Health, Care and Sport Committee
Wednesday 2 December 2026
13th Meeting, 2026 (Session 7)

Clinical governance, leadership and patient safety issues at NHS Grampian – Note by the Clerk

Introduction

1. At a recent work programme discussion, Members indicated they wished to hold a one-off evidence session on the subject of clinical governance, leadership and patient safety issues at NHS Grampian.

2. This decision followed the publication of the report by Healthcare Improvement Scotland (HIS), which was critical of clinical governance, leadership and patient safety issues at Dr Gray's Hospital in Elgin and NHS Grampian more widely[1]. HIS also published a second report into Dr Gray's Hospital[2].

3. In a separate development, a report from 2022 on hepatobiliary (HPB) surgery[3] in NHS Grampian was made public by a whistleblower who is currently a surgeon at Aberdeen Royal Infirmary (ARI). The independent surgical review was undertaken by Professor Stephen Wigmore, University of Edinburgh and Professor Giles Toogood, University of Leeds.

Background

4. NHS Grampian is one of the current 14 territorial health boards in Scotland. It is responsible for providing health and social care services to a population of over 500,000 people living in Aberdeen, Aberdeenshire and Moray.

5. There are several specialist acute hospitals in the NHS Grampian region, the largest being Aberdeen Royal Infirmary, with others including the Royal Aberdeen Children's Hospital and Aberdeen Maternity Hospital, Woodend Hospital, the Royal Cornhill Hospital and City Hospital, the location of the specialist Links Unit and several out-patient clinics.

6. Elsewhere in the region, specifically Elgin, there is Dr Gray's Hospital and The Oaks.

7. In May 2026, following concerns expressed at the time, the current Chief Executive of NHS Grampian, Laura Skaife-Knight, invited HIS to carry out the

[1] Healthcare Improvement Scotland, NHS Grampian Responsive Diagnostic Review, 12 November 2026. Available at: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2026/11/NHS-Grampian-Responsive-Diagnostic-Review-November-2026.pdf

[2] Healthcare Improvement Scotland, Dr Gray's Hospital, NHS Grampian – acute safe delivery of care inspection report, November 2026. Available at: Dr Gray's Hospital, NHS Grampian – acute safe delivery of care inspection report: November 2026 – Healthcare Improvement Scotland

[3] Hepatobiliary refers to the liver, gallbladder, and bile ducts.

aforementioned diagnostic review on the subject of clinical governance, leadership and patient safety issues at NHS Grampian.

8. **Paper 2 provides further detail on this report**. In summary, the key issues and concerns investigated focused on Dr Gray's Hospital in Elgin and NHS Grampian more widely. It makes comment in the following areas and then concludes with six recommendations:

    - Clinical governance systems, which the report says NHS Grampian "repeatedly failed to resolve"[4]

    - Leadership, structures and processes, which the report says are "weak" in NHS Grampian[5]

    - Organisational oversight, which the report says is "inadequate" in NHS Grampian[6]

    - The integration of Dr Gray's into NHS Grampian, which the report says is "inadequate"[7]

9. The separate HIS report into Dr Gray's Hospital detailed that HIS identified concerns regarding the medical model of care in the high dependency unit, which relied significantly on a locum consultant for the unit, with a lack of assurance of a robust medical structure to support the provision of care over 24 hours, 7 days a week.

10. As noted above, in a separate development, in recent weeks, a report from 2022 on HPB surgery was made public by a whistleblower. As noted in Paper 2, this report has not been published elsewhere, for example, by NHS Grampian. **As such, the analysis that follows and that in Paper 2 is based on public discussion of the report, primarily in the media**. Because certain reports and letters are not in the public domain, the clerks have not been able to independently verify certain points, for example, dates of letters and the contents of the 2022 report.

11. It has been reported that the review of HPB surgery in NHS Grampian was commissioned by the then Chief Executive of the health board, Professor Hiscox, and was carried out, as stated above, by an independent experts from the University of Edinburgh and the University of Leeds.

