APPROVED

Board Meeting
11.12.25
Open Session
Item 11.1

NHS GRAMPIAN

Minutes of **NHS Grampian Clinical Governance Committee**
held in **Open Session** on **Tuesday, 19 August 2025** at 1330hrs
virtually by MS Teams

Present

Dennis Robertson (DR)	Chair – Non-Executive Board Member (Chaired meeting pre break)
David Blackbourn (DB)	Non-Executive Board Member
Mark Burrell (MB)	Vice Chair – Non-Executive Board Member / Chair of Grampian Area Clinical Forum / IJB Clinical Governance Representative (Aberdeen City) (Chaired meeting post break)
Hussein Patwa (HP)	Non-Executive Board Member *(in attendance until 1415hrs)*
Miles Paterson (MP)	Public Representative
Dave Russell (DRu)	Public Representative
Alison Evison (AE)	Chair of Grampian Board/ Non-Executive Board Member/ Deputising for John Tomlinson, Non-Executive Board Member

Attendees

Paul Bachoo (PB)	Acute Services Medical Director / Integrated Specialist Care Portfolio Executive Lead (Items 9 & 10)
June Brown (JB)	Executive Nurse Director / Interim Deputy Chief Executive – (Item 7)
Shantini Paranjothy (SP)	Deputy Director of Public Health
Noha El Sakka (NeS)	Infection Prevention and Control Doctor / Clinical Lead – (Items 8, 8.1 & 8.2)
Lynn Morrison (LM)	Director of Allied Health Professions
June Barnard (JBa)	Nurse Director Tertiary and Secondary Care
Hugh Bishop (HB)	Executive Medical Director
Grace Johnston (GJ)	Infection Prevention & Control Manager (Items 8, 8.1 & 8.2)
Kenneth O'Brien (KOB)	Associate Director for Public Protection (Item 13)

Invitees

Gillian Poskitt (GP)	Associate Director Quality Improvement and Assurance (Items 6 and 11)
Linda Ann Lever (LL)	Team Lead Adverse Events and Feedback (Item 12)
Geraldine Fraser (GF)	Chief Officer – Acute Services (Item 14)(*Arrived 1607hrs*)
Jillian Gibbon (JG)	Child Protection L&D/Acute Paediatric Nurse CP (Item 13)
Rachael Little (RL)	Interim Team Lead - Quality Improvement & Assurance (meeting support)
Catriona Robbins (CR)	Chief Nurse (Item 14)(*Arrived 1607hrs*)
Christopher Middleton (CM)	Senior Manager (Item 14)(*Arrived 1607hrs*)
Angela Chalmers (AC)	Quality Improvement & Assurance Administrator (minute taker)

1 Apologies

Noted apologies received from: John Tomlinson, Adam Coldwells, Tara Fairley, Emma Houghton, Derick Murray, Steven Lindsay, Colette Blackwell and Sarah Duncan. 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 27 May 2025

Agreed as accurate.

5 Matters Arising

Gillian Poskitt, Associate Director - Quality Improvement & Assurance, updated the ongoing matters arising –

HPB Governance Review – item discussed at NHSG Clinical Governance Committee Closed session, 19 August 2025. Item closed.

Primary Care GPAS Data – Hugh Bishop, Executive Medical Director provided the Committee with detail regarding the reporting and escalation processes. GPAS data is collated by Individual practices and reported to LMC which creates a G-OPES status which is then communicated to Stakeholders. There is no reoccurring issues therefore, agreed Item does not require to be reported to the Board level Clinical Governance Committee. Item closed.

Paediatric Oncology Update – due for discussion in November 2026. Item remains open.

CRM report – amended report format part of the meeting papers for the meeting, 19 August 2025. Item closed.

Clinical Governance Workshop – paper to be presented at the NHSG Clinical Governance Committee meeting scheduled for 25 November 2025. Item remains open.

6 Cross-System Quality, Safety and Assurance Group Update

Gillian Poskitt, Associate Director - Quality Improvement & Assurance, highlighted key areas of paper circulated of discussion held during Group meeting on 12 August 2025.

