**APPROVED**

# NHS GRAMPIAN

Minutes of **NHS Grampian Clinical Governance Committee** held in **Open Session** on **Tuesday, 27 May 2025** at 1330hrs virtually by MS Teams

**Present**

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| Mark Burrell (MB) (Chair) | Vice Chair – Non-Executive Board Member / Chair of Grampian Area Clinical Forum / IJB Clinical Governance Representative (Aberdeen City) |
| David Blackbourn (DB) | Non-Executive Board Member |
| Hussein Patwa (HP) | Non-Executive Board Member |
| Dave Russell (DRu) | Public Representative |
| Miles Paterson (MP) | Public Representative |
| John Tomlinson (JT) | Non-Executive Board Member |

**Attendees**

| | |
|---|---|
| Gillian Poskitt (GP) | Associate Director – Quality Improvement & Assurance – Items 5, 10 & 13 |
| Paul Bachoo (PB) | Acute Services Medical Director / Integrated Specialist Care Portfolio Executive Lead – Item 8.2 |
| June Brown (JB) | Executive Nurse Director / Interim Deputy Chief Executive – Items 7 & 8.1 |
| Hugh Bishop (HB) | Executive Medical Director |
| Noha El Sakka (NES) | Infection Prevention and Control Doctor / Clinical Lead – Items 9 & 9.1 |
| Alison Evison (AE) | Chair of Grampian Board / Non-Executive Board Member |
| Lynn Morrison (LM) | Director of Allied Health Professionals – Item 12 |
| Tara Fairley (TF) | Associate Medical Director – Clinical Assurance & Quality – Item 6 |
| Grace Johnston (GJ) | Infection Prevention & Control Manager – Items 9 & 9.1 |
| Susan Webb (SW) | Director of Public Health |
| June Barnard (JBa) | Nurse Director - Secondary & Tertiary Care |

**Invitees**

| | |
|---|---|
| Geraldine Fraser (GF) | Chief Officer - Acute Services – Item 11 |
| Catriona Robbins (CR) | Chief Nurse - Acute – Item 11 |
| Stuart Stephen (SS) | Unit Operational Manager – Item 11 |
| Stephen Friar (SF) | Consultant – Critical Care – Item 11 |
| Rachael Little (RL) | Team Lead - Quality Improvement & Assurance |
| Paula Bray | Quality Improvement & Assurance Administrator (minute taker) |

## 1 Apologies

Noted apologies received from: Adam Coldwells, Dennis Robertson, Derrick Murray, and Emma Houghton. The meeting was quorate.

## 2 Declarations of Interest

There were no declarations of interest.

## 3 Welcome and Introduction

Chair welcomed members, attendees and invitees to meeting.

## 4 Minutes of Meeting on 11 February 2025

Agreed as accurate.

## 5 Matters Arising

Gillian Poskitt, Associate Director – Quality Improvement & Assurance - advised there were 9 items presently contained in the Matters Arising Log, three of which were to be discussed during this meeting. For noting, the Annual Delivery Plan has been embedded within the Annual Statement and will continue in this fashion going forward. For noting, there were two items with no discussion date assigned.

HB reported that he had discussed the Primary Care GP Data with E Houghton and will be reviewing the reports to determine which, if any, would be suitable to report back to the committee.

GP informed that the reporting template previously agreed and distributed to the group, had been superseded by one released recently, which is to be used by all committees going forward. This will be issued to all who provide reports to this group with guidance on its completion. Additionally, the frequency and scheduling of Portfolio reports were addressed, acknowledging that there are more portfolios than committee meetings.

The Chair agreed that the Committee's agenda setting would be utilised to decide if more than one Portfolio will be looked at in any meeting.

GP added there had been an omission identified in the collation and submission of Duty of Candour reports for the past two years. While individual events were appropriately identified, discussed and logged, the overarching reports were not compiled for Committee oversight. This is now being addressed, and the report is in preparation. It will be reviewed on 2 August by the Professional Directors Forum and will be scheduled for later submission to the Committee.

The Chair thanked GP for the information provided.