12. It has been reported in the media that the report highlights figures which suggest that the death rate for major liver resections were high. The figures cited, for the period 2017 and 2020, are believed to say that there were recorded mortality rates of 12% at 30 days and 18% at 90 days, compared to an expected rate of 2.2% based on national figures. It has been suggested that 31 people died and that 19

[4] Healthcare Improvement Scotland, NHS Grampian Responsive Diagnostic Review, 12 November 2026, page 9.
[5] Ibid, page 11.
[6] Ibid, page 10.
[7] Ibid, page 12.

were avoidable deaths among the 45 patients in liver and pancreatic surgery reviewed at Aberdeen Royal Infirmary (ARI).[8]

13. Other concerns that have been highlighted in the media coverage of the unpublished 2022 report include commentary on what is described as overly aggressive interventions, poor planning and a lack of non-surgical alternatives.

14. On 21 November in a letter to the Committee (**see Annex A**), and subsequently in the chamber on 24 November, the Cabinet Secretary for Health and Care announced that a senior member of the legal profession, a KC, will be appointed to lead an independent review into how concerns over HPB surgery at NHS Grampian were handled by the NHS and the Scottish Government. Paper 2 provides further details.

15. **Annex B** provides Members will an initial chronology of events, based on information currently available to parliamentary officials. The development of a full chronology is one of the tasks that has been suggested will be undertaken by the KC-led independent review.

16. **Annex C** contains written submissions from today's witnesses.

Today's meeting

17. The Committee will take evidence from the following panels of witnesses:

Panel 1

- Karen Titchener, Commissioner, and Gavin Bisset, Policy and Investigations Manager, Patient Safety Commissioner
- Dr Izhar Khan, Consultant Nephrologist & General Physician, NHS Grampian
- Professor Zygmunt Krukowski, former consultant general surgeon at ARI

Panel 2

- Laura Skaife-Knight, Chief Executive, NHS Grampian
- Professor John Connaghan, Interim Chair, NHS Grampian
- Professor Caroline Hiscox, former Chief Executive, NHS Grampian and current Chief Executive, NHS Lothian

18. Members will have up to 60 minutes for the first panel and up to 2 hours for the second panel.

19. Members will then discuss the evidence heard and what, if any, further action is needed in this area. This item will be taken in private unless Members decide otherwise.

Clerks to the Committee
November 2026

[8] BBC Scotland, Health secretary denies cover-up over NHS Grampian issues, 22 November. Available at: https://www.bbc.co.uk/news/articles/cmedqy496ngno

ANNEX A

Letter from the Cabinet Secretary to the Committee (dated 21 November)

Dear Convener,

I am writing to you in relation to the significant public interest there has been in recent days surrounding the concerns raised by a whistleblower focused on Hepatopancreatobiliary (HPB) surgery at Aberdeen Royal Infirmary, as well as a report concluded in 2022 regarding the deaths of patients who underwent HPB surgery.

From the outset, let me express my sincere condolences to any family that has lost a loved one and let me recognise the courage it has taken the whistleblower, Dr Mohammed Habib, to come forward with his concerns. I recognise he has sought to do this repeatedly, both to the Scottish Government and to a number of other bodies. Any member of staff in our NHS must be able to come forward freely and without fear of detriment.

I am deeply concerned at the allegations that have been raised by Dr Habib and agree with the comments made by the First Minister during First Minister's Questions that the standard of care and the necessity of high-quality care and patient safety must be uppermost in all circumstances in the NHS. Where concerns are raised, they must be properly and robustly pursued.

I have already set out to Parliament the unprecedented steps the Government is taking to provide external scrutiny of NHS Grampian and to ensure urgent changes are made to restore confidence in services. I have commissioned an external Intervention Support Team to support NHS Grampian to deliver the recommendations of the Healthcare Improvement Scotland (HIS) Diagnostic Review. I expect progress to be demonstrated by the end of the year and have been clear the option of escalating NHS Grampian to stage 5 remains on the table.

In relation to how the four pieces of correspondence received by the Government from Dr Habib in 2023, 2024, 2025 and 2026 were processed, you will be aware the First Minister has already asked the Permanent Secretary to conduct an internal review. This will identify if any changes to the current process for managing correspondence should be made.

