw, Associate Clinical Director.

The below key points were highlighted by Dr McAnaw

- Collaborative questions have been introduced to place greater emphasis on clinical experience and shared decision-making, rather than solely technical and operational aspects.
- Initial results from September were shared, establishing a baseline for assessing the delivery of realistic medicine through patient experience.
- The Sustainability, Climate and Realistic Medicine (SCReaM) network had been created to integrate realistic medicine, sustainability, and climate initiatives, with the aim of engaging and inspiring staff to increase awareness and lead related projects.
- Plans were mentioned for staff-led initiatives, such as one-minute video clips and team talks, with 12–13 staff members already involved and aspirations for further expansion.

A question was asked about the key challenges in advancing realistic medicine, and it was explained that the principal difficulty had been converting access data into meaningful intelligence, particularly in relation to patient journeys and the characteristics of service users. It was also noted that improvements were anticipated with the introduction of a new data warehouse, which was expected to enhance reporting and the measurement of service quality and effectiveness.

Dr Cook commended Dr McAnaw for his outstanding dedication and valuable contributions.

The Committee were content to note the paper.

NOTED

7.6 PATIENT SATISFACTION SURVEY REPORT

The Committee considered the paper 'Patient Satisfaction Survey Report Q2' [Paper No. 7.6] introduced by Mr Rafferty, Director of Nursing & Care.

Quarter 2 patient survey results were presented, the main points highlighted follow below:

- Artificial intelligence was used to generate summaries that highlighted recurring themes and provided insights from qualitative data collected.
- Patient Satisfaction monthly reports are shared with regional and service clinical governance meetings.
- CollaboRATEe questions were introduced and tested during Q2.
- Results indicate that while certain care pathways consistently met set targets, a review for mental health and dental pathways may be required and targets adjusted—potentially to just under 90%—to more accurately reflect real-world outcomes. Any decisions on such adjustments will be made collectively at the organisational level.
- The report has been made accessible to all staff and is published on the intranet.
- Analysis of the feedback identified a key challenge: many negative responses related to issues outside NHS 24's direct control, such as limited access to emergency dental or mental health services following initial contact.
- Improvements are ongoing, including the implementation of better referral pathways (such as direct referrals to oral maxillofacial services) and enhanced engagement with health boards.
- Although AI-driven analysis does not yet fully capture the total volume of feedback, the available data shows that staff interactions have been viewed very positively overall.

The committee, acting as an assurance panel to the board, emphasised the importance of focusing on areas for improvement, particularly by examining negative feedback, which is considered more relevant for driving assurance than the predominance of positive comments. In response, it was highlighted that the quality improvement and evaluation team conducts in-depth analysis, especially in mental health and dental services, to identify opportunities for enhancing the patient journey. Ongoing efforts are being made to use patient feedback for service improvement and to collaborate closely with relevant services.

Regarding the patient survey, the chair inquired about the collaboRATE questions, seeking clarification on whether they were new additions or replacements. It was explained that these questions were initially added alongside existing items during testing; some original questions were subsequently replaced to refresh the survey, but this did not adversely affect the response rate. Crucially, baseline data for the original questions remains available, enabling continuity in tracking progress over time.

The committee also discussed the contrasting feedback between call handlers and healthcare professionals. It was clarified that differences in approach—protocol-based for call handlers and more open, conversational for clinicians—naturally lead to varied user perceptions, which is expected rather than a concern for the organisation.

Another issue raised was the polarisation of user experience feedback, ranging from highly positive ("lifesaving") to highly negative ("a complete waste of time"), with little feedback representing the middle ground. The team acknowledged that strong opinions are more likely to be expressed, particularly in free-text responses, and that this may risk overemphasising a minority viewpoint. Nonetheless, it was

recognised that free-text feedback provides richer insights than previous paper-based methods, although careful calibration is needed to avoid misinterpretation of outlier feedback.

Finally, the use of the validated collaboRATE tool across multiple health boards was noted, supporting assessments of patient-clinician interactions and shared decision making. The committee agreed that interpreting qualitative data requires an impressionistic, rather than strictly quantitative, approach. Board assurance therefore relies on thoughtful analysis and the senior executives' interpretation of this nuanced feedback to inform quality improvements and organisational learning.

The Committee were content to note the paper.

NOTED

7.7 STAKEHOLDER ENGAGEMENT AND INSIGHTS QUARTERLY UPDATE

The Committee considered the paper 'Stakeholder Engagement and Insights Quarterly Update' [Paper No. 7.7] presented by Ms Stephanie Phillips, Director of Transformation, Strategy, Planning & Performance.