## 6 Whole System Clinical Governance Group Report

Tara Fairley, Associate Medical Director, Clinical Assurance & Quality presented the paper to the Committee for information and to invite feedback from members to support the ongoing development of the Whole System Clinical Governance Group and the wider operational clinical governance framework. The report summarises 18 months of work aimed at strengthening and aligning clinical governance arrangements across NHS Grampian, Moray, Aberdeenshire and Aberdeen City Health and Social Care Partnerships. The objective is to ensure that the appropriate staff are reviewing and discussing the relevant issues at the right time, facilitating timely local management, effective escalation, and consistent feedback to staff.

The work seeks to establish a coherent and standardised approach to clinical governance processes, supporting improved oversight and routine reporting to the Chief Executive Team. The framework is intended as a reference model for operational and tactical governance rather than a mandated structure, allowing services to benchmark existing processes while promoting greater consistency.

A gap was identified in whole system operational-level clinical governance oversight, leading to the formation of a Whole System Clinical Governance Group, which first met in October 2024. The group functions as a forum for information sharing, peer support, and collective decision-making in relation to serious or persistent clinical governance concerns. It aims to improve system-level visibility, support mitigation planning, and ensure effective escalation and feedback mechanisms.

The group has adopted a paper-light approach to encourage open and discursive engagement, welcoming early-stage concerns to support shared awareness and proactive management. Early meetings have been constructive, and the intention is to continue to develop this approach as part of strengthening clinical governance across the system.

The Chair welcomed the paper and the proposed approach to strengthening Clinical Governance arrangements, noting that progress appeared to be slightly ahead of schedule. He acknowledged the positive direction of this and reflected on feedback from the recent portfolio review and associated questionnaire, which suggested that Clinical Governance may have been less effective following the portfolio restructuring. This was noted as a key theme in the outcomes presented recently.

In considering the proposed clinical governance structure, the Chair queried how the Clinical Governance Committee would be positioned within the overall governance framework, particularly in terms of its reporting relationship to the NHS Board.

TF clarified that the routine reporting line for the WSCGG is to the CET. However, it was acknowledged that regular engagement with the Clinical Governance Committee is also important. As outlined in the paper, an annual report from the WSCGG to this Committee is proposed to ensure appropriate oversight and alignment.
The group is also expected to act as an early forum for identifying significant clinical governance issues. While it will not routinely report on all its activity to this Committee, any matter of serious concern arising from a particular portfolio or service area would be escalated through the CET for consideration by this Committee.
SW raised two points in relation to the paper. Firstly, with reference to the recommendation concerning co-chairs and the specification of job titles, it was suggested that consideration be given to identifying the competencies required to chair the group effectively, rather than defining the role solely by title. Secondly, while acknowledging the operational nature of the agenda, it was noted that the content appeared predominantly acute-focused, and the connection to the broader areas covered within the Clinical Risk Management framework was unclear. Further clarification on how the various components align was requested.
TF responded, with regard to the recommendation on co-chairs and the specification of job titles, it was suggested that consideration be given to outlining the competencies required to chair the group effectively, rather than defining the role solely by professional title. Secondly, while the operational focus of the agenda was acknowledged, it was noted that the content appeared primarily acute-focused. The link to the broader domains within the Clinical Risk Management framework was unclear, and further clarification was requested on how these elements are intended to align.

There followed more points from further members of the Committee and extensive discussion of all points raised.

The Chair thanked TF for her presentation to the Committee.

**Recommendation:** The Committee is asked to note this paper for information and provide feedback to help in the further development of this group.

The Committee agreed and accepted the recommendations.

## 7 Clinical Risk Meeting (CRM) Report

June Brown, Executive Nurse Director/ Interim Deputy Chief Executive noted that this would be the final iteration of the paper in its current format, as future reports will separate out the strategic risk content. Going forward, strategic risks will be reported at a higher level, and this paper will focus solely on activity emerging through the Clinical Risk Meeting (CRM) process.
In summarising the content of the current report, it was highlighted that ambulance turnaround times continue to fluctuate and remain challenging. This in turn impacts the use of non-standard patient areas across the system, which, while not reaching previous peak levels, continue to be utilised. In March, assurance walk rounds were conducted in these areas, and feedback from staff and patients was generally positive, though learning points were identified.
Additional inpatient capacity remains in operation across the system, particularly at Rosewell and Ward 309, and will continue to be used while wider system solutions are explored. Work has commenced on integrated care pathways, which may influence the currently paused bed-based review, particularly in relation to Cardiology, Orthopaedics, and Endoscopy.
It was reported that quality indicators for falls show a positive trend based on data from March 2024, suggesting an encouraging shift. This improvement is attributed in part to focused work within the SPSP acute workstream.
The Committee was invited to note the paper and the planned change in reporting format for future submission.