However, given the grave concerns raised by Dr Habib regarding how a 2022 report into patient deaths was handled, I believe it is vital we take urgent steps to assure ourselves of the role the Scottish Government has played in interrogating this report and responding. The First Minister and I are determined that the Government must act transparently and decisively on such matters.

I am therefore writing to inform the Committee, following discussion with the First Minister, that we will establish an independent review to examine the actions taken in response to concerns about HPB surgery in NHS Grampian, with a particular focus on the concerns regarding how the 2022 report into potential patient deaths was handled.

The review will establish the facts, including who knew what, when they knew it, what they did and why. This will include assessment of NHS Grampian's and the Scottish Government's handling, including the role of Ministers and the adequacy of the information and advice available to them.

Missed opportunities, unreasonable delay, and gaps in accountability or weaknesses in governance will be identified, as well as good practice and where processes and procedures worked well.

The review will be led by a suitably experienced and authoritative figure entirely independent of the Scottish Government, NHS Scotland and the events under examination. The final terms of reference will be determined by them to assure the independence of the process. I confirm the reviewer will have access to any of the material they require and NHS Grampian and the Scottish Government will be required to preserve and disclose potentially relevant records, subject to lawful restrictions notice. Last night, the Permanent Secretary issued a letter instructing officials and NHS Boards to preserve potentially relevant records to ensure records are protected and available to the review.

Arrangements will also be made to ensure that any evidence indicating risk to patient safety, potential criminality, serious professional misconduct or a need for urgent statutory action is referred promptly to the appropriate body, without waiting for the final report. There will be a clear presumption that the review's findings and final report will be published.

I intend to provide further details in a Statement to Parliament on this on Tuesday - subject to the agreement of the Parliamentary Bureau - as I recognise the significant Parliamentary interest in ensuring the safe and sustainable delivery of services in NHS Grampian and to ensuring the concerns raised by this whistleblower are fully addressed.

Finally, it is important to reiterate the comments I made last week, that the HIS Diagnostic Review and inspection reports published on 12th November recognise the safe, professional and high-quality care being provided on the ground for patients currently across NHS Grampian. Services are safe and patients should continue to use them. It is incumbent on all of us to ensure hard-working staff delivering excellent services feel supported and do not carry the blame for the failures of leadership and governance.

I also remind colleagues that NHS Grampian have established a helpline for any patients who may have questions or require advice or support on 08085 202030.

Yours sincerely,

Angela Constance
Cabinet Secretary for Health and Care

ANNEX B

Initial chronology of events (based on information available to officials)

2012	Concerns first raised in relation to ARI, via an audit report into HPB surgery
1 December 2014	NHS Grampian publishes an immediate action plan in response to the invited review of Quality and Safety at Aberdeen Royal Infirmary, the Royal College of Surgeons (England) report and the findings and recommendations from the unannounced Older People in Acute Hospitals Inspection.
2021	(based on media coverage) Dr Habib raised concerns with NHS Grampian, as well as with police and the Lord Advocate
2022	Review undertaken by Professor Stephen Wigmore, University of Edinburgh, into the period 2015-2021 period at 45 patient cases (not currently published due to concerns over patient confidentiality)
2022	Surgery paused and transferred to Lothian
January 2023	HPB surgery at ARI restarted and then ceased
May 2023	6-month review by Professor Wigmore gave reassurance that services were competent
2023 - 2026	(based on media coverage) Dr Habib sends four separate letters to Scottish ministers calling for a public inquiry into patient safety in HPB surgery at Aberdeen Royal Infirmary
Spring 2025	NHS board escalated to level 4
May 2026	Diagnostic review from HIS commissioned by Chief Executive of NHS Grampian
November 2026	HIS publishes inspection reports into Dr Gray's acute and maternity services, and maternity services at Aberdeen Royal Infirmary
November 2026	HIS issues report into the culture and leadership at NHS Grampian
21 November and 24 November 2026	Cabinet Secretary for Health and Care announces KC-led review on HPB surgery at Aberdeen Royal Infirmary
21 November 2026	Former FM and Cabinet Secretary for Health, Humza Yousaf, makes a statement saying he will cooperate fully with any investigation and supports action at the board

ANNEX C

Written submissions of evidence

Patient Safety Commissioner (relating to NHS Grampian)

Patient safety and clinical governance at NHS Grampian

1. Introduction

The Patient Safety Commissioner for Scotland welcomes the opportunity to give evidence on patient safety and clinical governance at NHS Grampian. This submission considers two distinct bodies of evidence: Healthcare Improvement Scotland's (HIS) published NHS Grampian Responsive Diagnostic Review, which focused on Dr Gray's Hospital and NHs Grampian's wider clinical governance arrangements, and the unpublished 2022 external review of hepato-pancreato-biliary (HPB) surgery at Aberdeen Royal Infirmary.

