NHS WESTERN ISLES
CLINICAL GOVERNANCE COMMITTEE

BOARD MEETING 26.06.2025
Item 11.3.2

MINUTES OF MEETING
19TH MARCH 2025
HELD AT 10:00AM
VIA MICROSOFT TEAMS

Members Present:

Sheena Wright	Non Executive Director / Whistle Blowing Champion (Chair)
Jane Bain	Non Executive Director / Employee Director
Karen France MacLeod	Non Executive Director / ACF Chair
Annetta Smith	Non Executive Director

In Attendance:

Frances Robertson	Nurse/AHP Director and COO (Executive Lead)
Janice MacKay	Head of IPC, Decontamination and Cleaning Services
Nick Fayers	Chief Officer, IJB
Gill McCannon	NHS Western Isles Chair (Ex-officio)
Colum Durkan	Director of Public Health
Janet Mackenzie	PA to Nurse/AHP Director/COO (Minute Taker)

1. WELCOME / APOLOGIES

Mrs Wright took the chair and welcomed everyone to the meeting.

Apologies noted:

Fiona Mackenzie	Nurse Director
Louise Sullivan	Head of Clinical Governance & Professional Practice
Gordon Jamieson	Chief Executive

2. MINUTES

2.1 Clinical Governance Committee Minute of 11.12.24

A number of changes are required to be made to the minutes.

2.3 Actions points

07.08.24 – 7.1 should read *develop local policy completed by end December but not available and will be verbal today.*

Page 4 – 4.1 first sentence should read *… monitor and inform us by exception.*

Page 4 – 4.2 – Falls Report – *it is a one-off falls awareness day not annual.*

Page 7 – 6.2 – Leadership walk round - 2nd paragraph – *Mrs Wright asked if non-executive Directors were to be included in leadership walk rounds. Ms Robertson confirmed that a programme of leadership walkround to be planned for 25/26 . Happy for Non-Executive Directors to join should they wish.*

Page 10 – 7.3 – Complaints Q2 Summary – Mrs Wright stated that it would be helpful to have further details into the clinical treatment complaints to get more of an understanding and identify areas for improvement.

Page 10 – 8.1 – INWO Investigation Report – We have now gone past the March 25 deadline for fitting the ligature free doors. Mr Fayers has scheduled the work around ward occupancy. The plan is being approached in two phases, therefore the deadline has been extended. The Committee asked for clarity around how they are managing admissions.
Mrs McCannon stated that we cannot delay this work much longer. However, there is a plan going forward and we have to show completion an update will be provided to the June 25 meeting.

2.2 Matters Arising
There were no matters arising for discussion.

Mr Durkan left the meeting.

2.3 Action Points as at 11.12.24
Action – 6.2 – Adverse Events Report
Mrs Bain stated that the transition to InPhase is going to plan, and the project team are meeting on a regular basis and the system will be fully integrated for May.

Action - 6.3 – HIS Inspection. Miss Mackenzie did not schedule a meeting with Mrs MacKay before her retirement. Ms Robertson stated that the group met prior to the first update being submitted to HIS and Mrs MacKay was at that meeting. Mrs MacKay reiterated that IPC were not included in the initial meetings and Miss MacKenzie was going to have a conversation with her about it.
Ms Robertson agreed to have a discussion with Mrs MacKay outwith this meeting. Will be discussed at Mrs MacKay's 1 to 1 in May.

2.4 ADTC minutes – 28.11.24
Issue: The Clinical Governance Committee was asked to note the minutes of the last meeting.
Discussion: These minutes were tabled for information only and for future meetings will be moved to the end of the agenda.
Decision: The Clinical Governance Committee formally noted the minutes.
Action: For future agendas they will be moved to the end of the agenda.

10. AOCB
10.1 Terms of Reference
The Chair took this agenda item next as Mrs McCannon is unable to stay for the whole meeting due to a diary conflict.
Mrs McCannon stated that the Clinical Governance Terms of Reference (TOR) was approved at the Board meeting, although minor changes are still required. One significant change is to increase the non-executive membership from three to four, which will be beneficial, especially if the new member has a strong clinical background. This adjustment aims to strengthen the governance arrangements for clinical governance. The Board approved this increase in non-executive membership. The quorum and remit of the committee will remain unchanged; only the non-executive membership will be adjusted. The minutes will be amended to include the change in membership. All those present agreed to this change in membership.