The Chair thanked JB for her very detailed report and added his attendance at these meetings had provided him assurance that these reports are being looked at on a weekly basis, which is reassuring.

**Recommendation:** The committee is asked to
review and scrutinise the information provided in this paper and confirm that it provides assurance that a reasonable and proportionate response is in place to minimise harm to patient and staff.

The Committee agreed and accepted the recommendations.

The committee was also asked to confirm if any escalation is required to another board committee or the board and specify the details of that escalation.

The committee agreed this was not necessary.

## 8 Strategic Risk Report

### 8.1 Risk 3068 Service Deviations

June Brown, Executive Nurse Director/ Interim Deputy Chief Executive informed it has previously been confirmed that each strategic risk will be reported to the Clinical Governance Committee twice yearly. The paper relates to the strategic risk concerning deviation from standards of practice and care delivery. The risk has been reviewed in the context of current complaints, particularly those relating to non-standard patient areas, alongside staffing considerations and existing controls.
At present, it is not considered possible to reduce the risk rating from intolerable due to the sustained pressures on the system, despite a range of mitigations in place. While several positive developments are under way, including the Route Map work focused on care pathway redesign and shifting care into community settings, these are still in progress and have not yet had measurable impact on the risk level.
Assurance remains limited in terms of the effectiveness of risk management, although continued monitoring of patient experience in non-standard areas is ongoing. The number of patients accommodated in such areas has increased in recent months, reflecting continued capacity challenges. It is anticipated that the development of integrated acute pathways will contribute to future improvement.
The chair raised a question regarding the impact of delayed discharges on this risk, noting that from the perspective of Aberdeen City IJB, and across the wider system, performance in this area continues to fluctuate. While some improvement has been seen, the situation remains variable and appears to have a sustained influence on system pressures.
It was further noted that, despite ongoing efforts, this risk has proven resistant to change over time. Concern was expressed that the continued use of non-standard patient areas may be becoming normalised. The Committee was clear that this model of care is not to be regarded as standard practice, and it was agreed that this position should be explicitly recorded in the minutes.

JT sought clarification on the extent to which progress in addressing the risk is dependent on additional financial resource. While recognising the complexity of the issue, it was suggested that greater transparency around what can be delivered within current resources versus what could be achieved with additional investment would be helpful. Such an approach would support clearer planning and prioritisation, not only in relation to this risk but also across other areas of clinical governance and the broader system.

JB responded, it was clarified that the query primarily relates to unscheduled care, particularly in connection with the bid proposal. At present, confirmation of funding has not yet been received. While work continues regardless of funding, it was acknowledged that the availability of additional resource would support further improvement, and such impact can be measured over time. Planned care, by contrast, was noted to be more readily quantifiable in terms of activity and cost, and it was suggested that further detail could be provided by relevant colleagues. Unscheduled care remains more variable and inherently less predictable.

DRu queried the description of current controls under section 3.4 as "incomplete" rather than "ineffective." It was noted that this wording implies the controls are appropriately designed but not yet consistently applied. Clarification was requested as to whether this accurately reflects the position, or whether further work is required to develop or strengthen the underlying controls and processes.

In response, JB explained that the description of certain controls as “incomplete” reflects situations where appropriate tools and processes are in place but are not yet being applied consistently. For example, the patient placement tool is well-defined and designed to support safe decision-making but is not always utilised by staff at ward level when transferring patients. The focus is therefore on embedding consistent use of such tools rather than redesigning them.

There was further discussion by the group.

The Chair thanked JB for her well-prepared paper.

**Recommendations:** The Committee is asked to:

- Review and scrutinise the information provided in this paper and confirm it provides assurance that processes regarding the management of Strategic Risk 3068 are in place, and any gaps in controls identified are being addressed.
  The Committee agreed and accepted amended recommendations.
- Determine if the Assurance Level assigned to the management of the risk is appropriate – Limited.

  The Committee agreed.
- Confirm if any escalation is required to another Board committee or the Board and specify the details of that escalation

The Committee agreed no escalation was required presently.

