Board Meeting
19.03.26
Open Session
Item 12.1

APPROVED

NHS GRAMPIAN

Minutes of **NHS Grampian Clinical Governance Committee** held in **Open Session** on **Tuesday, 25 November 2025** at 1330hrs virtually by MS Teams

Present

Dennis Robertson (DR)	Chair – Non-Executive Board Member (Items 5 & 6)
David Blackbourn (DBl)	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)
Hussein Patwa (HP)	Non-Executive Board Member
Miles Paterson (MP)	Public Representative
Alison Evison (AE)	Chair of Grampian Board/ Non-Executive Board Member
John Tomlinson(JT)	Non-Executive Board Member

Attendees

Laura Skaife-Knight (LSK)	Chief Executive
Paul Bachoo (PB)	Acute Services Medical Director / Integrated Specialist Care Portfolio Executive Lead (Item 13)
Shantini Paranjothy (SP)	Director of Public Health
Noha El Sakka (NeS)	Infection Prevention and Control Doctor / Clinical Lead – (Item 9)
Lynn Morrison (LM)	Director of Allied Health Professions
June Barnard (JBa)	Nurse Director Tertiary and Secondary Care (Items 8, 10 & 14)
Hugh Farrow Bishop (HB)	Executive Medical Director
Grace Johnston (GJ)	Infection Prevention & Control Manager (Item 9)

Invitees

Gillian Poskitt (GP)	Associate Director Quality Improvement and Assurance (Item 7)
Linda Ann Lever (LL)	Team Lead Adverse Events and Feedback (Item 12)
Geraldine Fraser (GF)	Chief Officer – Acute Services (Item 15)
Sean Coady (SC)	Head of Service (Item 11)
Kathryn French (KF)	Acting Clinical Nurse Manager (Item 11)
Rachael Little (RL)	Interim Team Lead - Quality Improvement & Assurance (meeting support)
Angela Chalmers (AC)	Quality Improvement & Assurance Administrator (minute taker)

1 Apologies

Noted apologies received from: Emma Houghton, June Brown, Tara Fairley & Dave Russell. The meeting was quorate.

2 Declarations of Interest

Under item 11, transparency statements were made for the abundance of caution. HP, noted his membership of the Diverse Experiences Advisory Panel and role as lived experience representative on the Scottish Government's Mental Health and Well-Being Leadership Board, but confirmed he did not feel conflicted and would remain in the meeting. DR, similarly declared his position as Chair of the Moray Integration Joint Board, stating this was for transparency only and that he too was not conflicted. No other declarations of interest were recorded.

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

DR (Chair), updated the ongoing matters arising –

The national Paediatric Audiology Report, which had been scheduled to return in November 2026 on an 18-month timescale. The Chair DR, questioned whether revisiting it at that stage was appropriate, noting that current NHS Grampian priorities should remain the focus. MB, suggested the matter may now be operational and managed as business-as-usual rather than requiring committee oversight. PB confirmed that an update had already been provided to the Scottish Government on 22 November 2025 regarding audiology waiting lists, highlighting recruitment of a fully qualified audiologist, ongoing recruitment for a new post in Moray to address capacity, reduced appointment times in specific clinics, and targeted clinics for adult reassessments and paediatrics. The Chair concluded that this update was adequate for committee purposes and, unless the Scottish Government requests further assurance, the matter does not need to return to this Committee.

6 Review of Terms of Reference

DR (Chair), highlighted recommendations of change for the Clinical Governance Committee Terms of Reference -

The committee considered the interim review of the terms of reference, brought forward following previous discussions on the transition from the former cross-system Quality and Safety Assurance Group to the newly established Action Learning Group for quality and safety, and its link with the Whole System Clinical Governance Group. It was noted that a full review of the terms of reference, in line with other board subcommittees, is scheduled for May 2026. The main focus of discussion was the organogram, with members confirming the agreed terms of reference from earlier meetings. MB, highlighted the importance of maintaining relevance through future reporting mechanisms via the Acute Governance Group. JT, raised points of detail regarding public representation, recommending the wording reflect a minimum of one representative, and sought assurance that the forward planner would indicate reporting against remit for audit purposes, which the Chair confirmed. LM, noted for accuracy that the Associate Director of Public Protection and the Director of Allied Health Professions are now separate roles, both of which should be listed as members. These amendments were agreed and noted.

