

NHS Grampian

Meeting:	NHS Grampian Board
Meeting date:	8 October 2026
Item Number:	9.4
Title:	Clinical Quality and Safety Improvement Programme – Developing Key Performance Indicators
Responsible Executive:	Hugh Farrow Bishop, Executive Medical Director Rabina Tindale, Interim Executive Nurse Director
Report Author:	Kate Danskin, Chief of Staff Gillian Poskitt, Associate Director – Quality Improvement and Assurance

1 Purpose and recommendations

This report updates the Board on the development of key performance indicators for the Clinical Quality and Safety Improvement Programme and sets out the governance route for their refinement and formal approval.

This is presented to the Board for:

- Assurance
- Endorsement

Recommendation(s)

The Board is asked to:

- Scrutinise the development approach and confirm that it provides an appropriate basis for producing meaningful, evidence-based key performance indicators, while recognising that final assurance cannot be provided until baselines, trajectories and data quality have been validated.
- Endorse the proposed route for finalising the indicators following further refinement on receipt and consideration of the Healthcare Improvement Scotland responsive diagnostic review report, as follows:
 - a. Clinical Quality and Safety Improvement Programme Board at its scheduled meeting on 16 November 2026;
 - b. Consideration by the Executive Team at its meeting on 1 December 2026;
 - c. Scrutiny and recommendation by an additional December meeting of the Clinical Governance Committee; and
 - d. Final formal approval by NHS Grampian Board.

- Consider the final proposed key performance indicators for formal approval following scrutiny by the Clinical Governance Committee.

This report relates to:

- Board Annual Delivery Plan – Clinical Quality and Safety 2026/27 priority for delivery

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

The subject matter of this report is relevant to mitigation of the following strategic risk:

- 3068 – Deviation from recognised service standards of practice and delivery

2 Report summary

2.1 Situation

Clinical Quality and Safety is a Board priority for 2026/27. Robust key performance indicators are essential to provide an objective view of performance, support early identification of variation or emerging concerns, and demonstrate whether improvement activity is delivering the intended outcomes. An initial set of programme key performance indicators has been developed, as set out in Appendix A, covering the agreed priority workstreams in adverse event review improvement, complaints improvement, implementation of the Clinical Governance Framework, organisational learning and improvement, and quality and safety assurance data. The indicators remain developmental in 2026 while baselines and trajectories are validated and the supporting programme arrangements are completed. It is also recognised that the improvement work in progress and the associated KPIs developed and proposed by the Programme at this point may require to be reviewed and refocused following receipt and review of the anticipated Healthcare Improvement Scotland (HIS) responsive diagnostic review report as findings may affect the programme's priorities and the measures required. The Board is asked to note progress and endorse the proposed route to finalisation and approval.

2.2 Background

The NHS Grampian Board approved Clinical Quality and Safety as a priority on 11 June 2026. Previous reports to the Board have described the need for a consistent organisation-wide approach to clinical governance and the programme foundations required to support assurance and improvement. The developing measures align with the Healthcare Improvement Scotland Clinical Governance Standards (February 2026) and are intended to demonstrate whether programme activity is leading to stronger governance, more timely

and higher-quality review processes, clearer organisational learning and more reliable assurance data.

2.3 Assessment

The current indicator set has been developed with advice from the Head of Performance to ensure alignment with the KPIs in place for other organisational strategic priorities and provides a credible starting point but may require further review before final approval. Several proposed measures require validated baselines, realistic improvement trajectories and confirmation that the supporting data can be collected consistently; and work is in progress to determine these in collaboration with Health Intelligence colleagues in 2026. At its meeting on 17 September 2026, the Clinical Governance Committee agreed that the Healthcare Improvement Scotland responsive diagnostic review report will be a key influence in determining priority areas and associated meaningful indicators. The report is expected in November 2026 and will be reviewed to confirm or change the programme's priorities and measures.