### 8.2 Risk 3065 Planned Care

Paul Bachoo, Acute Services Medical Director / Integrated Specialist Care Portfolio Executive Lead, informed that discussions to separate planned and unplanned care into distinct strategic risks began in 2023, with the planned care strategic risk formally designated as intolerable in January 2024. This assessment reflected ongoing challenges including demand exceeding prioritisation controls, limited gains in productivity from efficiency measures, and persistent backlog pressures. The committee received a summary of the trajectory-based improvement plan aligned with the national planned care framework and National Operational Improvement Plan, targeting delivery milestones by March 2026.
By that point, the system aims to achieve compliance in endoscopy, radiology, and cancer treatment performance, with significant progress in inpatient Treatment Time Guarantee, though outpatient compliance remains out of reach. It was confirmed that two key risks, the Clinical Decontamination Unit and the RACC ambulatory care facility, are no longer viable enablers for the 2026 targets. Progress continues regarding the development of a day-case surgical unit. Key enablers include initiatives with the Centre for Sustainable Delivery, internal improvement work, and the allocation of just under £13m in additional funding, 25% of which is recurring. This financial support is critical to ensuring sustained improvement. Future risk reviews may be considered as milestones are achieved, but it was emphasised that, despite progress, patients continue to wait unacceptably long for planned care services, with consequential impacts on morbidity and quality of life.

MB asked for clarity on whether there is a move from intolerable risk to very high or if the trajectory was headed in that direction, but it is not quite there at the present time.

PB informed the agreed delivery of activity takes us to a trajectory at the end of 2026 where we would be in a better place than we are currently, but that remains under continuous review and is subject to all known and unknown risks which affect plan care.

DRu queried if there were any areas on specific outpatient performances where there had been better performances seen than had been planned for or if there were any outliers noted.

PB responded that there has been an in-depth re-engineering of outpatient activity undertaken over the past 18 months. This work identified significant variation across services in terms of activity patterns, return-to-new appointment ratios, and clinic utilisation. Much of this variation has since been addressed, resulting in approximately 90% monthly utilisation of the outpatient clinic footprint at ARI. While this work has not yet extended to DGH, unused and unstaffed capacity has now been consolidated to specific days of the week. The next phase will focus on activating this latent capacity, supported by additional funding for diagnostics, laboratories, radiology, and other resources as they become available.

HP asked for clarity on several key points related to the planned care strategic risk and associated funding, seeking to better understand the definition of agreed delivery, whether it refers to the achievement of specific, quantifiable performance targets or a broader, positive direction of travel. Also highlighted, only 25% of the additional funding is recurring, while 75% is non-recurring and performance-dependent, raising concerns about the long-term sustainability of current improvements.
HP further questioned what the implications might be if, by 2026–27, the strategic risk remained at an intolerable level, particularly in the context of uncertain future funding and ongoing system pressures. He noted the importance of distinguishing between short-term gains and sustainable improvement. While expressing sincere appreciation for the extensive work undertaken and recognising the contribution of both additional funding and staff commitment, it was emphasised there was a need to understand how the current trajectory could influence future resourcing, risk assessments and strategic planning.

PB thanked HP for his appreciation for the work carried out by the team concerned, then clarified for the first point around trajectory, a model has been developed that sets out the minimum additional activity we can deliver each month, over and above the baseline. This model has been tested for viability and used as the basis for discussions with government. It forms the foundation of our agreement and is directly linked to the funding received. To date, we have consistently delivered against our agreed activity levels, which has helped secure continued support.
Regarding the recurring and non-recurring funding, PB acknowledged the risks associated with this. While 25% of the current funding is recurring, the remainder is not guaranteed, and there is a clear risk of falling back into a position where demand again outstrips capacity if additional work is not sustained and why the recovery work must run in parallel with broader reform. This includes the integration of care pathways, use of regional and national resources, transforming referral routes, and the adoption of digital solutions and innovation. These strands are essential not only to maintain progress but to ensure that any gains are sustainable in the longer term. Without that reform, the risk remains that we could fall back to the same position.

MB asked how this would be integrated into the primary care interface pathway work as outpatients are very much dependant on the primary care structure referring in, how improvements can be actuated as this is a default position and this is essential for primary care going forward.