The Commissioner does not seek to determine individual clinical culpability or prejudge ongoing investigations. The central question is whether concerns were recognised, escalated and acted on effectively, and whether there is now evidence that patients are safer.

The Commissioner's Office has been unable to obtain a copy of the HPB review through informal enquiries. If necessary, the Commissioner may use statutory powers to require its production.

2. Dr Gray's Hospital and the HIS diagnostic review

HIS undertook the review in response to persistent, serious concerns about safety, quality, governance and leadership, many of which had already been raised with NHS Grampian. It examined whether the Board's governance arrangements worked in practice: how risks were escalated, how leaders responded, and whether oversight and learning led to sustained improvement.

HIS's diagnostic summary identifies four overarching areas of concern:

1. Dr Gray's Hospital was insufficiently integrated within NHS Grampian;
2. NHS Grampian had repeatedly failed to resolve clinical governance concerns effectively;
3. NHS Grampian's Board-level scrutiny and oversight of clinical governance were inadequate; and
4. leadership and management of the medical workforce were weak.

Staff at Dr Gray's told HIS that they did not feel sufficiently supported or listened to. The review identified concerns about patient safety, staffing and inadequate investigation of risks, many of which extended beyond Dr Gray's.

Escalation and response

Some risks had been escalated before publication of the review. For example, HIS formally escalated concerns to NHS Grampian on 1 May 2026 regarding the safe delivery of level 2 critical care at Dr Gray's Hospital. In July 2026, HIS also raised significant concerns about the safe and effective care of critically unwell children, including staff training and an increase in reported adverse events relating to timely transfer.

Elective paediatric surgery was temporarily suspended on 9 July alongside an existing suspension of emergency paediatric surgery. However, HIS subsequently reported that elective paediatric dental and ENT surgery had continued until 6 August. HIS stated that this affected its confidence in the reliability and consistency of information received from NHS Grampian.

In the Commissioner's view, the Committee should establish when each significant risk was first recognised, who was informed, what action followed and how it was monitored, what assurance reached the Board and external oversight bodies, and what evidence demonstrated that risk had reduced.

3. Learning from harm

HIS reported serious concerns about patterns of repeated and avoidable harm and identified major deficiencies in NHS Grampian's review of a patient's death during surgery. These included inadequate analysis of key contributory factors and insufficient senior and executive oversight. HIS also reported incorrect information had been provided to it, together with inconsistent accounts concerning executive medical involvement for which it had not received a satisfactory explanation at the time of publication.

HIS has indicated that a separate review of NHS Grampian's systems, governance and quality relating to significant adverse event reviews (SAERs) will be undertaken.

NHS Grampian has since acknowledged that aspects of the case were not examined in sufficient detail initially, apologised to the next of kin and reopened the SAER with external support and family involvement. The Commissioner's Office is also aware of plans to commission an external company to review approximately 100 outstanding SAERs.

Completing a review is not, in itself, evidence that learning has taken place. The test is whether the findings lead to changes in practice that reduce the risk of recurrence.

4. Aberdeen Royal Infirmary and the 2022 HPB review

The external review of HPB surgery by Professor Stephen Wigmore and Professor Giles Toogood has not been formally published. The Scottish Parliament has discussed reports of at least 19 deaths described as avoidable. Parliamentary questions lodged on 23 November about NHS Grampian's and the Chief Medical Officer's responses to the September 2022 report remained unanswered at the date of this submission. The Commissioner does not adopt the reported clinical conclusions without examining the primary evidence.