Outlined recent developments within the Cross System Quality, Safety and Assurance Group (CSQSAG), including the proposed transition to a new model of working through the Action Learning Group for Quality and Safety (ALG-QS). The purpose of the paper is to seek the Committee's assurance and endorsement for this transition, which aims to strengthen system-wide learning, reduce duplication, and create space for collaborative action on complex quality and safety challenges.

Intentions to move Cross-System Group towards a focus on organisational learning, with a focus on governance, assurance and performance.

HP requested Assurance on Membership of the group and suggested an Ad-hoc Public Representative to be involved.

GP agreed and reported a Public Representative position was advertised but was unsuccessful.

HP thanked GP for the assurance that a Public Representative is being considered.

Chair thanked GP for Update and Assurance.

JB highlighted the separate Public Protection process, which is multi-agency and aligns to the NHSG Public Protection Committee. The NHSG Public Protection Committee can report directly in to the NHSG Clinical Governance Committee and the whole system.

Recommendation:

Assurance – Review and scrutinise the information provided in this paper and confirm it provides assurance that the proposed transition from Cross System Quality, Safety and Assurance Group (CSQSAG) to Action Learning Group for Quality and Safety (ALG-QS) is aligned with NHS Grampian's strategic

ambitions, supports system-wide learning, and maintains appropriate

Governance oversight through Whole System Clinical Governance Group (WSCGG).

Escalation – Confirm if any aspect of the proposed transition or reporting

changes requires escalation to another Board committee or the Board,

Particularly where risks or governance gaps may arise during implementation.

Endorsement – Endorse the proposal to transition the CSQSAG to the ALG-QS; the development and ownership of the draft Terms of Reference (ToR)

(Appendix 2) within the group itself; and support the revised reporting structure whereby formal oversight is directed to WSCGG and other reports are made accessible via a central repository.

The Committee agreed and accepted the recommendations.

Chair – Assured, members content.

7 Clinical Risk Meeting (CRM) Report

Prof. June Brown, Executive Nurse Director, provided key highlights from the CRM Report circulated to Committee. Paper intended to provide assurance and management of board level deviations and is aligned to Strategic Risk 3068 'Deviation from recognised service standards of practice and delivery'.

MB thanked for detailed report and acknowledged the useful summary section.

JB commented on the handling of complaints and amendment to escalation process for Level 1 complaints over 80days with 61 outstanding which is not compliant with the National Limit.

Falls increase in Moray which will be discussed at the Strategic Falls Committee on 03 September 2025.

Increase in Mental Health services with individual patients requiring different types of support. This is a pattern we see in the spring.

Increased number of complaints on wait times at Orthopaedics.

Improvement with Ombudsman cases only 1 out of 9 upheld this quarter.

Chair thanked JB for the Report and commented on the reassurance of investigation into Increase of Falls in the Moray area. Request for update at a later meeting.

MB commented on Information Governance colleagues feeling overwhelmed with the workload, timescales and escalations. Explanation was given regarding 2 Streams of workload. 1 being Statutory work, Freedom of Information and the other Assurance DPIA's. An additional Band 7 was introduced to the team for Assurance work but the process in gaining Band 3 support would depend on financial demands.

CET Escalation for Statutory Backlog and Increase support.

HB suggested a ticket type system for Freedom of Information in order of application.

AE thanked HB and JB for the update.

GP suggested Shared Learning Events, Quality Improvement and Assurance newsletter article to capture our colleagues who would benefit from the information.

JB content with recommendations and will discuss with TF. Update due 25 November 2025 meeting.

Committee Content.

Recommendations: The Committee is asked to:

Assurance – 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 patients and staff.

Escalation – 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 actioning the escalation)

Future reporting – this report is a standing agenda item for this committee and

Therefore is presented quarterly.

The Committee agreed and accepted the recommendations.

8. **Healthcare Associated Infection (HAI) Report – August 2025**

Dr Noha El Sakka, Infection Prevention and Control Doctor / Clinical Lead, updated on Healthcare Associated Infection report circulated to Committee. Key points related to Healthcare Built Environment, National Surveillance Key Performance Indicators, Multi Drug Resistant Organisms (MDRO) Screening, and Risks.

Chair thanked for comprehensive update and detailed report.