PB outlined several ongoing initiatives. Cardiology teams are working with primary care to revise referral criteria, aiming to streamline pathways and reduce unnecessary demand on secondary services. Public health colleagues are also progressing work on cardiovascular risk assessments to support earlier intervention.
Through the Interface Group, led by Robert Lockhart, a proposal is underway to fund early-career GPs with special interests to support outpatient activity. These fully trained doctors, along with others already certified in specialist areas, contribute additional capacity to outpatient services.

These actions form part of a broader reform effort to improve integration, efficiency, and long-term sustainability in planned care delivery.

The chair thanked PB and added it was hoped this could be discussed again at a future date.

**Recommendations:** The Committee is asked to:

- Assurance –review and scrutinise the information provided in this paper and confirm that it provides assurance that:
- The strategic Risk Planned Care 3065 is being reviewed

  The Committee agreed
- The risk is being mitigated using operational actions internally and additional capacity from national funding

  The Committee agreed
- Acknowledge improvements are well placed to positively impact the Strategic Risk Level for Planned Care, 3065.

The Committee agreed.

- **Endorsement** – endorse the proposals contained in this paper

The Committee agreed.

- **Decision** – agree that the committee is assured that the Planned care Risk is being managed and note a further report against the delivery plan will be taken to the Chief Executive Team to review the strategic risk against risk appetite

The Committee agreed.

- **Future reporting** – to request that at a future date a further report on this subject be presented to the committee

The Committee agreed and requested that a further report be taken to the Committee at a future date.

The Chair thanked PB for his detailed presentation.

## 9 Healthcare Associated Infection (HAI) Report

Dr Noha El Sakka, Infection Prevention and Control Doctor/Clinical Lead, updated on Healthcare Associated Infection report circulated to Committee, informed there were two key areas of concern were raised for the Committee's awareness. The first relates to the healthcare-built environment, specifically the Baird and Anchor new build projects. These are being overseen through the established governance structure, with reporting through the Baird and Anchor Board and escalation via the appropriate governance route. However, given the scale and significance of these developments, the matter was brought to the Committee for additional visibility.

The second relates to the monitoring of national surveillance KPIs, as outlined in the accompanying paper. The Board reports regularly to the Scottish Government on three key infection indicators: E. coli bacteraemia, SAB and CDI. These are compiled nationally and benchmarked across health boards. In the most recent report, published on 8 April 2025 and covering the period October to December 2024, the Board's rates for E. coli bacteraemia were below the national average across both healthcare-associated and community-acquired cases. However, rates for SAB and CDI were above the national average. Although national variation is expected, the rise in CDI has been subject to further review. An SBAR has been submitted to ARHAI Scotland outlining contributory factors and proposed mitigations, and a response is awaited.

MDRO screening figures have shown improvement but remain below the national average. Several actions are being progressed by the infection prevention and control team, including

targeted education, face-to-face training, monthly reporting to the Nurse Director and Chief Nurse, and development of a dashboard to support data visualisation and trend monitoring. Indicators continue to be reviewed regularly, on a case-by-case basis to support early intervention where required.

JT asked for clarification on access to environmental testing detailed in the report.

NES detailed that the issues under discussion are not unidirectional but rather form part of a complex and multifaceted set of parameters contributing to the progression of environmental IPC concerns. Environmental testing is one element and is currently under consideration. This includes testing conducted both externally in private laboratories and internally within microbiology services. Effective implementation requires appropriate facilities, clinical input to interpret results and provide advice, as well as adequate staffing to undertake sample collection in line with guidance, including adherence to cold chain requirements for sample transport. Environmental testing is just one aspect; other areas of concern include non-standard patient areas, involvement in HAI-Scribe, and other related factors.

JT further raised as to whether, in the context of commissioning the Baird and Anchor projects, the Board's actions would be considered reasonable and defensible, particularly in a worst-case scenario, when assessed from a quality, safety and legal standpoint.

JB responded that the Baird and Anchor builds operate under their own governance structures, reporting through a dedicated project board. Decisions, including those relating to derogations in the build, are informed by input from a range of technical stakeholders including IPC, engineering, and construction teams. NHS Scotland Assure provides an additional layer of governance. Where consensus cannot be reached at project board level, as was the case with the proposed removal of sinks in both environments, issues are escalated to the Chief Executive Team. Following further discussion, the Chief Executive made a final decision, supported by documented rationale, and in consultation with NHS Assure and the Scottish Government. It was acknowledged that while IPC advice was fully considered, it was not the determining factor in the final decision, which reflected a broader balance of risk and the need to progress the project. The IPC team sought to ensure that their professional position, while not ultimately followed, was formally recognised.