The Commissioner recommends that the Committee obtain the report and establish a documentary chronology: why it was commissioned, what evidence it examined and what it found and recommended; who received it and when; how the NHS Grampian Board and national leadership responded; what patients and families were told; and whether subsequent evidence showed that any identified risks had reduced. The later HIS findings make these questions important but do not establish what happened in 2022.

Patient confidentiality and other legal considerations may prevent publication in full. However, those responsible for scrutiny should have access to the report, and there should ordinarily be public transparency about material safety findings, recommendations and the response to them.

5. Listening to staff, patients and families

NHS Grampian should consider concerns raised by staff, patients and families alongside complaints, adverse events, outcomes data, audits and external reviews. Looking at these sources together can reveal patterns that individual reports may miss.

However, evidence relating to one source or set of concerns should not automatically be taken as establishing what happened in another.

The NHS Grampian Assurance Board's June 2026 minutes identified a need to strengthen staff involvement and confidence that speaking up would lead to action. The Committee should test whether staff concerns lead to timely investigation, escalation, feedback and action, rather than simply whether a reporting route exists.

Patients and families affected by serious harm should be told openly what happened, invited to contribute to reviews, and given clear explanations of the findings and information about what changed. They should receive appropriate support, particularly when a case is reopened.

The Commissioner's Office was assured that Duty of Candour conversations had taken place with 15 out of 19 of the patients or families involved.

The findings do not mean that all care across NHS Grampian is unsafe. Published HIS inspection material also records compassionate care and good practice. NHS Grampian has advised patients to keep attending appointments and seeking care when needed and has established a helpline for people concerned about their care.

During the Commissioner's recent visit on 24 and 25 November, staff at both Dr Gray's Hospital and the Aberdeen Royal Infirmary raised significant concerns directly with the Commissioner about patient safety, the culture around speaking up and the support available from management. These concerns are consistent with issues being raised through the Commissioner's enquiries inbox, including patients and families reporting that they do not feel heard and that important questions about their care are not being answered.

6. Current oversight and evidence of improvement

NHS Grampian has accepted the HIS findings, apologised and committed to setting out what needs to change, who is accountable and how improvement will be measured.

NHS Grampian was escalated to stage 4 of the NHS Scotland Support and Intervention Framework on 12 May 2025 for finance, leadership and governance. A Scottish Government Assurance Board oversees its Improvement Plan.

In August and September 2026, the Assurance Board's records showed that NHS Grampian was still developing its quality and safety indicators, strengthening links between quality, safety and risk management, and seeking external support to address backlogs in complaints and SAERs.

The Committee should ask NHS Grampian to demonstrate, for each significant recommendation, who is accountable, what action is due and when, what evidence shows that practice has changed and risk has reduced, and how any remaining risk will be managed. A revised procedure or completed action is not, on its own, evidence that care is safer.

7. National accountability for unresolved risks

HIS can recommend changes, but a recommendation from a review such as this does not, by itself, legally oblige an NHS Board to accept or implement it. To the Commissioner's knowledge, no organisation in Scotland has a direct statutory power to require an NHS Board to implement such a recommendation. In practice, the system relies on Boards accepting recommendations and acting on them, supported by monitoring and escalation to the Scottish Government or Scottish Ministers where necessary. Escalation does not make a recommendation legally binding.

The Committee should establish where responsibility lies for ensuring that a serious patient safety risk is addressed. It should also test whether HIS, NHS Boards and the Scottish Government have a clear route under the Support and Intervention Framework to escalate recommendations that are rejected, delayed, inadequately implemented or closed without evidence of improvement.

The experience at NHS Grampian raises the question of whether an enforceable mechanism for significant patient-safety recommendations could have prompted earlier action and prevented some risks from persisting. It is not possible to know whether such a mechanism would have changed the outcome in this case. The Committee may also wish to consider whether a proportionate statutory mechanism is needed where a Board does not act and a serious risk remains.

This is a question about Scotland's wider patient-safety framework rather than a suggestion that NHS Grampian rejected the HIS recommendations.

8. Conclusion

The two reviews should not be conflated, but both raise the same question for the Committee: what happened when concerns were raised, and did the response make care safer?