MB asked for progress update on Very High Risk 3770 "Apparent Lack of Appropriate Organisational Governance of Ventilation Systems in NHSG." NeS advised, ongoing work with Infection Prevention and Control Team (IPCT) and Facilities and Estates Team working in collaboration to develop a Ventilation Safety Group where concerns and recommendations can be discussed

HP asked whether a piece on Earlier intervention would be helpful and questioned High Scribe system. NeS commented on High Scribe input and earlier intervention from IPCT is important as sometimes once they are involved it's often too late.

MB noticed the CPE Screening Compliance is low. NeS agreed, still below National Average but still improving. Ward Staff and Clinical Teams are responsible for CPE Screening and Swabbing and hospital pressures can be challenging which can delay the Screening and Swabbing. Turas Training modules and Whole Infection Control Guidance is available. Wards with gaps and ward pressures will be targeted.

MB suggested mandatory training for Clinical Teams.

JBa commented on working to close IPCT Risk and will hope to see figures increase as the teams work towards compliance.

Committee Content

8.1 Healthcare Associated Infection (HAI) Report 27 May 2025 (revised)

8.2 HAI Report – April 2025

Recommendations: The Committee is asked to:

Assurance and Awareness of Risk.

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

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

The Committee agreed and accepted the recommendations.

9. **Independent National Whistleblowing Officer Report**

Paul Bachoo, Acute Services Medical Director / Integrated Specialist Care Portfolio Executive Lead, highlighted key points from paper circulated to Committee.

PB assured the committee that Learning around Timescales to mitigate Risk and acknowledge Evidence of Learning.

DR commented Positive response and going in the right direction.

MB requested that this subject matter to be discussed at future meeting.

AE suggested raising with Staff Governance Committee.

Committee content with Papers, progress and IAP work.

Recommendations: The Committee is asked to:

Assurance –review and scrutinise the information provided in this paper and confirm that it provides assurance that actions are being comprehensively progressed in line with the recommendations from the INWO report.

Escalation - 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 actioning the escalation)

The Committee agreed and accepted the recommendations.

10 **Highlighted Portfolio – ISCP (Risk 3065 Planned Care)**

Paul Bachoo, Acute Services Medical Director / Integrated Specialist Care Portfolio Executive Lead, highlighted key points from paper circulated to Committee.

PB updated Planned care in addition to NHSG Board for Cancer Services and Care performance. Data suggests we remain the same for Wait Times. On 08 July 2025 at the Strategic Risk Group assurance was provided on Re-opening Short Stay, Statutory Risk is very high and out with intolerance but improving. Funding planned for smaller allocations and projections are on target for Board position in March 2026.

MB welcomed the reduction in Risk and gave Credit to the Teams good response.

AE questioned Equality and Diversity within the Risk.

PB answered Reporting performance on target, however certain levels of Sub Group Wait times to access treatment in the first place is not satisfactory. Selected Cohort awaiting treatment, not to ignore but to balance and prioritise.

AE queried whether working Regionally or Nationally on papers and working with other Boards is happening and are the findings similar.

PB assured AE on working with National Treatment Centres for treatment due to capacity around other Boards. Working in collaboration with National Treatment centres for balanced treatment times.

JB pointed out the Paper did not include reference from Intolerable to Very High. PB agreed this should be included in the paper and welcomed the suggestion. PB to update the Paper.

MB requested update on Out Patient performance monitoring at a future meeting.

GP asked Committee members to be mindful that this item will be put to the Auditing Committee.

Committee Content with Paper to be amended and future update.

Recommendations The Committee is asked to:

Assurance – Review and scrutinise the information provided in this paper and confirm that it provides assurance that appropriate plans are in place.

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

The Committee agreed and accepted the recommendations.

11 **Duty of Candour Annual Report**

Gillian Poskitt, Associate Director - Quality Improvement & Assurance, highlighted key areas of paper circulated, provided an overview of paper circulated to Committee.

GP reported 2 years Duty of Candour, (DoC). Statutory requirement annually. Backdated 2023/2024 and 2024/2025. Good Learning and Early Service Improvement. Reassurance around Learning with Assurance perspective will come to November's Committee.

MB thanked GP for detailed overview.

DRu mentioned 118 incidents with any from complaints received. Whether raised prior or after complaint received.