3. DECLARATION OF INTEREST
There were no declarations of interest however, Mrs Bain noted that there was nobody from Risk Management in attendance at the meeting today and there are a lot of papers associated to them. Therefore, Mrs Bain will support in her capacity as Health & Safety Manager and not Employee Director.

4. ADVERSE EVENTS

4.1 HEPMA

Issue: The Clinical Governance Committee was asked to note the verbal update.

Discussion: Ms Robertson reported that she has not been made aware of any major issues and the system has been successfully deployed across the organisation without any unplanned outages. A planned outage is scheduled for the end of the month to accommodate the clock change, and an additional Clinical Support Nurse (CSN) will be on duty that night to provide support. Prescription issues are being addressed through the adverse events report. Mrs Smith asked if support is being provided across all hospitals, to which Ms Robertson agreed.

It was discussed as to whether this needs to remain as a standing item. It was decided to remove this item and report by exception in the future, and it was agreed to take it off as a standing item.

Decision: The Clinical Governance Committee noted the verbal report.

Action: Agreed to remove from agenda as a standing item.

Mr Fayers left the meeting.

4.2 Falls Report

4.2.1 Appendix 1 – Falls Report Oct-Dec 24

Issue: The Clinical Governance Committee were asked to note the report.

Discussion: Ms Robertson reported that the Health & Safety Team and the Clinical Governance Team have collaboratively reviewed all falls, and the report is tabled for assurance. The total number of falls is decreasing, although there was a slight rise in December, the specifics of which are not known. No patient falls have been reported to RIDDOR. The team is involved in the National Falls Collaborative and presented at the recent Scottish Patient Safety learning event. Falls are sporadic across the three hospitals, with a spike in Medical 1 and an increase in falls observed in OUAB, which will be addressed through targeted work. The Falls Awareness Day was well received and well attended, with plans to hold another one in the future. The team is developing a falls TURAS module, and a detailed falls improvement work report is completed monthly. A falls group is being established, and SBAR and posters have been developed for display around the hospitals.

It was noted that a frequent faller review will take place for a particular patient.

Mrs Smith noted that it is encouraging to see that the number of falls is decreasing and that the interventions are proving effective. She inquired as to whether there are persistent reasons for recurring falls, for example could it be due to specific patients falling repeatedly. She also asked if there were any other specific issues. Mrs Bain responded, stating that nothing has been identified regarding daytime falls or any other particular factors.

Mrs McCannon expressed satisfaction with the improvement work and inquired whether the SBAR tool has been implemented and if tangible outcomes are visible. She questioned why monthly reports are not being received regularly, emphasizing the importance of up-to-date figures to monitor improvement actions. Mrs Bain explained that historically, reports have been issued a quarter behind, but moving forward, they can be made more current. Mrs Bain also mentioned the review of hotspots and frequent fallers, indicating a willingness to adopt these measures and bring a report back to the next meeting.

Ms Robertson noted that the trend in falls for Medical 2 is going down and appears to be staying down, which reflects the ongoing improvement work. Mrs McCannon asked if there are any visible improvements and what actions are being taken with the data collected.

Mr Durkan rejoined the meeting.

Mrs McCannon suggested that having an updated paper by exception would be beneficial, as it provides a more current picture of the situation. She emphasized the importance of having up-to-date information to better understand and address any issues.

Ms Robertson agreed to follow up with Mrs Bain and Mrs Sullivan outside of the meeting to address the action items. She highlighted the importance of understanding the narrative at each table, specifically whether the falls are due to one person having multiple falls or many people having a single fall. Mrs Bain noted that this level of detail could potentially make the individual identifiable.

Mrs McCannon clarified that while they will not be identifying personal details, the data will help identify frequent fallers. This information could be linked to medication, which is crucial to know.
Decision: The Clinical Governance Committee were assured by the report.
Action: Ms Robertson, Mrs Bain and Mrs Sullivan to discuss the report in more detail and make the amendments noted.

