APPROVED

NHS GRAMPIAN

Minutes of Meeting of Staff Governance Committee held
on 28 August 2025 at 10am
virtually by MS Teams

Board Meeting
11.12.25
Open Session
Item 11.5

Present	Joyce Duncan	Chair
	Colette Backwell	Non-Executive Board member
	Bert Donald	Non-Executive Board member/Whistleblowing Champion
	Alison Evison	Board Chair
Attending	Paul Bachoo	Medical Director, Acute Services (for item 10)
	Louise Ballantyne	Head of Engagement (for item 13)
	Laura Binnie	RGU representative
	Adam Coldwells	Interim Chief Executive
	Ian Cowe	Head of Health and Safety
	Faye Dale	Interim Head of People and Change – from 11am
	Jamie Donaldson	Staff Side
	Amanda Farquharson	Operational Lead, Specialist Mental Health & Learning Disability Services (for item 6.1 and 6.2)
	Lorraine Hunter	Head of Service, HR Service Centre (for item 9)
	Gerry Lawrie	Head of Workforce
	Kylie McDonnell	Staff Side
	Martin McKay	Partnership Representative (for item 6.1 and 6.2)
	Lynn Morrison	Director of Allied Health Professions, Deputy for June Brown
	Jason Nicol	Head of Wellbeing, Culture and Development
	Philip Shipman	Interim Director of People and Culture
	Alan Wilson	Director of Infrastructure, Sustainability and Support Services (for item 12)
	Elizabeth Wilson	HCSA Implementation Programme Manager (for item 8)
	Cathy Young	Head of Transformation (for item 10)
	Diane Annand	Staff Governance Manager (notetaker)
Apologies	Steven Lindsay	Employee Director
	Mohamed S. Abdel-Fattah	Aberdeen University representative
	June Brown	Executive Nurse Director
	Jill Matthew	Head of Occupational Health Services

Item	Subject	Action

1 Apologies

Noted as above.

2 Declarations of Interest

None raised.

Item	Subject	Action

3 Chair's Welcome and Introduction

4 Minutes of Meeting on 3 July 2025

The minutes were approved as an accurate record.

5 Matters Arising

5.1 Action Log 3 July 2025

The Chair noted that the actions SGC51, SGC72 and SGC73 were on the 28 August 2025 meeting agenda. All other actions were planned for future 2025 meetings. For SGC68 and SGC70 discussions were in progress therefore timetable of directorates and areas attending the Committee would remain unchanged currently.

6 Mental Health Specialist Services

6.1 Staff Governance Standard Assurance

6.2 Workforce Information

The Chair outlined that the purpose of the Staff Governance Standard Assurance report was to assure the Committee that the Standard is embedded, with work focussed on improvement. The Aberdeen City report had been deferred to the October 2025 meeting to ensure it was of appropriate standard and provided adequate explanation on compliance with the Standard.

The Operational Lead referred to the Mental Health Specialist Services report, which provided an update from the last attendance at the Committee in February 2024, highlighting the following:

- Mental Health Specialist Services were hosted under Aberdeen City H&SCP.
- Writing the report had allowed time to reflect on a busy year, in which there had been a strong alignment to the Staff Governance Standard.
- The report gave examples of achievements over the last year and the challenges to be faced in Mental Health Specialist Services.
- First health board in Scotland to seek to obtain Pathway to Excellence accreditation. Accreditation gives a strong grounding, improves morale and patient outcomes, which should assist with the challenge of recruitment and retention.
- In line with the commitment to safety, wellbeing and psychological safety there had been a staff support hub created, access to a staff gym, and trauma informed practice offered.
- Launch of mental health and wellbeing week.

- Reinforcing of policies such as whistleblowing.
- Provision of reflective spaces to reduce burnout.
- Recently completed workforce tools and common staffing methodology for nursing to realign nursing workforce.
- Retention of nursing workforce with new revised recruitment process.
- Reduction of the backlog of adverse event reviews by 26% at the time the report was written increased now to 42%, continuing on the trajectory for level 1 and 2s. There had been good engagement at shared learning events, with all levels doing reviews.
- Due to the financial pressures and strategic responsibilities there were strict controls on recruitment and training. Working with services to determine where there may be the possibility of grant funding and other avenues of funding.
- Service redesign for mental health and workforce for the future – keep strategic and financial alignment.