The developing indicators were discussed by the Clinical Quality and Safety Improvement Programme Board on 18 September 2026. A further meeting of key Programme Board colleagues has been arranged in September to continue the detailed discussion and further at the Programme Board in October 2026. The Medical Director has also discussed the developing indicators with the Deputy Chief Medical Officer, providing an additional opportunity for external challenge.

Following receipt of the Healthcare Improvement Scotland responsive diagnostic review report, its findings will be considered and the proposed indicators reviewed and finalised by the Clinical Quality and Safety Improvement Programme Board at its scheduled meeting on 16 November 2026. The proposals will then be considered by the Executive Team at its meeting on 1 December 2026 before scrutiny and recommendation at an additional meeting of the Clinical Governance Committee in December 2026. Subject to that scrutiny, the final proposed indicators will be submitted to the NHS Grampian Board for formal approval. This sequence supports evidence-based refinement while maintaining appropriate pace and oversight.

2.3.1 Quality / Patient Care

Meaningful indicators will strengthen oversight of clinical quality and safety, support earlier identification and escalation of concerns, and provide clearer evidence that learning and improvement actions are resulting in safer, more effective and person-centred care. Setting targets before baselines and external findings are fully understood could create misleading assurance; the proposed staged approach mitigates this risk.

2.3.2 Workforce

Current workforce resources are being utilised to develop robust KPIs for this improvement programme.

2.3.3 Financial

No additional financial decision is required from the Board at this stage. Any resource implications associated with data development, improvement support or backlog recovery will be considered through the appropriate governance arrangements.

2.3.4 Risk Assessment / Management

The programme supports mitigation of Strategic Risk 3068, “Deviation from recognised service standards of practice and delivery”. Clinical quality and safety issues require more detailed articulation within Strategic Risk 3068, which is currently being reviewed and will be progressed through established governance routes for strategic risks.

A potential risk specific to KPI development for this Improvement Programme is the possibility that measures set before relevant evidence is available could divert from focused delivery or create false assurance. This is being managed through the phased development, Programme Board oversight, Clinical Governance Committee scrutiny and consideration of the Healthcare Improvement Scotland findings before final approval.

2.3.5 Equality and Diversity, including health inequalities

An Equality and Diversity Impact Assessment has not been completed because this paper concerns the development and governance of programme measures rather than a specific service change. The need for an impact assessment will be reviewed as individual measures and improvement actions are finalised.

2.3.6 Other impacts

No other material impacts have been identified at this stage.

2.3.7 Communication, involvement, engagement and consultation

Development has involved the Executive Team, Clinical Quality and Safety Improvement Programme Board, Clinical Governance Committee, clinical governance and improvement colleagues, and analytical support. A further discussion involving Programme Board colleagues has been arranged. The Medical Director has also discussed the developing indicators with the Deputy Chief Medical Officer. Wider engagement will continue as the baselines, measures and trajectories are refined.

2.3.8 Route to the Meeting

The developing key performance indicators were considered by Executive Team on 1 September 2026, the Clinical Governance Committee on 17 September 2026 and by the Clinical Quality and Safety Improvement Programme Board on 18 September 2026. The Clinical Governance Committee agreed that the Healthcare Improvement Scotland responsive diagnostic review report should be central to determining meaningful final indicators.

2.4 Recommendation(s)

The Board is asked to:

- Scrutinise the development approach and confirm that it provides an appropriate basis for producing meaningful, evidence-based key performance indicators, while recognising that final assurance cannot be provided until baselines, trajectories and data quality have been validated.
- Endorse the proposed route for finalising the indicators following further refinement on receipt and consideration of the Healthcare Improvement Scotland responsive diagnostic review report, as follows:
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3 Appendix/List of appendices

Appendix A – Draft Clinical Quality and Safety Improvement Programme Key Performance Indicators