4.3 Adverse Events Report
4.3.1 Appendix 1 – Adverse Events Report – Nov 24 to Jan 25
Issue: The Clinical Governance Committee were asked to note the report.
Discussion: Ms Robertson reported that the information was pulled from DATIX, with 308 incidents still pending investigation. Of these, 36% have been investigated. There has been ongoing work to clear some of the historical DATIX entries, with staff being supported in this effort. The three main categories of incidents are medications, slips, trips and falls, and blood and blood products. There were 27 adverse events related to staff accidents and 4 related to waste. The main report on page 4 shows a significant reduction in medication-related incidents, with increased reporting by the Pharmacy Team and the help of HEPMA for better oversight.

Mrs McCannon raised concerns about the historical DATIX entries and the length of time they remain in the holding bay. She suggested including the dates in the report of when incidents were generated, a timeline for completion, and the current status in the table. She emphasized the importance of quickly escalating high-risk incidents and adding a statement to ensure this happens. Ms Robertson agreed to speak to the team and ask for a timeline to be included in the table, including the RAG status and the period of time beyond 90 days.

Mrs Smith noted that delayed learning from adverse events, particularly blood transfusion events, makes it difficult to be confident that learning has taken place. She mentioned that the data is complex and challenging to work through.

Ms Robertson explained that some blood-related issues were due to flight times, while others were caused by samples missing the flight times. The blood transfusion team review these events and report back to the Hospital transfusion committee. Mrs McCannon suggested that there might be an easier way to report this information, noting that it currently seems disjointed across three documents. Mrs McCannon recommended consolidating it into one report for ease of interpretation and analysis, emphasizing the need to understand the learning outcomes and actions taken.

Mrs Wright expressed willingness to meet with Ms Robertson and Mrs Sullivan to discuss this further. Additionally, Mrs Wright mentioned that the date of the next meeting might need to be changed, as Mrs Sullivan is unavailable, and proposed that Mrs Wright and Mrs MacKenzie take this forward.
Decision: The Clinical Governance Committee noted the report.
Action: Ms Robertson to discuss the additional information within the table with Mrs Sullivan.
Mrs Wright to meet with Ms Robertson and Mrs Sullivan regarding the reports.
Mrs Wright and Mrs Mackenzie to discuss the date of the next meeting.

4.4 Significant Adverse Event Review Improvement Plan Tracker – February 2025

Issue: The Clinical Governance Committee was asked to note the report.

Discussion: Ms Robertson mentioned that it would be easier to consolidate the information into one report rather than two, following on from the last discussion. This consolidated report would include a live action plan along with the RAG status.

Mrs McCannon agreed, stating that this level of detail is necessary and beneficial. Additionally, Mrs McCannon suggested adding dates to these as well.

Decision: The Clinical Governance Committee noted the tracker.

Action: Report to be consolidated and dates added.

4.5 Major Haemorrhage Protocol

Issue: The Clinical Governance Committee were asked to note the protocol.

Discussion: Ms Robertson stated that the policy was tabled for awareness as a draft protocol. It has been approved by the Hospital Transfusion Committee and will be reviewed and approved by the Policy Review Group.

There were no comments on the contents of the protocol.

Decision: The Clinical Governance Committee noted the protocol.

Action: No action required.

4.6 Emerging Significant Clinical Risks

Issue: For the Clinical Governance Committee to be made aware of an emerging significant clinical risks

Discussion: Mrs Wright stated that this will now be a standing item on all agendas going forward.

Ms Robertson reported that the main issue is the increasing number of delayed discharges, with 25 currently. 20 in the Western Isles Hospital, 1 in APU and 4 in OUAB. The upcoming closure of Blair Buidhe at the end of April is adding significant pressure, as they need to hold beds in nursing homes to accommodate the move. Capacity has been challenging over the last few weeks. They are encouraging the use of hospital-at-home services, and the involvement of different locums is also having an impact.

Mr Durkan stated that there is nothing to report from him.