The Staff Side congratulated the service in recruiting three international Learning Disability nurses given there is no local course to recruit from and commented that it was good to know lessons had been learnt from entering bronze control; and that there was good progress in the visibility of senior management through drop in sessions in the café. The Operational Lead stated that they had tried to facilitate online workshops to deliver financial messages however after limited engagement, managers went into staff areas to hear from the staff. This allowed visibility to staff and break down perceived barriers with management.

The Operational Lead informed that entering bronze control was a considered decision. Within special mental health services 25 continuous interventions are expected however these were up to 45/50, combining with an increase in flow in, decrease in flow out, acuity of unwell patients and deficit in staffing. Entering bronze control drove forward changes and staff feedback was that it was helpful and supportive in a challenging environment to take a command and control stance and they welcomed direct communication. Since then there had been a review of wider contingencies, using the learning.

The Committee raised that the staff gym although a good facility to have was closed to new inductions which was a concern as everyone did not have equal access. The Operational Lead responded that they were actively working with NHS Charites and grant funding to obtain funding outwith core budget to provide further inductions, working through all options including external options across the wellbeing agenda as a whole.

The Committee asked for clarification on the ask of the Committee with regard to support to help mitigate challenges to achieve safe staffing. The Operational Lead outlined that it was an acknowledgement that the service was doing well in understaffed circumstances as historically Mental Health had a deficit in staffing and that the acuity and unwellness of patients had increased whilst

workforce remained historic. It was not a direct ask of the Committee, more the organisation.

The Whistleblowing Champion asked what had been done to raise awareness of the Whistleblowing Standards. The Operational Lead outlined that the services had had two whistleblowing concerns raised over the last year – one partially upheld and one not upheld. Raising awareness work had been done with the multi-disciplinary team; targeted work in specialist teams e.g. nursing, psychology along with raising the Standards in meetings. As occurs after an adverse event, the service wants to reinforce whistleblowing as part of learning. The Operational Lead explained that they meet with professional leads to obtain assurance which includes on whistleblowing which feeds into Aberdeen City. The Whistleblowing Champion offered to meet staff in the service as requested.

The Committee raised the below performance adverse event reviews asking what is done to avoid reoccurrence before a review can be done. The Operational Lead responded that they were leading the improvement action plan with the Head of Specialist Services. There had been recognition of the underperformance however there had been real areas of improvement. The leadership team had developed an improvement action plan to ensure level 1, the most severe were done. Seven were open, all of which will be closed by the end of year but as some are at the report writing stage these could be closed within a couple of months. For the Level 2s there were lots of reasons why there had been a lack of engagement with services to undertake the reviews but there had been conversations with managers about their responsibility. Due to the service having a higher number of violence and aggression adverse events reviews, tolerance was higher resulting in more level 2 and 3s. In order to progress, additional support had been provided; work was underway on the feedback loop (working with the Team Lead Adverse Events and Feedback) with governance and learning events well attended (60 employees last event). A dual process (backlog and current adverse events) was being worked with the expectation that when next reporting the figures to the Committee they should look different. The Operational Lead outlined that to avoid a reoccurrence before a review was undertaken, a process was introduced six months ago, in that all adverse events were considered at a weekly meeting to prioritise adverse events and complaints for review.

The Committee asked how the current low level of signed off appraisals would be improved. The Operational Lead acknowledged there was lots to be done. It had been identified that professional leads required protected time to have a conversation with staff, with the responsibility to undertake the appraisals in a timely manner outlined. Compliance levels had been caused by the pressures of workload and other barriers however improvement was a priority area over the next year.