**Recommendations:** The committee is asked to:

- Review and scrutinise the information provided in this paper and confirm it provides assurance of ongoing mitigations regarding Key Performance Indicators and HBE, where possible.

The Committee agreed.

- Confirm if any escalation is required to another Board committee or the Board and specify the details of that escalation. (what is the issue, where is it being escalated to and who is responsible for auctioning the escalation)

The Committee agreed that no escalation was required.

- Acknowledge the concerns raised by the IPC Team and the risk held by NHSG as a result of decisions not to accept the IPC advice on several aspects of the Baird & Anchor Projects.

The Committee was unable to agree this point, following discussion, it was agreed that there would be work carried out to re-work the report to reflect earlier work carried out around the projects and be reviewed thoroughly at a later meeting.

### 9.1 HAI Quarterly Report – October 2024

NES advised that the report was provided for information.

Committee content the report is for noting.

## 10 Cross-System Quality, Safety & Assurance Group – Critical Thinking Session Update

Gillian Poskitt, Associate Director – Quality Improvement & Assurance reported that in November, the Cross-System Quality and Safety Group held a dedicated session focused on communication, a recurring theme identified through complaint analysis and adverse event reviews. Although complaints represent just 0.1% of total patient activity, communication consistently emerges as a contributory factor. The session drew 50 colleagues from across clinical and quality improvement backgrounds, offering broader representation than usual. Adopting a new format, the session encouraged open dialogue, with 83% of participants reporting they felt heard and found the discussion helpful. Networking opportunities were also noted as a key benefit. Despite the ambitious agenda, the session was well received and generated strong energy and engagement. Participants agreed to develop a more defined aim and scope for future work on communication.
The topic will be brought forward for further discussion at the upcoming committee meeting, where the group will formalise objectives and structure next steps.

HP welcomed the focus of the paper on communication, noting that although complaints data represents a small proportion of patient activity, communication frequently emerges as a critical issue, particularly from an equalities perspective, where it strongly influences patient experience and outcomes. While acknowledging the paper's November 2024 origin, HP asked whether there had been any subsequent developments or measurable outcomes arising from the programme. Specifically, whether there were any examples of changes in practice, improvements in metrics, or emerging insights from the group's ongoing work that could now be reported and expressed strong support for the thematic approach and commended the emphasis on communication as a priority area.

GP responded that no thematic or statistical data was currently available, as the group is focused on clarifying its aim and shaping a programme of work. Since the initial session in November, only one follow-up meeting occurred in December. The group has faced some challenges in defining its identity within the broader governance structure, but renewed discussions are planned for the upcoming meeting. It is hoped this will bring clarity, energise next steps, and possibly shift participation to include colleagues closer to frontline care.

The Chair thanked GP for her presentation.

**Recommendations:** The Committee is asked to:

- Review and scrutinise the information provided in this paper and confirm it provides assurance that improvements to policies and processes are being made and appropriate evidence of these has been provided to Board satisfaction.

The Committee agreed.

- Confirm if any escalation is required to another Board committee or the Board and specify the details of that escalation.

The Committee did not feel escalation was needed.

- Agree the use of the Cross System Quality and Safety Group meeting time to support similar sessions in the future.

The Committee agreed.

## 11 Highlighted Portfolio - Medicine and Unscheduled Care

Geraldine Fraser, Chief Officer Acute Services, introduced colleagues from the Medicine and Scheduled Care Portfolio, namely Catriona Robbins (Chief Nurse), Stuart Stephen (General Manager for Medicine), and Stephen Friars (Portfolio Medical Director for Unscheduled Care), who joined to support the presentation of the portfolio's governance report. The paper, prepared using the new reporting template, outlines the governance processes and procedures in place across the services within the portfolio's remit. While the report includes reference to risk management, it does not focus in detail on the operational risks, which are reported through separate mechanisms; further information on these can be provided if required, and further

clarified that the emergency department and AMIA (Acute Medical Initial Assessment Unit) both fall under this portfolio. AMIA functions as a front-door service for referrals, primarily from GPs, but also from other healthcare professionals, handling around 40 patients daily, with approximately two-thirds subsequently admitted. The unit also hosts the Flow Navigation Centre and RAAC (Rapid Ambulatory Assessment Clinic). GF then invited CR to highlight key elements from the report.