Mrs Smith stated that these issues have been discussed extensively at IJB, highlighting the lack of social care, supported accommodation, and assessment delays. She raised concerns about what happens to patients while they are awaiting discharge and the rehabilitation they are being offered. Mrs Smith questioned the intensity of the rehab plans for patients and referred to the HIS report, which raised issues about documentation and planned discharge dates. She emphasized the need to promote patients' health and wellbeing to increase their chances of being discharged. She also noted the pressure on rehab services within the hospital to support patient needs.

Ms Robertson stated that the rehabilitation efforts will continue and priority is given to acute patients, such as those with hip and knee conditions.

Mr Fayers joined the meeting.

Ms Robertson stated that some children come into the Hospital and performed Highland dancing for some of the patients. Ms Robertson will link with Mrs Symington, PFPI Development Officer to explore additional activities to provide stimulation for patients. Staff are doing their best, but it is extremely challenging when wards are at maximum capacity.

Mrs McCannon mentioned that there is a request for Boards to preserve planned care and inquired about the impact on planned care and whether it has affected planned surgeries.

Ms Robertson confirmed that any decisions to cancel elective surgery go through the Chief Executive, who makes the final decision. Over the last few months, there have been approximately 10 such decisions, which are extremely challenging. Securing side rooms for admissions sometimes happens at the last minute. Regularly, medical patients are being boarded in the surgical ward, which is challenging. Since early February, the process has been one admission in and one discharge out, day by day.

Mrs McCannon discussed the Corporate Risk Register, highlighting system pressures and the 2024-2025 timeline. She noted that delayed discharges are grouped with various pressures. There is a disruption in planned care activities. Therefore, delayed discharges should be considered a more substantive risk with specific mitigations around it, rather than being grouped with other pressures.

Mrs McCannon leaves the meeting.

Mrs MacKay noted that patient placement is challenging, with extra beds in the bays becoming the norm, which adds pressure on the wards and reduces space around the beds. She highlighted the lack of social care and suggested that having an activity coordinator within the hospital would make a significant difference for patients. Staff are also struggling with feeding patients due to time constraints, and there is no day room for patients to use.

Mr Fayers reported that the closure of Blair Buidhe has resulted in the loss of 38 nursing home beds, and there is a vacancy gap in care at home due to staffing shortages. He mentioned that he and Ms Robertson will discuss this further outside of the meeting. Mr Fayers emphasized the need for a whole-system approach to find alternatives to admissions, focusing on urgent and unscheduled care and its interface with hospital-at-home services. The priority should be on identifying and implementing alternatives to hospital admissions.

Decision: The Clinical Governance noted the emerging risks.
Action: Mr Fayers and Ms Robertson to discuss closure of Blair Buidhe and staff shortages is more detail.
Delayed Discharges should be considered a substantive risk with specific mitigations. Mr Fayers and Ms Robertson to take forward.

5. INFECTION, PREVENTION AND CONTROL

5.1 HAIRT Combined Summary

5.1.1 Appendix 1 – HAIRT Report October/November 24 & Dec/Jan

Issue: The Clinical Governance Committee were asked to note the report.
Discussion: Mrs MacKay reported that there are 19 alert organisms between the two reports, which significantly increases the staff workload. The Infection Prevention and Control (IPC) team now conduct a root cause analysis for all these patients, a task previously handled by a multidisciplinary team. These incidents are all recorded on DATIX, and Critical Incident Reviews (CIRs) are discussed at the learning review group. Mrs MacKay mentioned plans for a WINE session (NHS Western Isles Nurse Education session) on IPC and catheter monitoring. She also highlighted the importance of cleaning, hand hygiene, compliance with the dress code, and afternoon education sessions with the student nurses. Mrs Wright acknowledged Mrs MacKays concerns.

Mrs Smith inquired if IPC is part of the new staff orientation, to which Mrs MacKay confirmed that hand hygiene is included for new locums as part of the education program.

Decision: The Clinical Governance Committee were assured by the report.
Action: No actions required.