The Committee highlighted the assessment that all staff were involved in decisions, asking how the level of engagement was

measured. The Partnership Representative stated that Mental Health services had a long standing relationship between management, staff and staff side. As a specialist service staff tended to stay for a long time with relationships embedded. There was never a closed door in the service for staff side and concerns were not played down as the staff side opinion resulting in open discussion and transparency of the staff experience. It was difficult to measure engagement through numbers as it was difficult to get staff off the floor therefore there was a high expectation on staff side to be that voice whenever required. It was great when there was good engagement at a session but if not routes are constantly open, never shut down. The Committee commented that the depth of engagement should be reported on as just described.

The Partnership Representative stated that the decision to go into bronze control should be commended due to the level of patient need and staff safety. It was not a sign of desperation rather strength, a brave decision, appreciated by staff, as a means to get mutual aid.

The Partnership Representative referred to adverse events in specialist services which were invisible in terms of no ambulances stacking however five members of staff could be caring for one patient, in an environment with no corridor care. The level 2 adverse events were high as incidents were being properly reported, for example violence and aggression as attention was paid to verbal aggression. The Partnership Representative recognised the work to encourage staff to take breaks and other wellbeing work, all necessary as if the staff were not looked after they cannot look after the patients.

The Head of Health and Safety commented that due to the level of violence and aggression adverse events it would have been helpful if the compliance level of practical training was included in the report.

The Committee commended the quality and comprehensiveness of the report, confirming they were assured.

7 Oversight group flash reports

- Health, Safety & Wellbeing
- Colleagues and Culture (not available due to workshop format of 23 June and 19 August meetings)

The Interim Director of People and Culture referred to the Health, Safety & Wellbeing flash report following the 7 August 2025 Occupational Health, Safety & Wellbeing Committee, acknowledging the support provided from the Head of Health & Safety and team, highlighting the following:

- Emphasis from reporting to action including the opportunity for deep dives to understand.
- Wellbeing may be removed from the remit of the Committee

- Future concentration on statutory compliance.
- The HSE was satisfied with the response to the HSE Notice of Contravention for patient choking incidents.
- Concerns over lack of engagement with H&S in MUSC.
- Concern over the lack of First Aid training to be escalated to the Chief Executive Team. The delivery of training had been person dependent in OHS and that individual had left.

Staff Side raised a concern that there was no first aid training as this may lead to areas with no qualified first aider. They were aware that Aberdeen City H&SCP had paid, from their budget, an external company to train ten members of staff in first aid. Staff Side asked what was being done in the interim. The Interim Director of People and Culture stated that no interim action was being taken, within OHS, as the delivery of the first aid training had been person dependent with no one else in the service trained to take on the role. As a frequent refresher was not required it was hoped that a sufficient level of First Aiders would be maintained in the interim. The topic was to be discussed at the next Occupational Health & Safety Committee. As the need for a First Aider was based on a risk assessment in services, the number of First Aiders required across the organisation was unknown.

The Committee raised a number of other matters from the flash report that required action, for example target for referrals to counselling not being met, on which the Committee required assurance action was being taken. The Interim Director of People and Culture agreed as this was linked to the briefing given that there was a change of emphasis for the Occupational Health& Safety Committee from reporting to action. This included the opportunity for deep dives to understand, the first of which will be prevention and management of violence and aggression due to the risks involved.

The Committee discussed the lack of engagement in MUSC with the health and safety agenda and potential escalation to encourage action. This may be due to not seeing health and safety as a priority in the many other issues being dealt with. The Head of Health and Safety stated that acknowledgement was needed from the service that time was required to be spent on health and safety. The corporate health and safety team would help as much as possible however managers did require to engage with agenda. The Interim Chief Executive stated that they would take the escalation, for discussion with the Interim Director of People and Culture outwith the meeting to ensure the Acute Services had the necessary structure in place.

The Committee raised the absence of a timeline and any indicators for the short, medium and long term; and the detail who owns it. The Director of People and Culture acknowledged this and the work that will be taking place at the Occupational Health & Safety Committee to improve the situation. The Committee commented health and safety is owned by people not a committee however work was required for all to understand their individual responsibility

as health and safety was not the responsibility of others. The Staff Side added that the accountability for health and safety should be in all job descriptions.