CR informed that the report was submitted to provide assurance regarding the systems and processes in place across the portfolio. In response to team feedback about the volume and complexity of reporting, governance structures have been revised to offer improved clarity and support. Monthly meetings are now held with each clinical pathway, encompassing clinical, staff, and health and safety governance, with early feedback describing this combined approach as constructive and positive. This has enabled a clearer focus on complaints, feedback, and adverse event monitoring. In addition, a monthly system integration meeting brings together colleagues from across the organisation and beyond to strengthen shared oversight. A clinical risk management structure is in place; however, a gap was noted in senior leadership monitoring of risks. In response, a new fortnightly forum has been established to focus on the risk register and level 1 and 2 adverse events, improving oversight of high-level risks. The report also references workforce and financial governance, though the committee's focus is on clinical aspects. Key risks within the emergency department were acknowledged, including ambulance wait times, one of which has now been downgraded following committee discussion. Collaborative structures with ambulance services, including a joint governance and operations meeting, support robust oversight of adverse events. Notably, no significant adverse events have been reported through this process in the past 12 months, suggesting an encouraging trend in front-door care.

The Chair commended the team for their proactive response to earlier feedback, noting that some actions appeared to have been implemented in advance of the committee discussion, coinciding with the morning's portfolio meeting. While acknowledging the focus of the report on clinical governance, the Chair highlighted that workforce stress, reported at 31%, is a significant concern likely to impact clinical delivery and asked whether any specific actions were being taken, or planned, to address this issue and support staff wellbeing.

CR stated it was confirmed that workforce stress is being actively monitored through the portfolio, with a particular focus on staff wellbeing. Governance reporting has been streamlined from weekly to monthly at the pathway level to foster a more supportive and sustainable structure. Emphasis is placed on recognising positive contributions as well as addressing challenges, with close collaboration underway with staff wellbeing leads and occupational health. Efforts are also being made to monitor and promote rest and recovery time, particularly for medical staff, though this is being extended across all staff groups. The importance of safe staffing levels and structured governance was reiterated, with targeted support for both nursing and clinical teams to ensure break-taking and staff welfare are embedded into day-to-day operations.

SF informed that a key source of staff stress often stems from a perceived inability to influence change within their working environment. In response, the portfolio has been working collaboratively with the Centre for Sustainable Delivery to develop and embed improvement initiatives across the portfolio and the wider system. This approach, encouraged by CfSD, seeks to empower frontline staff to actively participate in service changes, fostering a sense of ownership and enabling meaningful contributions. It was emphasised that this collaborative improvement work is a valuable component of the portfolio's broader efforts to support staff wellbeing and continuous service development.

JB asked for clarity on the statement that there had been no significant event analysis review on the previous 12 months.

CR clarified that while there have been significant adverse events reported over the past year, these have been attributed to pathways led by the Scottish Ambulance Service, rather than

events originating within the Emergency Department. As such, no level 1 reviews have been commissioned directly through the ED team. All outstanding adverse event reports have been concluded, with associated actions implemented. Robust systems are now in place, including a rapid review process conducted jointly with Scottish Ambulance Service colleagues. This approach has enabled clear identification of pathway ownership and supported effective governance. Jointly commissioned reviews ensure a coordinated and transparent process, reinforcing collaborative oversight and shared learning.
CR added that the fortnightly joint meeting serves as a valuable mechanism for shared learning between the portfolio and Scottish Ambulance Service colleagues. Both the CR and SF have participated in rapid reviews alongside SAS representatives, which have proven to be informative and constructive. This collaborative approach has supported the development of robust terms of reference for any adverse event reviews, strengthening governance and consistency in review processes.