6. QUALILTY & SAFETY

6.1 Mortality Review

Issue: The Clinical Governance Committee were asked to note the review documentation.
Discussion: Ms Robertson reported that the team does complete a review on every inpatient hospital death. Out of 36 deaths, 29 were at the Western Isles Hospital. 28 reviews have been completed, with 11 outstanding due to sickness and administrative demands, and the team is

working on these. Four reviews scored as poor or adequate, 16 as good, and 8 as excellent. The team will identify any concerns and escalate them for a second review by the Lead Nurse. The outcome from the second review might result in an escalation to a SAER briefing note or an action plan with identified learning monitored through the Learning Review Group. Documentation and communication remain significant concerns. The outstanding SAR action tracker is also being addressed. Further discussion will be held at the June meeting.

Decision: The Clinical Governance Committee noted the review document.
Action: Discuss in more detail at the June meeting.

6.2 Leadership walk round

Issue: The Clinical Governance Committee were asked to note the report from the leadership walk round.

Discussion: Ms Robertson reported that last year, three reviews were undertaken. The intention is to reintroduce these reviews with a light touch so that the Executive Team is seen as supportive, and the ward can raise any concerns they have. Areas discussed included contingency bed use, role of the SCN and rehab provision.

Mrs France-Macleod joined the meeting.

The HDU admission policy for Medical 1 will be addressed, and Ms Robertson will work with Mrs MacDonald to plan a wider schedule of visits for 2025. Mrs Wright and Ms Robertson have discussed having non-executives join them going forward. Mrs Bain noted that it is good to see the reviews being reintroduced, especially since there has been a change in SCNs, and it is important to support them.

Decision: The Clinical Governance Committee noted the report.
Action: No actions noted.

6.3 HIS Inspection and action plan

Issue: The Clinical Governance Committee were asked to note the inspection and action plan.

Discussion: Ms Robertson stated that she is happy to take any questions regarding the evidence, as it is a substantial document.

An unannounced visit was undertaken in September 2024, followed by several follow-up meetings. The inspection identified eight areas of good practice and 22 areas requiring improvement. All acute areas within the Western Isles Hospital were inspected, and details of the inspection can be found in the report. Concerns were raised regarding the care of children, fire safety, and other issues.

HIS has requested monthly reports on the action plan for six months, with the final report due on the 17th April 25. Feedback has been minimal, and no concerns have been received, which is positive. Out of 62 actions, 42 are green, and the remaining are amber, with none marked as red. There are 17 amber actions still within their timelines, focusing on training, completion of SOPs, and refurbishment of Medical Ward 2. The dedicated pediatric area was reinstated at the end of December, with a secure bay and side room, and Paxton access for the doors. Efforts are ongoing to de-clinicalize the area, and the Endowment Committee have approved the purchase of chairs that convert into camp beds for parents, along with bright linens and curtains. Significant improvements in training include funding and support for 22 staff in Medical 1 to complete the BASICS pediatric program. Additionally, 164 fire marshals have been trained across the hospital, which is remarkable, and 81.6% of staff in acute services have completed their fire safety training, showing a huge improvement in staff training.

Mr Durkan left the meeting.

It has not been possible to complete the refurbishment in Medical 2 without closing the ward. Plans include installing the legal requirement for ventilation simultaneously, which has been delayed due to the pandemic. The ward will decant to Erisort, with work set to commence in 2026. Additionally, work on the MRI installation will begin this year, impacting Medical 2. The main concern is the showering facilities.

There is currently a lack of a patient call system in the Emergency Department (ED). Once the refurbishment is complete, a full call bell system will be in place. Despite the negative aspects highlighted in the report, it is important to recognize the positive care and feedback from patients and their relatives. There are good staff wellbeing initiatives in place, with Stuart King conducting staff focus groups that have been well received. Ms Robertson thanked everyone for their hard work in completing the action plan, noting that staff have embraced the learning from it and the focus is now on maintaining these improvements. The final update to HIS is due in April, and a re-inspection is expected soon. The Maternity and Mental Health inspection program started in January. The action for Medical 2 will remain amber until the refurbishment work can be completed. Mrs MacKay mentioned that she has linked up with Maternity and conducted several high-level walkarounds in the department, which have been thorough. The Clinical Governance Committee appreciates the significant amount of work done to achieve and maintain these improvements.

Decision: The Clinical Governance Committee noted the inspection report and action plan.