The Committee was partially assured due to the high number of areas to be dealt with.

8 2025/26 Quarter 1 internal report The Health and Care (Staffing) (Scotland) Act

The Interim Director of People and Culture introduced the first quarterly internal report for 2025/26 by NHS Grampian's Board Level Clinicians (Executive Nurse Director, Director of Public Health and Medical Director) to the Committee on behalf of the Board.

The Interim Director of People and Culture highlighted that this was the first time the Board Level Clinicians had been asked to provide their individual views of compliance, indicating a level of assurance for each of the roles in scope professionally aligned to their Board Level Clinician role. Work will continue with services across all areas of the act.

The Interim Director of People and Culture informed the Committee of the updated positon on the status of the Programme Team in that funding was in place until March 2027.

The Committee highlighted that the level of assurance for the Healthcare scientists group was not as expected and sought assurance that it was an area of focus. The HCSA Implementation Programme Manager responded that they had been working with the Medical Director to build a process so they receive assurance from their direct reports, with a focus on this work over the next quarter. There was regular attendance and engagement from the Healthcare scientist representative at the implementation meeting although it was recognised the category was made up of a broad group of professional fields.

The Committee asked whether three levels of escalation for risks was excessive and within that structure would a risk be handled quickly. The HCSA Implementation Programme Manager gave assurance that when there was an immediate need for escalation it was handled outwith the quarterly meetings with direct contact with the Interim Director of People and Culture for urgent escalation.

The Committee asked if the individual view from the Board Level Clinicians was accepted practice and if a Board level view of level of assurance could be given at the start of the paper. The HCSA Implementation Programme Manager responded that the Act required the individual views however there was a need to ensure each Board Level Clinician had considered all aspects in giving that view. The format had been amended to focus on overarching and exception reporting on other duties however feedback was welcomed in order to match the needs of the Act and Committee.

The Committee highlighted that there was no high cost agency breaches reported for nursing, asking how this had been actioned and whether safe staffing still existed. The Director of Allied Health Professions responded that there had been an extensive programme of work with the nursing

workforce to rebalance substantive workforce need over the use of bank/agency. This had been the main reason for change. The breaches for Allied Health Professions would be zero by quarter 2. The Committee commended the achievement of this position whilst maintaining staff staffing. The Interim Director of People and Culture informed that the Chief Executive Team had approved the over recruitment of newly qualified nurses resulting in a greater number than establishment was in post but it would decrease the need for agency/bank use. Taking into account turnover those in post would be back in balance with the establishment. This approach was however not possible for the medical workforce as there was no ability to over recruit consultants.

The Committee was assured that the Board Level Clinicians had provided their individual view on compliance however felt it was not the most appropriate way to receive assurance. This required further discussion. Escalation was not required to another Board committee or the Board. **JD/PS**

The Head of Workforce left the meeting.

9 Agenda for Change Reform Programme flash report

The Director of People and Culture referred to the flash report highlighting the following:

- All workstreams were on track except protected learning time due to the progress of the national work.
- The Reduced Working Week detailed action plan was on track for internal approval and submission by 1 October 2025.
- From the survey undertaken through the Daily Brief, 79% of respondents agreed that the reduced working week had a positive impact on worklife balance, which was greater than informal feedback. The positive or neutral impact on staff was good to see and in line with the intent.
- 79% conversation rate from a Band 5 to a Band 6 from the submissions to date. This was broadly consistent with the rest of NHS Scotland which was in excess of what modelling had suggested.

The Committee asked if the protected learning time progress was due to the target being too ambitious nationally. The Head of Wellbeing, Culture and Development responded that the intent of circular was ambitious however work on the nine core modules was almost complete. The work to map job family specific training for each profession, each band was ongoing with NHS Grampian first to produce a list. The Committee was reassured by the response.