Ms Phillips summarised that the team had been focused on supporting the implementation of the new system, especially in partner engagement, and has also been working on capacity building as the organization transitions into service transformation work. Discussion was then opened up to the group.

A question was raised regarding the establishment of a cross-directorate group focused on equalities work, including its formation status and intended participants, with particular interest in public involvement. It was explained that the final meeting of the Equalities Impact Review Group (EIRG) was scheduled and that this meeting would address the terms of reference for the new group. Public involvement was already included in the EIRG, and the forthcoming group was intended to be more operationally focused, with further details to be confirmed and shared after the meeting.

Another inquiry concerned whether there were any hard-to-reach groups that had not yet been engaged in stakeholder activities and whether there were existing gaps in this engagement. The response indicated that the team actively sought to reach these groups through various means, such as collaborating with umbrella organisations, and that no particular group had been overlooked, though ongoing monitoring was in place.

Additionally, a question was posed about the segmentation of feedback from different user groups and whether a more sophisticated analysis was performed. It was clarified that segmentation and targeted engagement were conducted on a project-by-project basis; for instance, bespoke engagement activities had been carried out with young people, those with accessibility needs, and in deprived areas, with the level of segmentation determined by each project's objectives.

The Committee were content to note the paper.

NOTED

7.8 MINUTES OF SENIOR CLINICAL FORUM MEETING

The Committee received the minutes of the Senior Clinical Forum meeting of 9 October 2025 and were content to note these.

Dr McAnaw remarked that the agenda for the recent meeting was shorter than usual, owing to the forthcoming system launch. He addressed questions concerning the organisation's approach to the quality dimensions, reassuring the group that more in-depth discussions on quality are scheduled for

future meetings. Responding to queries about potential changes to the six quality dimensions, Dr McAnaw explained that although the categories have been reworded to improve their relevance, there have been no major or fundamental changes—the primary categories remain aligned with the original government quality strategy but are now tailored specifically to NHS 24.

7.9 MINUTES OF NATIONAL CLINICAL GOVERNANCE GROUP

The Committee received the minutes of the National Clinical Governance Group meeting of 23 October 2025 and were content to note these.

ITEMS FOR AWARENESS

8.1 PUBLIC PROTECTION SUPPORT TO NHS NSS

The Committee received the paper 'Public Protection Support to NHS NSS' [Paper 8.1], presented by Mr Rafferty, Director of Nursing & Care.

Support was provided by NHS 24 to NHS National Services Scotland (NSS) on public protection matters over the previous two to three years, focusing on educational materials, advice, and collaborative relationship-building. The number of cases was small, with only two recorded in the current year, and most support centred on education and governance improvements. This partnership was now formalised through a memorandum of understanding, ensuring ongoing collaboration and governance oversight. Although the case numbers were limited, the arrangement would result in positive developments and strengthen public protection expertise within NSS.

Questions were raised regarding the meaning of "work undertaken" in the memorandum, particularly the reference to "no cost" and whether there was an option to exit the agreement should circumstances change. Clarification was sought on what would happen if the level of required support increased, including whether it would be possible to renegotiate or withdraw from the arrangement given the "no cost" clause.

It was explained that the agreement allowed for four weeks' notice to exit and that the "no cost" clause was intended to provide flexibility if the support or educational requirements changed in future.

Further questions were asked about whether the merger of NSS and NHS Delivery would impact the public protection support arrangement. The response confirmed that, at present, processes remained separate for NSS and NES, and the current agreement would continue. Should the merger result in changes to support needs, the arrangement would be revisited, although there was no established timeframe for when the merger might affect the current support.

The Committee were content to note the paper.

NOTED

ITEMS FOR NOTING

9.1 CC/CRM Training Evaluation Phase 2: Mental Health Hub Training Evaluation Update

The Committee were content to note the paper.

NOTED

9.2 DL-2025-19 - Appointment of First Patient Safety Commissioner for Scotland

The Committee were content to note the paper.

NOTED

COMMITTEE BUSINESS

10.1 CLINICAL GOVERNANCE COMMITTEE MEETING DATES 2026/27

The proposed dates were **ENDORSED**, subject to being checked with the new Chair in due course

10.2 CLINICAL GOVERNANCE COMMITTEE WORKPLAN 2025/26

The Committee considered the Workplan for 2025/26 and noted the planned items for upcoming meetings

10.3 CLINICAL GOVERNANCE COMMITTEE DRAFT WORKPLAN 2026/27

Questions were raised regarding the process for selecting deep dive sessions, seeking clarification on whether these had already been determined. It was explained that there exists a bank of potential topics, and selections are made during an agenda planning session with representatives from the committee and executive team.