Action: An update on the final report to HIS to be provided by Ms Robertson.

6.4 Integrated Admission Documentation Audit Report

Issue: The Clinical Governance Committee were asked to note the report.

Discussion: Ms Robertson reported that the Quality Improvement (QI) team has completed the work, although it is slightly out of date and improvements have been made. There are plans to expand documentation audits outwith of acute services. The integrated admission document is under review and being updated and is currently undergoing PDSA testing and amendments made and feedback from staff. Medical clerking impacts overall compliance, especially with different locum doctors coming in. Planned discharge dates should be established upon admission.

Mrs Smith noted low rates of medical clerking in surgical inpatients, which affects patient safety and compliance. Ms Robertson mentioned that ongoing work should lead to improvements and that the new Medical Director will be engaged in this process. The appointment of three new surgeons will help, and an update will be provided at the June meeting.

Decision: The Clinical Governance Committee noted the report.

Action: Update in compliance following recruitment of new surgeons to be provided at the June meeting.

6.5 HealthCare Staffing

Issue: The Clinical Governance Committee were asked to note the report.

Discussion: Ms Robertson stated that the annual HCSA draft report will be presented to OSDT next week, followed by CMT, and then back to the Clinical Governance Committee. Staffing Escalation Flow charts are available in all departments.

Ms Robertson stated that we are required to complete quarterly HCSA reports, with the annual report due in April. We are currently working on the report from October to January (Q3), which will be submitted this month. The Corporate Management Team (CMT) has agreed that we will produce a localised version of the HCSA report that covers all the duties within the act.

The focus is on ensuring that we have the necessary processes in place and providing assurance of their effectiveness. Efforts are ongoing to onboard the remaining staff groups to eRoster and SafeCare is considered the gold standard for measuring real-time staffing and risk.

Decision:

Action: Paper to be presented to the June 25 meeting.

6.6 Staff Escalation Plan

Ms Robertson provided a verbal update and will present a paper at the June meeting.

7. CLINICAL GOVERNANCE

7.1 Whistleblowing Report

Issue: The Clinical Governance Committee were asked to note the report.

Discussion: Ms Robertson stated that there were no new concerns raised. One remains open from the pervious time frame.

Decision: The Clinical Governance Committee noted the report.

Action: No actions noted.

7.2 Corporate Risk Register

Issue: The Clinical Governance Committee were asked to note the report.

Discussion: Ms Robertson stated that this item was for information. It is updated monthly.

Mrs Bain stated that some of the actions have retired colleagues against them. Ms Robertson will get this amended.

Decision: The Clinical Governance Committee noted the report.

Action: Owners of actions to be amended.

7.3 Complaints Q3 Summary

Issue: The Clinical Governance Committee were asked to note the report.

Discussion: The report was tabled for awareness. The main theme is that the whole system is under pressure.

Decision: The Clinical Governance Committee noted the report.

Action: No actions noted.

7.4 Clinical Policies and Procedures Update

Issue: The Clinical Governance Committee were asked to note the report.

Discussion: Ms Robertson stated that the annual update regarding the situation is included in the work plan for this meeting. The Improvement Team will provide assurance that the Clinical Policies Group's assessments are complete and sorted in a document management system.

Mrs Bain has raised concerns about one clinical policy being updated and not communicated to staff, resulting in staff being unaware of changes within the policy. It is crucial to disseminate this information as soon as possible.

Ms Robertson stated that on the day we were made aware of the approval, it was promptly emailed to the relevant teams.

Decision: The Clinical Governance Committee noted the report.

Action: No actions noted.

8. COMPLAINTS

8.1 INWO Investigation Report

Issue: The Clinical Governance Committee were asked to note the report.

Discussion: Ms Robertson confirmed that all work that can be completed has been completed, although there are challenges with the installation of the ligature free doors. The group has met to start planning the work, and the engineering team will need a date to begin. While there is no definitive date yet, the work is progressing. The Board will be updated in the interim.

Decision: The Clinical Governance Committee noted the report.

Action: Update to be provided to the June meeting.