Recommendations: The Committee is asked to:

Assurance – Review and scrutinise the information provided in this paper and confirm that it provides assurance that

the terms of reference and processes necessary are in place and are robust

the terms of reference and processes are working effectively, any gaps have been identified and assessed, and risks are being mitigated effectively

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

Endorsement – Endorse the amended Terms of Reference Appendix 1

The Committee agreed and accepted the recommendations.

Chair – Assured, members content.

7 NHSG Clinical Governance Committee Workshop 02 June 2025

Gillian Poskitt (GP), Associate Director Quality Improvement and Assurance

GP Highlighted Key Points from the Report on recommendations and themes from the June 2025 Clinical Governance Committee workshop, which built on discussions from the Board Seminar in May 2025 and focused on templates, reporting, triangulation of data, and standard operating procedures. Seven unique recommendations on reporting templates and nine on SOPs were identified, with recognition that SOPs for situations where committees are not assured may apply across all board committees, not just Clinical Governance. Members commended progress already evident in recent papers, particularly improvements in clarity and plain English, while highlighting the need for consistency between open and closed session papers to ensure equity, accessibility, and effective scrutiny. It was agreed that adopting the same format across both sessions would strengthen assurance and support committee members in their oversight role.

Recommendations: The Committee is asked to:

Assurance – Review and scrutinise the information provided in this paper and confirm that it provides assurance that the collated feedback from the workshop and processes necessary are in place and are robust to identify themes, actions and recommendations for the Committee to consider

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

Endorsement – Endorse the themes, actions and recommendations from the workshop collated feedback.

Committee agreed the recommendations with no escalation required.

8. Clinical Risk Meeting Report

June Barnard (JBa), Nurse Director Secondary & Tertiary Care

JBa, Shared Key Points with in the submitted report and dashboard for July–September 2025, presented in the revised format incorporating workshop changes. The report provided assurance on quality and safety elements from weekly Clinical Risk Meetings (CRM), highlighting two escalations to the Chief Executive Team: information governance compliance with statutory requests, and Scottish Public Services Ombudsman (SPSO) case submissions. Mitigations include recruitment processes and improved timeliness, with positive news that 13 recent SPSO cases were not taken forward. An extraordinary CRM meeting was held to review escalation processes and ensure clear triggers. Additional updates included engagement with HIS inspections, actions to address non-compliance with level one adverse event reviews against the 90-day target, variation in falls data with ongoing improvement work, progress in the LEAF project reducing national falls rates, increased complaints linked to waiting times in integrated specialist care, and continued risk monitoring.

Members welcomed the clarity of the report and raised concern over capacity issues affecting level one reviews, with assurance provided that measures are being taken to improve compliance, training, and distribution of workload to reduce fatigue and strengthen shared learning.

LSK queried whether there were key themes or headlines emerging from the review into the quality of significant Adverse Event reviews, and if recommendations would be brought to the next committee. GP confirmed that progress was being made through the Action Learning Group, with facilitated sessions addressing challenges around Level 1 reviewers and the impact on individuals undertaking reviews. She advised that a short life working group, chaired by Pamela Milliken (PM), Senior Responsible Officer – Acute Pathways Integration, will be established to take forward the action plan from the external diagnostic review alongside recommendations from the SCR. This group will report to the CRM, with updates provided

through committee papers, and is expected to conclude its initial work by March 2026, setting clear plans and scopes for ongoing actions. DR (Chair), sought assurance that the group would have defined terms of reference and timelines, which was confirmed.

Concerns were also raised regarding Clinical Risk oversight within Health and Social Care Partnerships, with JBa highlighting the importance of a Whole-System Governance approach to ensure transparency and shared responsibility. HFB confirmed that, following previous discussions, the portfolio Medical Director has now been formally nominated to join each IJB Clinical Governance structure, with letters issued to committee chairs to strengthen medical input. DR requested wider sharing of these letters for transparency, which HFB agreed to check. GP noted that the live Illuminate dashboard provides detailed operational and strategic data to support assurance. The committee reviewed the clinical risk report and confirmed that it provides assurance of proportionate responses to minimise harm, with no escalation required at this stage, though some action points will be taken forward by GP and RL.