GP commented that information is unavailable at this point and assured Adverse Events are picked up during or after a complaint is received which is not necessary in the National Parameters however is carried out within NHSG.

MB agreed this can be labour intensive but necessary.

HB commented both papers give influence Duty of Candour early. Also pointed out that any Clinician can do Duty of Candour if they feel it necessary to do so and does not have to involve the complaints process.

A Presentation on Duty of Candour would be great and welcome training. HB happy to facilitate and include in November 2025 meeting.

Committee Content.

Recommendations: The Committee is asked to:

Assurance – Review and scrutinise the information provided in this paper and confirm it provides assurance that the policies and processes are working effectively, with improvements being made and appropriate evidence provided.

Escalation – 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 actioning the escalation).

Future reporting – To request that the 2024-2025 DoC report to be presented to the Committee in November 2025.

The Committee agreed and accepted the recommendations.

12 **Handling and Learning from Feedback Annual Report 2024/2025**

Linda Ann Lever, Team Lead Adverse Events and Feedback, summarised reporting template circulated to Committee.

LL reported Staff working towards improvements. Most complaints upheld or part upheld. Organisation slightly remains extremely challenging with 20day window for investigating and closing complaints. In 2024, 1065 complaints were received which is an increase of 9%. Complaints about staff is at 38%, down from previous year which was 43%. 61% of the staffing complaints came from Medical or Dental. There has been a 21% increase with The Scottish Ombudsman. The backlog from Covid19 era has now been caught up, however still remains challenging for the 20 day expectations. A Reduction in compliments and a Rise in Care Opinion.

MB questioned Early Resolutions and commented this would save a considerable amount of time for Complaints and Feedback team. LL agreed and assured the committee that over a week around 11% of complaints are closed by Early Resolution.

AE thanked LL for a very clear report and reflected on what we want as an organisation. What next, looking forward to seeing more improvements.

LL assured with confidence appropriate adjustments are in progress.

JBa echoed Early Resolution encouragement.

LL explained working towards Real Time Feedback funded by charity and will work towards Early Resolution in Real Time. This will be included in next year's report.

MB thanked LL for detailed Report and overview.

Recommendations: The Committee is asked to:

Endorsement – Endorse that the Handling and Learning from Feedback Annual Report is suitable for publication.

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

The Committee agreed and accepted the recommendations.

13 Public Protection Team Annual Report - 2024

Kenneth O'Brien, Associate Director – Public Protection and Jill Gibbon, Child Protection L&D/Acute Paediatric Nurse, highlighted key points from the requested Annual Review paper circulated for the Committee.

This report provides to the Committee a narrative update on all public protection areas – including developments, key risks and controls put in place.

Public Protection involves actions and activities that have the purpose of supporting, assisting and making safe citizens – some may have a greater degree of vulnerability to harm than the rest of the population. Public protection activity is divided into 7 different 'areas'; Child Protection, Adult Support and Protection, Gender Based Violence, Female Genital Mutilation, Human Trafficking, People at Risk of Radicalisation and Offender Management.
The annual report – provides as an appendix – summarises significant Public Protection activities.

MB thanked KoB and JG for the Annual Report.

DR requested, future reports to include general population resources directed to the appropriate services.

KoB agreed and assured the committee the report will include this in the following year report.

HB provided gratitude for the Annual Report and acknowledged the complicated cases. Also pointed out that often this is a one-time option to provide protection for any kind of abuse and it is so important to respond actively. Teams, Individuals, Small Groups training is extremely important for early intervention.

JB acknowledged the volume and complexity of these reports and was grateful for the volume of work. Also commented Gender Based Violence sits with Public Protection which has no Statutory or National Guidance and recognised how difficult it can be without such Guidance.

DR agreed broader communication where we are learning with development days and exploring our options with the resources available to us, especially with multi agency days.

KoB happy to engage with further development work.

MB asked the committee if they were content with the report and discussion outcome.

Committee Content.

Recommendations: The Committee is asked to:
Assurance – Review and scrutinise the information provided in this paper and confirm that it provides assurance that the policies and processes are working effectively. Any gaps have been identified and assessed and risks are being mitigated effectively.