9. GOVERNANCE

9.1 Clinical Governance Committee Workplan 24-25

Issue: The Clinical Governance Committee were asked to note the report.

Discussion: Ms Robertson asked if members can approve the tabled workplan.

Mrs Wright stated that members can review the document and report back at the June meeting.

Decision: The Clinical Governance Committee noted the report.

Action: Members to review workplan before June meeting.

10. AOCB

10.1 Terms of Reference

This item was already discussed.

11. EVALUATION

QUESTION	YES	NO	COMMENTS
For Chair only to complete: Was the draft minute and action plan/log received within the 5 day timeframe for you to review? If not state how many days before receipt.			
Were you satisfied that the agenda items presented covered the current significant areas?	x		
Was there sufficient time allocated to all agenda items?		x	
Were the Executive Summaries an accurate reflection of the detailed paper?	x		
Was the information contained within the meeting papers, clear, focused, explicit and enabled members to make information and effective decisions? If not state what information would have helped.	x		
Were you able to contribute to the discussion and have your views considered?	x		
Was there sufficient refreshment breaks?	x		
Did you consider that the CGC discharged its duty in respect of • Proper scrutiny • Relevant questioning • Constructive challenging	x		
Are there any significant issues which should be raised to the Board or Corporate Management Team		x	
Do you have any suggestions for improvement or additional comments about this meeting?			Please update Janet MacKenzie

12. DATE AND TIME OF NEXT MEETING

Venue: Microsoft Teams link
Time: 10am
Dates: 18th June 2025

NHS WESTERN ISLES CORPORATE VALUES & OBJECTIVE 2023 – 2025

NHS
Eileanan Siar
Western Isles

CORPORATE VALUES

EXCELLENCE

- We will ensure that the care we provide is based on evidence of the best available quality.
- We will individually and together strive to make a positive difference to become "the best at what we do".

SAFETY

- We will strive for excellence in safety.
- We will view avoidable harm as unacceptable.
- We will each take personal responsibility for the safety of our patients, colleagues and the public.

CONFIDENTIALITY

- We will ensure that confidentially is maintained in all that we do.
- We will disclose confidential information only with the consent, where there is a risk of harm to the patient or others, or where there is a legal obligation to do so.
- We will treat breaches of confidentiality seriously.

DIGNITY

- We welcome, and will respect and value the wishes, rights and informed choice of the individual to be the person they are.

HONESTY

- We will earn and keep the trust of those we attempt to help, care for and work with.
- We will seek the views and opinions of those we serve, and will be truthful, open and transparent about our failures and successes.

FAIRNESS

- We will make judgements that are based on merit and free from discrimination, dishonesty and injustice.

SELFLESSNESS

- We will neither exhibit or be motivated by concern or gain for ourselves rather, our patients and providing excellent services will be our priority.

INNOVATION

- Encourage innovation by supporting an adaptive and agile culture of continuous improvement.

ACCOUNTABILITY

- We will take responsibility both individually, as an organisation, for achieving the things we agree to deliver in terms of people, purpose, performance and progress.

CORPORATE OBJECTIVES

CO1 To provide person-centred care, focusing on the evidence based health needs of our increasingly diverse population, identifying and taking every opportunity to improve our patients' health, experience and outcomes.

CO2 To protect individuals from avoidable harm by continually assessing and managing risk learning, and improving the reliability and safety in everything we do.

CO3 To champion efficiency and effectiveness in our services that delivers minimum possible waiting times.

CO4 To pro-actively stimulate and intensify our search and application of effective innovation to improve how we care for patients today and into the future.

CO5 To promote and support people to live longer healthier lives.

CO6 To specifically target early years, health inequalities, vulnerable and underrepresented and more difficult to engage with groups.

CO7 To continually improve and modernise our integrated healthcare services and assurance systems.

CO8 To value, support the wellbeing of, and develop and sustain a compassionate, confident, competent, flexible and responsive

workforce.

CO9 To deliver our commitment to partnership working to deliver national standards, targets and guarantees.

CO10 To have a sustained focus on prevention, anticipation, support self-management and care at home.

CO11 To ensure that all resources are deployed to the best effect, achieving desired outcomes, value for money and progressive approach to sustainability.