DR thanked the author for the structure of the paper and the informative presentation.

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.

Committee agreed the recommendations with no escalation required.

9. Healthcare Associated Infection (HAI) Report

Noha El Sakka (NeS), Infection Prevention & Control Doctor/Clinical Lead

NeS highlighted Key Points from the submitted papers which included ongoing concerns with the Healthcare built environment, monitoring of National Surveillance KPIs, and Risks linked to the Central Decontamination Unit and Neonatal Unit, both under active incident management. Surveillance data showed mixed performance against national averages for E. coli, C. difficile, and Staph aureus bacteraemia, though NHS Grampian was not identified as an outlier. Assurance was provided that multidisciplinary measures are in place, including enhanced cleaning, surveillance, and infection control interventions, with recent progress noted. Additional assurance was given regarding agreed solutions for sink spacing in the Baird Hospital Neonatal Unit. Discussion from the committee around hand hygiene compliance, particularly among medical staff, and the importance of reinforcing standards across patient environments.

The committee welcomed the assurances provided, and agreed continued focus on infection prevention and control measures.

Recommendations: The Committee is asked to:

Review and scrutinise the information provided in this paper and confirm that it provides assurance of ongoing mitigations, where possible.

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

Committee agreed the recommendations with no escalation required.

10 HIS/NES Action Plan Update (Deferred from August 2025)

June Barnard (JBa), Nurse Director Secondary & Tertiary Services

JBa provided the Committee with an update on progress against the external scrutiny action plan, originally initiated following correspondence highlighting concerns around leadership, culture, clinical quality and safety, cardiology and orthopaedic services, maternity re-provision, unscheduled care, medical leadership, workforce and governance. Members were reminded that most of the required actions have been completed, with only two items remaining under active monitoring. The portfolio review and the establishment of the acute sector triumvirate, and the integration work on acute pathways including cardiology vetting which is being monitored through the Chief Executive Team, with completion expected by January 2026.

The Committee welcomed the progress made but emphasised the need for continued focus on cardiology leadership and vetting processes. Clarification was sought on whether CET oversight would conclude the process or whether further reporting to the Committee would be required. JBa and LSK confirmed that CET would oversee completion but, given the significance of the issues, a full closure report will be brought to the next meeting, setting out the final governance arrangements and escalation routes.

The Committee welcomed the assurances provided and agreed to schedule this for February 2026.

Recommendations: The Committee is asked to:

Assurance – Review and scrutinise the information provided in this paper and confirm that it provides assurance in relation to the External Scrutiny Action plan completion to date. The 2 outstanding actions have been transferred to the Chief Executive Team action tracker which will be monitored until completion.

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).

Committee agreed the recommendations with no escalation required.

11 Ligature Reduction, Ward 4, Dr Gray's Hospital

Sean Coady (SC), Head of Service & Kathryn French (KF), Acting Clinical Nurse Manager

SC highlighted key points from the submitted papers and provided an update on the longstanding ligature-reduction risks in Dr Gray's Hospital, Ward 4, noting that the authors were unable to attend due to national mental health commitments, with the Clinical Nurse Manager presenting the paper. The report highlighted that Ward 4 remains a non-ligature-reduced environment, that mitigation measures continue to be required, and that the associated risk is currently recorded only within the Moray HSCP register rather than on the NHS Grampian Corporate Risk Register. The committee questioned the lack of progress over several years and sought assurance on patient safety, particularly regarding the transfer of high-risk patients to Royal Cornhill Hospital. SC confirmed that Cornhill has accommodated all escalations to date, with contingency arrangements, including use of older adult wards and constant interventions available when required. HP requested clarity on the definition of "ligature risk," and it was confirmed that this refers to environmental fixtures that could enable self-harm through anchoring. The Committee noted informal feedback from the recent Mental Welfare Commission visit, which praised staff but raised further environmental concerns. Members queried why the risk was not already on the corporate register. KF advised this gap had only recently been identified and would be corrected. An options appraisal, including capital costs and governance proposals, will be presented to the Chief Executive Team on 9 December.