GF acknowledged that ambulance stacking remains an ongoing issue, though several safety measures have been implemented to mitigate associated risks. A triage system is now in place whereby ED nurses assess patients within ambulances to prioritise admission based on clinical urgency. While this has supported safer queue management, it was noted that Scottish Ambulance Service (SAS) colleagues continue to experience adverse events, primarily due to delays in ambulance release. Work is ongoing to refine protocols allowing ambulance redeployment during life-threatening incidents, and to review the geographical distribution of ambulance crews to reduce risk. These areas are being actively progressed through the Joint Tactical and Joint Governance Groups, supported by weekly monitoring. In parallel, broader system-wide improvement work is underway, aimed at shifting the balance of care toward community-based services. Related transformation proposals have been submitted to the Scottish Government for approval, and feedback is awaited to advance this.

The Chair and JB both thanked the team for their hard work around this.

**Recommendation:** The Committee is asked to review and scrutinise the information provided in this paper and confirm that it provides assurance:

- The policies and processes necessary are in place and are robust.

The Committee agreed

- The policies and processes within the portfolio of MUSC are working effectively.

The Committee agreed

- Any gaps in MUSC governance processes have been identified and assessed.

The Committee agreed

- Any risks identified within the portfolio are being mitigated effectively.

The Committee agreed

- Any improvements to policies and processes are being made and appropriate evidence of these has been provided to Board satisfaction.

The Committee agreed

## 12 Professional Assurance for Allied Health Professionals

Lynn Morrison - ~Director of Allied Health Professionals, presented a professional assurance report focused on Allied Health Professions in NHSG, forming part of the broader series of professional assurance updates. The report, aligned with the established template, outlined governance arrangements across the portfolio and detailed how professional standards are managed, particularly regarding regulation, fitness to practise, education and training, and compliance with workforce legislation. AHPs are regulated by the Health and Care Professions Council, with NHSG employing 12 of the 14 regulated professions under this umbrella. Notable variation exists in workforce scale, for instance, one art therapist compared to over 300 physiotherapists. The report set out the registration and renewal processes, highlighting differences from nursing and medical revalidation frameworks. Assurance measures include monthly pathway-level meetings, supervision structures, preceptorship, and education support

aligned with national frameworks. A new PALS database is due to launch in June to consolidate fitness to practise data; currently, five cases are recorded. Workforce challenges persist, particularly regarding recruitment and national supply issues, addressed locally through an AHP workforce forum. The report also acknowledged paramedics as a growing AHP workforce in unscheduled care, which has been prompting ongoing discussions on appropriate governance.

JT asked if the report was indicative of what would be shared with the Clinical and Care Governance Committees of the IJBs.

LM responded that to date, this has not been but there is no reason why it cannot be in the future.

**Recommendations:** The Committee is asked to review and scrutinise the information provided in this paper and confirm it provides assurance:

- There are sufficient controls to support the Professional Assurance Framework.
  The Committee agreed
- The Allied Health Professions workforce in NHS Grampian are suitably qualified, trained and supported to provide safe and effective patient care.
  The Committee agreed

The Committee is also asked to:

- Note the current risks highlighted and mitigations to manage these.
  The Committee agreed that this was noted
-

**13 Clinical Governance Committee Annual Assurance Statement**

Gillian Poskitt, Associate Director – Quality Improvement & Assurance presented the Clinical Governance Committee Annual Assurance Statement, which follows the established format used in previous years, with the addition of a section referencing the Annual Delivery Plan. The report summarises key activity across the financial year, noting four quorate meetings and four closed sessions. Structured into sections covering learning and development, risk mitigation, external scrutiny, the Annual Delivery Plan, and routine reporting, the paper offers a synopsis of key themes and discussions rather than a full minute of each meeting. The Committee was invited to review and endorse the statement as an accurate and comprehensive summary of its governance activity over the reporting period.

**Recommendation:** The Committee is asked to:

- Review and scrutinise the information provided in this paper and confirm it provides assurance that the policies and processes are working effectively. Any gaps have been identified and assessed, and risks are being mitigated effectively.

The Committee agreed.

- Confirm if any escalation is required to another Board committee or the Board and specify the details of that escalation.

The Committee confirmed no escalation was required.

- Agree that the Committee approves the Clinical Governance Committee Annual Assurance Statement 2024/25 and confirm the Committee has fulfilled its remit, and whether adequate and effective governance arrangements have been in place for the year ended 31 March 2025.

The Committee agreed.

**14 Any Other Competent Business**

No AOCB raised.

**15 Date of Next Meeting**

05 August 2025, 1330 – 1630 Hours, MS Teams.

The Chair thanked members, attendees and invitees for their contributions and closed the meeting.