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Area of Action	Key Performance Indicator	
	Measure	Target
1. Adverse Event Review Improvement – Reduce the backlog of Adverse Event Reviews to support risks being acted upon by reducing the number of outstanding reviews; and improve the quality by implementing the agreed new model's quality standards.	Reduction in the backlog of overdue Level 1 and Level 2 adverse event reviews from the September 2026 baseline.	X% reduction in Level 1 adverse event reviews. X% reduction in Level 2 adverse event reviews. Note: Health Intelligence is reviewing data using statistical process control to understand the current trajectory. Once this is understood, alongside the facilitation resource available, specific targets and trajectories can be set.
	Percentage of Level 1 review commissions and final reports that meet required quality standards at first Executive review.	Baseline established by December 2026 for the number of final draft reports and commissions requiring amendment following Executive review. Note: The new Executive review process commenced on 17 August 2026. Once the baseline is established, an improvement trajectory and key performance indicator will be agreed.
	Percentage of reviews undertaken in compliance with the new model.	By the end of September 2026, documentation for the refreshed delivery model will be shared across NHS Grampian and teams to participate in testing will be identified through the short life working group. This will lead to final launch by the end of November 2026. A detailed key performance indicator to be achieved by the end of March 2027 will then be described.
2. Complaints Improvement – Validate and reduce the overdue complaints backlog,	Reduction in overdue complaints from the September 2026 baseline.	X% reduction in overdue complaints.

improve compliance with agreed response timescales, and implement a consistent process for identifying, assigning, monitoring and evidencing improvement actions arising from complaints.		Note: Health Intelligence is reviewing data using statistical process control to understand the current trajectory. Once this is understood, alongside the facilitation resource available, specific targets and trajectories can be set.
	Increase in the percentage of complaints responded to within agreed timescales from the September 2026 baseline.	Percentage to be calculated once the baseline is established. Note: Health Intelligence is reviewing data using statistical process control to understand the current trajectory. Once this is understood, alongside the facilitation resource available, specific targets and trajectories can be set.
	Percentage of complaints assessed as requiring improvement action that have a specific action recorded in Datix, with an accountable owner, due date and intended improvement, from the September 2026 baseline.	X% of complaints requiring improvement have recorded actions. X% of complaints with an improvement action have an owner, due date and intended improvement. Note: Health Intelligence is reviewing data using statistical process control to understand the current trajectory. Once this is understood, alongside the facilitation resource available, specific targets and trajectories can be set.
3. Clinical Governance Framework Implementation – Develop, approve and implement a consistent Phase 1 Clinical Governance Framework. Complete and validate maturity assessments across in-scope clinical services to establish an organisational baseline, and support clinical governance groups that do not meet the minimum maturity	Percentage of clinical services completing the agreed Clinical Governance Maturity Assessment to provide a clear baseline.	50% of clinical services have completed the assessment. Phase 1 Framework expected to be approved for use by the Clinical Quality and Safety Improvement Programme Board in October 2026.
	Percentage of identified governance groups compliant with agreed Phase 1 Clinical Governance Framework	X% compliance. X% of non-compliant groups have agreed improvement plans.

level to implement time-bound improvement plans to achieve it.	requirements to ensure a consistent quality approach to clinical governance meetings: • current terms of reference; • defined membership; • healthcare professional chair or vice-chair; • defined reporting route; • defined escalation route; • action log; and • core agenda items used.	Percentage to be calculated once the baseline is established.
4. Organisational Learning and Improvement – Learning is translated into change and implementation is monitored so patients receive safer care.	Percentage of agreed improvement actions completed by their due dates, covering actions arising from adverse events and complaints that are recorded in Datix, and actions arising from Healthcare Improvement Scotland inspections that are not recorded in Datix. Until March 2027, the focus will be on visibility of the actions.	For adverse events, complaints and Healthcare Improvement Scotland inspections: • X% increase in actions recorded in Datix for adverse events and complaints; and • X% increase completed on time. The baseline will be determined by the end of September 2026, after which the specific key performance indicators can be stated.
5. Quality and Safety Assurance Data – Define and implement the Clinical Quality and Safety Improvement core quality and safety dataset across clinical governance groups.	Clinical governance groups using the agreed core dataset.	• Core dataset developed and implemented by all clinical governance groups. • Process for additional specialty-specific datasets to be agreed.