The Interim Chief Executive asked the Interim Director of People and Culture to highlight the financial and performance risks from the reduced working week plan. The Interim Director of People and Culture stated that the reduced working week is equivalent to a reduction of 334 WTE for the 1 hour reduction, or 501 WTE for the full 1.5 hour reduction. Within Nursing/Midwifery as a result of the 1.5 hour reduction there would be a 247 WTE reduction. There was a risk that services could be destabilised if there was no backfill due to the financial situation. Due to the current financial position the reduction in the working week could not be backfilled for all, as

this would be to a cost of £7m recurring. When the first reduction occurred there had been a robust process to request backfill. NHS Grampian had been asked to present their process at a national governance group. For this second reduction there was updated criteria for requesting backfill and enhanced scrutiny. Using learning the aim was to finance backfill when a service cannot be redesigned rather than when it was too difficult to redesign. The categories this may apply to may not always be obvious, for example in administration as this includes the Switchboard which provides a 24/7 service. Backfill recommendations would be made by a small multi-disciplinary governance group with ultimate approval being made by the Chief Executive Team.

10 Medical Leadership

The Medical Director, Acute Services referred to the distributed report, stating that the majority of those in medical leadership posts attend a medical reconnect meeting to review key agenda items. The Head of Transformation had engaged with the medical leadership team as Senior Responsible Officer for a number of projects. The Head of Transformation outlined that they had ensured that medical leadership understood the expectations of them with regard to the rota banding work and reducing locum spend locums. The group had been supportive and engaged, asking useful and practical questions on how to implement in their areas.

The Committee commented that the paper showed progress and asked if the impact of extending the on call rate reduction to commence at 10pm (currently commencing at midnight) had been considered, to be assured there had been wider thinking. The Medical Director, Acute Services responded that there had been consideration. There had been no negative response when the rate of on call after midnight was reduced so the time period was being extended from 10pm as by that time most things in the wards are resolved, with perhaps the exception of AMIA where the requirement may be different.

The Committee asked how much confidence there was that the work to date regarding senior medical consultant locums would achieve balance between reducing cost pressures and encouraging recruitment. The Medical Director, Acute Services responded that he was confident due to work done to date and that there would be no effect on the level of risk. There were individuals who undertake agency locum work in the North East of Scotland as a career choice who will still engage with NHS Grampian.

The Committee asked if the target to reduce medical locums would be achieved. The Medical Director, Acute Services responded that there will be no support for exceptional circumstances to pay outwith tier 1 payment and there was progress to move long term locums to substantive role or a fixed term contract of 12 months.

The Committee asked for the progress on break planning for Resident Doctors across NHS Grampian. The Head of Transformation gave a presentation to show significant activity to ensure understanding what breaks are and how to get them to take it.

- Ability to support break taking

- Break entitlement is a contractual obligation for both NHS Grampian and the Resident Doctors.
- At Your best with Rest Campaign.
- Interested in additional medical staff to improve rota resilience.
- Breaks entitlement is covered at corporate induction and local induction.
- Information on entitlement, MDT support and Clinical Emergencies has been shared – define what is a clinical emergency.
- Resident Doctors are sign posted to Resident Doctors SharePoint page which included break entitlement information.
- Break Project Team to deliver focus around importance of break taking.
- Simplified reporting system for missed breaks which enables analysis.
- Reporting of issues with break taking and Improvement plans to address issues.

- Why break planning is being implemented
  - Since November 575 missed/late breaks reported.
  - 72% of these are FY1 and FY2 level Resident Doctors.
  - Long days and night shifts remain the most problematic for break compliance, often due to sustained workload and lack of cover.
  - Weekends have an average of 2.75 reports/day, weekdays this reduces slightly to 2.51 reports/day.
  - Planning enables ongoing focus and visual reminder so colleagues can support one another and identify early if escalation for support is required.

The Committee gave thanks for the update as it helped understanding of what was being done to address non taking of breaks.