There was a proposal to conduct a deep dive session focused on the population health framework and its organisational impact, with a query about whether this should be addressed at committee level or by the full board. The response welcomed such proposals, and it was agreed that this topic would be scheduled as the deep dive topic at the February 2026 CGC meeting to be discussed at the next CGC agenda setting meeting.

The draft Workplan for 2026/27 was **ENDORSED**.

10.4 ANNUAL COMMITTEE SELF-ASSESSMENT OF EFFECTIVENESS SURVEY RESULTS

The Board Secretary gave a collective overview of the results of the committee's self-assessment effectiveness survey which showed that most responses were positive, with most agreeing on the effectiveness of the committee. A small number of responses indicated uncertainty or disagreement, particularly around the areas of training, sufficiency of information in meeting papers, and clarity/prompt circulation of minutes. One outstanding action from the previous plan remained in progress and was set to be carried forward. The discussion also emphasised the importance of balancing comprehensive information for good governance with the need to avoid overwhelming members, favouring concise executive summaries to support effective decision-making.

Action: Board Secretary

The Committee were content to note the paper.

NOTED

10.5 Integrated Governance (Key Points Arising)

It was agreed that the proposed review of National Healthcare Quality Report would be raised owing to possible impingement on what goes to Planning and Performance Committee. Dr Cook/Mr Rafferty will feedback proposed changes to Integrated Governance Committee

Action: Dr Cook/Mr Rafferty

10.6 COMMITTEE HIGHLIGHTS FOR THE BOARD

Ms Campbell to draft the Committee Highlights Report for review and approval by Ms Gibson

11 AOCB

None

IMPROVEMENT UPDATES AND DISCUSSION

12 Psychological Services

Alison Sharp, Head of Psychology, outlined recent developments in Psychological Services, focusing on improving adult mental health access through expanded digital interventions such as the Silver Cloud programme and planned video appointments. A multidisciplinary team had been established to ensure quality, governance, and sustainability, with digital referrals launching soon and further enhancements including group sessions and tailored care for high-intensity users. Clinical psychology's broader contribution was emphasised, encompassing workforce awareness, trauma-informed care, staff well-being and research.

When discussion was opened up to the group, questions were raised regarding several key areas: the exclusion of young people from digital mental health access; the nature of interventions designed for high-intensity users; the impact of psychological support on staff well-being and absence rates; and the potential contribution of psychological expertise to the recruitment of resilient staff for demanding roles, such as those in the mental health hub.

In response, it was explained that the current government focus was on adult services, although digital programmes for children and young people existed and could be rolled out in the future, pending workforce capacity and pilot evaluations. For high-intensity users, a personalised approach was described, which involved assessing unmet needs and working with local boards to develop both proactive and reactive strategies, thereby supporting appropriate service use and reducing system pressures.

Regarding staff well-being, a range of measures were outlined, including the use of digital platforms and apps, reflective practice, supervision, and tailored training, alongside collaboration with HR to address specific needs. It was indicated that psychological expertise could be applied to recruitment processes for resilience-focused roles, though further discussion would be required to tailor these approaches to organisational needs.

Further clarification was given that the initial intention for certain mental health services was to include young people, but the current government directive prioritised adults, with future expansion to children and young people under consideration. Ongoing work in the wider children and young people's mental health space was acknowledged. There was also emphasis on the need to support young people, address long waiting times for neurodiversity assessments, and ensure staff psychological safety and training.

The importance of normalising and validating feelings of distress was highlighted, distinguishing between ordinary distress and disorders requiring intervention, and stressing that not all distress should be medicalised.

Previous work reviewing calls to the mental health hub found a significant proportion of callers had occupational needs, suggesting the value of collaboration between allied health professionals and psychological services. Interest was also expressed in developing self-management advice for those

awaiting neurodiversity assessments, particularly for ADHD or autism, and in drawing on patient safety programmes to enhance psychological safety within the organisation.

A question was raised about the potential for NHS 24 to provide support for individuals presenting at A&E in crisis, particularly young adults whose needs were not fully met in that setting. It was noted that early intervention and prevention through brief safety planning or crisis sessions could help these individuals without requiring full engagement with long-term services, thus preventing premature entry into adult mental health pathways and supporting those in crisis before escalation.

DATE OF NEXT SCHEDULED MEETING

Thursday 5 February 2025, 10am, Boardroom, Lumina/MS Teams.

The meeting concluded at 1:30 pm.