Future reporting – To request that a further annual report on this subject be brought back to the Committee in one year's time.

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

The Committee agreed and accepted the recommendations.

14 Strategic Risk Report Risk 3639 Unscheduled Care

Christopher Middleton, Performance Improvement Senior Manager, Geraldine Fraser, Chief Officer – Acute Services and Catriona Robbins, Chief Nurse, highlighted key areas of paper circulated, provided an overview of paper circulated to Committee.

The risk trajectory of 3639, based on the current position, remains largely static. If taken over the last 12 months the majority of movement has been in the direction of increased severity with control measures either being ineffective or managing only the symptoms of the risk. Future performance in reducing this risk, based on extant control measures, the likely reduction of community inpatient capacity in Aberdeen City HSCP, and flow in to care homes in Aberdeenshire, may worsen without a significant and robust alternative to the capacity currently delivered in Rosewell House and a different solution to utilise currently unoccupied care home places in Aberdeenshire.

To reduce the risk there will be a requirement to reduce acute hospital occupancy and improve flow of patients home or to a community setting. The NHS Grampian USC Improvement Plan has been framed to focus on areas which will give maximum impact for this and is in line with the Scottish Government's Operational Improvement Plan. Anticipated Scottish Government improvement funding (£3M for 2025/26) will be focused on a whole system solution between the acute hospitals and the Health and Social Care Partnerships:
Admission Avoidance:

- FNC reinforcement to complete 24/7 coverage and increase capacity at peak times.
- Frailty at the Front Door capacity to redirect patients to community services.

Rapid Patient Journey through Acute Settings

- Increase out of hours and weekend pharmacy opening times.
- Expand the Frailty Liaison Team and AHP provision.
- Extend opening times of DGH discharge lounge.
- Expand weekend AHP coverage.

Increase Pull-Through capabilities to community

- Establish an Aberdeenshire Frailty Unit.
- Provide 7 day therapy service for Frailty.

Increase downstream capacity

- Support 30 DD/DTOC rapid moves to Aberdeenshire Care Home spaces.
- Establish a Discharge to assess capability in Aberdeenshire.
- Consider increases to Aberdeen City H@H and boundary shift to include south Aberdeenshire.

Longer term plans to improve Flow. Wider Health board Occupancy Levels, Targeted Interventions, whole Bed base and Community –ways of working.

Demand remains High on a Demographic focus on Frailty and General medicine areas. Strategic actions for more complex ongoing care.

MB commented on the System wide aspect and agreed operational aspect. Frailty improvements where attendance rate is lowest in Scotland. Upcoming improvement work with Paediatrics, Pioneering Chest pathways and GP referring to Clinics who don't require hospital setting. Acutely unwell beds – redirection for flow dynamically through the system to stop deconditioning throughout the system.

HB thanked CM for the report and asked whether the Risk is Static or declining and the Risk as it stands gives limited proportionate description and suggested the Risk to be escalated to High 20 outside Tolerance and High Risk. Unrealistic Projections although the Spring Centile line is slightly improving.

CM agreed in the last quarter improvement in some metrics but may be seasonal variations.

AE commented HB's wording around Risk provides a good picture of where we are and Actions are being taken. Push further on unscheduled Care planning and Whole system around it. Proves more work required. The risk is not where we want it to be in terms of management and stated It is our responsibility to Action and Deliver.

MB stated mitigations to be Identified and Addressed.

Recommendations: The Committee is asked to:
Assurance – Review and scrutinise the information provided in this paper and confirm that it provides assurance that:
Minor improvements are being made regarding the management of Strategic Risk 3639, and appropriate evidence has been provided of these improvement activities, though potential remains for a significant reverse.
Gaps in the coordination and prioritisation of controls or mitigations across the whole system have been identified need to be addressed.
Decision – Determine if the Assurance Level assigned to the management of the risk is appropriate – Limited
Escalation – Confirm if any escalation is required to another Board committee or the Board and specify the details of that escalation

MB posed the question of contentment within the Committee.
Request for the wording to be changed to Risk High 20 Outside Tolerance High.
Committee Content.

15 Any Other Competent Business

No AOCB raised.

16 Date of Next Meeting

25 November 2025, 1330 – 1630 Hours, MS Teams.

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