The Committee agreed that the risk should be added to the corporate register and that the ligature oversight group should be reinstated, with a further update to return following the December review.

Recommendations: The Committee is asked to:
Assurance – Review and scrutinise the information provided in this paper and confirm that it provides assurance that actions and escalations have been followed through to the Board's satisfaction.

Escalation –

Report to update the Chief Executive Team

Completed Options Appraisal and Report to the Asset Management Group

Decision – Agree with the recommendations outlined in Section 1 of this report.

Endorsement – Endorse the proposals contained in this paper.

Committee agreed the recommendations with no escalation required.

12 Duty of Candour Annual Report 2024 – 2025

Linda Lever, Team Lead Adverse Events and Feedback

LL highlighted key factors of the annual Duty of Candour Report and noted that the number of cases remains similar to last year. Assurance was provided that the organisation continues to learn from events and improve systems and processes. A brief explanation was given on the difference between the professional Duty of Candour, which applies to individual healthcare staff, and the statutory Duty of Candour, which applies to the organisation when significant harm occurs.

The Committee discussed the small number of cases identified through complaints and noted ongoing work to strengthen consistency across services. Members welcomed the increasing involvement of families in the process and highlighted the importance of sharing learning widely. The Committee also recognised the value of linking Duty of Candour information with other feedback to support a positive organisational culture.

GP noted continued progress in strengthening family involvement in adverse event reviews, supported by the Family Liaison Manager and aligned with the national framework that predates the statutory Duty of Candour. Examples were shared of families actively participating in learning meetings, with staff increasingly open to constructive dialogue. It was also highlighted that some events are initially over-reported as statutory Duty of Candour when they are in fact professional duties, reflecting a positive reporting culture. The Committee discussed the need for improved triangulation of cultural indicators, including complaints, whistleblowing, Datix and staff feedback, with work underway to develop an organisational culture dashboard.

Members emphasised the value of compassionate conversations with families and encouraged continued development in this area.

The report was noted and the Committee was assured by the progress described.

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).

The report was noted and the Committee was assured by the progress described with no escalation required.

13 Strategic Risk Report
Risk 3065 Planned Care
Paul Bachoo (PB), Acute Services Medical Director / Integrated Specialist Care Portfolio Executive Lead

PB provided an update on Strategic Risk 3065 (Planned Care), noting that while the risk remains very high, it has improved from an intolerable level earlier in the year. A formal review of the risk rating will take place at the end of Quarter 4 following completion of the operational improvement plan. The Board acknowledged the significant challenges faced, workforce constraints, short-stay unit pressures, flow issues and Central Decontamination Unit (CDU) disruption and commended teams for adapting effectively. Progress was noted in reducing long waits, stabilising 52-week breaches, and improving performance across Treatment Time Guarantee (TTG), diagnostics and cancer pathways, supported by strengthened governance, validation processes and digital initiatives. The Board also discussed the new Golden Jubilee pathway for rapid colonoscopy for screening-identified patients, recognising its potential impact and the need to monitor capacity, sustainability and staff wellbeing.

While trajectories remain positive, the Committee agreed that the strategic risk cannot yet be reduced from “very high” to “high,” with further evidence required, including understanding the impact of CDU and rising complaints within specialist care. PB noted that, subject to continued progress and full delivery of the operational improvement plan, he is hopeful that by the end of the quarter a request to downgrade the strategic risk may be brought forward.

Recommendations: The Committee is asked to:
Assurance –

Review and scrutinise the information provided in this paper that:

(1) Presents an overall understanding of the Risk

(2) Management of the Risk with effective control measures that are impactful and improving the Risk profile from Very High to High and towards Tolerance levels for our organisational Risk appet

Recommendation:

Review and scrutinise the information provided in this paper and confirm that it provides assuranc that the policies and processes necessary are in place and are robust.

To note the report

Request an update during Quarter 1 2026/7
Escalation – Confirm if any escalation is required to another Board committee or the Board and specify the details of that escalation.