The Committee stated that the information given on the ongoing work gave assurance that:

- Staff governance principles remain a high priority of our focus for the acute sector in supporting our medical leadership team.
- The overview of actions taken to date and outlined for the 2025–26 programme of work support establishing improvements in rota compliance and break planning for Resident Doctors across NHS Grampian.
- The work to date regards senior medical consultant locums is intended to achieve balance between reducing cost pressures and encouraging recruitment.
- The senior medical leadership team are engaged with the medical workforce.

Escalation was not required to another Board committee or the Board.

The Medical Director, Acute Services was asked to give an update in 12 months.

PB

11 Update from 5 June extraordinary meeting

The Interim Director of People and Culture delivered an update on the focus on fundamentals presentation to provide assurance of progress:

Broader Context

- Leadership and governance to be part of the plan for sustainability and performance improvement in response to Level 4 escalation.
- Staff Governance Committee identified need to "focus on fundamentals" in culture and leadership development activity.
- Equality Diversity and Inclusion and anti-racism not currently mainstreamed.
- Whistleblowing action plan required identification of leadership skills to respond to concerns.

Vision

- We are clear and consistent in the expectations we have of ourselves and our leaders throughout the system.
- We have a consistent way of identifying what development each of our leaders needs to help deliver on those expectations.
- We have a clear and consistent way to provide those development needs.
- We build leadership confidence and capability across the system.

Where Are We Now – Governance

- Held two workshops to simplify our governance arrangements for culture development.
- Propose focussing on 3 pillars:
  - Equality – including anti-racism
  - Leadership
  - Wellbeing
- Link tangible organisational expectations of our managers with the leadership behaviours and skills needed to deliver upon those expectations – then find a way to fit all of this into our business as usual processes, rather than additionality, to make a step change in our management capability.
- Measure leadership capability through the expectations that we have set rather than by measuring the capability itself.
- NHS Scotland have launched a new Operational Leadership Success Profile (OLSP).

Where Are We Now – Leadership

- Staff Governance Committee and Chief Executive Team agreed in principle the framework for clarifying the organisational expectations of leaders and the skills needed to deliver on those.
- The Chief Executive Team have identified outline expectations against a range of leadership fundamentals including Equality, Diversity and Inclusion.
- The Chief Executive Team have agreed to embed the new Operational Leadership Success Profile as the method for delivering the above.

OLSP

- Provides a consistent approach to finding, growing and empowering leaders.

- Self-Assessment against defined dimensions - of enabling outcomes, shaping cultures and empowering systems.

OLSP – Gap

- OLSP does not include what are the specific expectations of leaders.
- The Chief Executive Team have outlined initial expectations – but needs broader stakeholder engagement.
- Example of work to date – expectations would be to ensure regular team meetings take place, undertake and record appraisals with all staff on an annual basis and levels of statutory/mandatory training regularly reviewed with action taken when outwith reasonable levels.

What's Next?

- Leadership – engage with range of stakeholders (including GEMS, NEG, SEN) to finalise leadership expectations.
- Leadership – map expectations against support available.
- Leadership – update the Committee on "Focus on Fundamentals" – target 30 October 2025 meeting.
- Governance - finalise updated governance arrangements via Staff Governance Committee – target 30 October 2025 meeting.
- There should be no surprises but never previously written down the organisational expectations of our managers or how to identify where there are skills gap.

The Interim Director of People and Culture informed that a comprehensive update would be provided at the 30 October 2025 meeting.

The Committee responded that this was an important piece of work for the benefit of staff and patients.

The Committee acknowledged that all the points raised at the extraordinary meeting on 5 June 2025 had been recognised, acknowledged with action commenced in response. It was recognised that it was a long term piece of work however requested that the update to be provided at the 30 October 2025 meeting be focused on outcomes and how the direction of travel will be taken forward. The Committee thanked colleagues who raised the concerns for action to be taken.

The Committee was assured with the progress to date.

12 Update on whistleblowing action plan

The Director of Infrastructure, Sustainability and Support Services referred to the distributed report. This gave an update on resource to administer and assess whistleblowing concerns received; processes and templates to simplify and speed up handling of whistleblowing concerns; and improvement to governance and oversight of whistleblowing processes.

The Committee asked for clarification on the role of the executive lead for whistleblowing going forward. The Director of Infrastructure, Sustainability and Support Services responded that their role can be whatever is needed in terms of support and leadership and they would be prepared to take on board more operational aspects.

The Committee highlighted aspects raised at the pause and reflect session in June 2024 were not included in the update, asking if these would be taken forward by the new whistleblowing governance group. The Director of

Infrastructure, Sustainability and Support Services responded that at the first meeting of the Whistleblowing Governance group all aspects requiring action would be collated. For example it will become business as usual for executive leads to take ownership of whistleblowing concerns. The Whistleblowing Champion added another example of increasing the number of confidential contacts particularly for concerns at a senior level and reintroduce for medical staff.

The Whistleblowing Champion stated that this was an important paper for the Committee and the organisation, was encouraged by the progress being made, but implementation should be concluded in the shortest time. They commented that the review undertaken on current whistleblowing processes had been comprehensive, thanking all those involved.

The Committee thanked the Head of Engagement for bringing the concern to the Committee's attention. The Committee acknowledged the progress made and confirmed they were assured, requesting a further report at the 30 October 2025 meeting. Escalation was not required to another Board committee or the Board. **AW**

Statutory Information, Reports and Returns

13 Whistleblowing 2025/26 Quarter 1 report

The Head of Engagement presented the 2025/26 Quarter 1 report to the Committee, highlighting the following:

- Over 2023/24 and 2024/25 the number of whistleblowing concerns raised had stabilised at 18 a year.
- The Whistleblowing Co-ordinator will give additional resource to encourage concerns to be handled as business as usual thus decreasing the number of level 2 investigations. The Co-ordinator role will also assist the Whistleblowing Manager to take forward the action plan.
- During the period 1 April to 30 June 2025 there were 6 new concerns raised through the whistleblowing route. 3 of the 6 met the criteria for whistleblowing with the remainder routed and supported to other more appropriate routes. On average 1.5 concerns open and close each month.
- On average the timescale to close a concern was three months, contributed by undertaking a full investigation. It was hoped that from the additional resource there would be a decrease in the timescale being presented.

The Committee asked if there was any succession planning for the Speak Up Ambassadors. The Head of Engagement responded no, as all eighteen Speak Up Ambassadors remained in place following the training two years ago. No additional Speak Up Ambassadors has been recruited as there was a balance between giving those currently in role the opportunity to keep skills up-to-date given the current number of concerns being raised. There would be a conversation with the Speak Up Ambassadors to ensure an easy exit strategy was present.

The Head of Wellbeing, Culture and Development asked how any learning from the concerns raised linked back into the system, as it may have given

the opportunity to highlight trends earlier. The Head of Engagement responded that the quarterly and annual reports did outline trends, which were the same as that raised in the focus on fundamentals presentation delivered by the Interim Director of People and Culture. However with the additional resource cross system learning would be discussed at the Whistleblowing Governance group. The Whistleblowing Champion commented that learning was so important and must be done as a result of every concern raised. There was room for improvement with a link to the wider cultural work. The Whistleblowing Champion agreed that the strengthened structure to handle concerns gave the opportunity for learning to be identified, shared and sustained. The Director of Infrastructure, Sustainability and Support Services confirmed that learning would be covered at the Whistleblowing Governance group, potentially following a similar process to that used to feedback on adverse events.

The Committee confirmed they were assured.

14 Items for Noting

The Committee noted the following approved minutes/report:

14.1 BMA Joint Negotiating Committee Minutes – 22 April 2025

14.2 Colleagues and Culture Oversight Group minutes – not available as meetings conducted in workshop format

14.3 Occupational Health, Wellbeing and Safety Committee – 29 May 2025

14.4 GAPF Board report – covering the June and July 2025 meetings

14.5 Area Clinical Forum – no new approved minutes

15 Any Other Competent Business

None raised

16 Date of Next Meeting

Thursday 30 October 2025 10am to 12.30pm via Teams