Committee agreed the recommendations with a requested update in May 2026.

14 Strategic Risk Report
Risk 3068 Service Deviations
June Barnard (JBA), Nurse Director Secondary & Tertiary Care

JBa provided a comprehensive update on Strategic Risk 3068, (Service Deviations), covering financial performance, operational delivery, governance matters, and key strategic transformation initiatives. Members noted steady progress against plan, with particular attention to emerging financial pressures, operational dependencies, and regulatory expectations. The Committee discussed the associated risk profile, including mitigation measures, assurance activity, and the need for strengthened cross-functional oversight. Assurance reaffirmed support for the transformation roadmap while emphasising disciplined execution, transparent reporting, and alignment with long-term organisational priorities. It was agreed that management will provide a further integrated update at the next meeting to ensure continued visibility and effective governance.

Recommendations: The Committee is asked to:
Assurance - Review and scrutinise the information provided in this paper and confirm that it provides assurance that:
Processes regarding the management of Strategic Risk 3068 are in place, and any gaps in controls identified are being 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

Committee agreed the recommendations with no escalations required.

15 Strategic Risk Report
Risk 3639 Unscheduled Care
Geraldine Fraser (GF), Chief Officer – Acute Services

GF updated as reported on the ongoing pressures within unscheduled care, noting that recent performance remains below the level expected and continues to present a significant strategic risk. The Board was assured that strengthened operational controls have been implemented, including enhanced daily system-wide oversight, increased senior management presence, refined discharge reporting, and the introduction of daily tactical meetings to support timely decision-making and escalation. Work is underway to refine local escalation frameworks and trigger points, aligned with national models, in response to sustained increases in demand and acuity. The Committee also noted progress on the Scottish Government–approved Unscheduled Care Improvement Plan, with 18 workstreams now linked to key performance indicators and a near-complete logic model to assess cumulative impact. While medium- to long-term improvements are expected, the Board acknowledged that pressures remain acute during the winter period, and further discussions are ongoing with the Scottish Government regarding immediate levers, including recently announced social care funding. The Committee emphasised the need to maintain focus on hospital flow, frailty and general medicine pathways, and recognised both the substantial improvement work underway and the residual risks that continue to require close oversight.

The Committee sought assurance on when the impact of the extensive work on unscheduled care would become visible, asking specifically about trigger points, escalation thresholds, and the actions available to prevent deterioration before triggers are reached. In response, GF confirmed that detailed modelling is underway to refine local triggers, recognising that national thresholds would be met almost continuously given current pressures and to develop a clearer sliding scale of preventative actions. The Committee was advised that strengthened daily operational controls are in place, alongside discussions with the Scottish Government on

short-term funding to support higher-cost interventions such as accelerating patient flow to long-term care destinations. Members also queried the role of clinical leadership and primary care in upstream improvement. GF highlighted strong clinical engagement across the programme, including clinician-led workstreams, a new part-time GP role within the team, and growing collaboration through the flow navigation centre and shared data opportunities.

The Committee noted positive early staff feedback, the impact of winter pressures, and the need for continued scrutiny of both immediate mitigations and longer-term improvement outcomes.

Recommendations: The Committee is asked to:

Assurance – Review and scrutinise the information provided in this paper and confirm that it provides assurance about the monitoring and management of the Strategic Risk and provides appropriate information about potential improvements to the mitigation of this risk.

Escalation – Confirm if any escalation is required to another Board committees 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)

Committee agreed the recommendations with an update requested on 17 February 2026.

16 Any Other Competent Business

No AOCB raised.

17 Date of Next Meeting

17 February 2026, 1330 – 1630 Hours, MS Teams.

GP highlighted, timelines for the February meeting, noting that papers for the 17 February session would require submission to the Chief Executive Team by 6 January for a six-week cycle, or by 20 January for a four-week cycle. Although tight, the Committee agreed these timelines were necessary given ongoing scrutiny from the Assurance Board. Members were also advised that a Scottish Government directive requires a review of maternity services early in the new year, with a report scheduled for the February meeting. A forward planner will be developed through the agenda-setting process and shared at the next meeting.

The Chair thanked members and presenters for their contributions and closed the meeting.