Escalation can bring an unresolved patient-safety risk to the attention of Scottish Ministers, but it does not, by itself, legally require an NHS Board to implement a Healthcare Improvement Scotland recommendation.

Patients, families, staff and Parliament should be able to see not only which actions were completed, but what changed in practice, which risks have reduced and how any unresolved concerns are being addressed.

Patient Safety Commissioner (relating to her wider annual report)

Paper 1

Purpose

This paper summarises the principal activities, themes and learning arising from the first year of operation of the Patient Safety Commissioner for Scotland (PSCS). A full Annual Report has been provided separately.

Please find our annual report:

https://www.patientsafetycommissioner.scot/media/5a5m51fk/pscs-annual-report-2025-26.pdf

Establishing the Office

The reporting period covered the establishment of Scotland's first Patient Safety Commissioner and the creation of the supporting Office. During the year, work focused on developing the governance, policies, systems and partnerships necessary to support delivery of the Commissioner's statutory functions. This included establishment of an Advisory Group, publication of the Patient Safety Charter, development of governance arrangements and recruitment of the initial staff team.

Patient Voice and Engagement

A central priority during the year was listening to patients, families, carers and healthcare professionals.

Engagement activity identified a number of recurring concerns across Scotland's healthcare system, including:

- communication and involvement in care;
- access to healthcare services;
- coordination between services;
- rural and island inequalities;
- escalation of concerns; and
- confidence that concerns are heard and acted upon.

The Office has used these perspectives to inform priorities and to develop its understanding of emerging patient safety risks.

Priority Areas

The Commissioner identified six priority areas for focused attention:

1. maternity and neonatal services;
2. displaced care and Hospital at Home services;
3. single-sex hospital wards;

4. acute mental health care;
5. rural healthcare inequalities; and
6. NHS board restructuring.

These priorities reflect concerns raised through engagement activities and the Commissioner's assessment of their potential significance for patient safety.

Emerging Themes

Several themes emerged consistently across different aspects of the Commissioner's work.

The most significant was the existence of what the Commissioner has described as an "assurance gap": circumstances where concerns are recognised but where there is limited independent assurance regarding whether risks have been adequately addressed or learning embedded. This issue was observed across a number of settings and forms part of the Commissioner's ongoing work programme.

Additional themes included:

- openness and speaking up;
- management of adverse events;
- safeguarding and protection of vulnerable groups; and
- consistency of organisational learning.

Building Relationships Across the System

The Commissioner undertook extensive engagement with NHS boards, patient organisations, regulators, professional bodies, third-sector organisations and governmental partners throughout the year.

Particular attention was given to engagement with rural and island communities and to establishing relationships with organisations involved in patient safety, healthcare improvement and oversight.

Looking Ahead

During 2026-27 the Office intends to focus on:

- implementation of the investigation framework;
- publication of a Strategic Plan;
- establishment of a Research and Evidence Programme;
- further development of patient engagement arrangements;
- development of national partnerships and memoranda of understanding; and
- continued work on identified patient safety priorities.

Conclusion

The first year of operation has focused on establishing a new parliamentary office, engaging with patients and stakeholders, and developing a clearer understanding of patient safety risks across Scotland's healthcare system.

The Annual Report demonstrates the value of patient voice in identifying concerns, informing priorities and shaping future work to improve patient safety.

Paper 2

Purpose

This paper provides an overview of the investigation framework developed by the Patient Safety Commissioner for Scotland (PSCS). The framework establishes how concerns will be assessed, how decisions regarding investigations will be made and how learning will be taken forward.

Please find our Investigation Framework:

https://www.patientsafetycommissioner.scot/investigations-hub/patient-safety-oversight-framework-and-investigation-policy/

Background

The role of the Commissioner is to promote patient safety and contribute to improvement in the safety of health care through learning, advocacy and independent scrutiny. The Commissioner is distinct from complaints processes, regulators and inspectorates.

The investigation framework has been developed to provide a clear and consistent approach to identifying, assessing and, where necessary, investigating and making recommendations in relation to health care safety.

The framework forms part of a wider Patient Safety Oversight Framework through which information from patients, families, healthcare professionals, public bodies, regulators, published evidence and other sources is brought together, assessed and reviewed for health care safety issues that require further consideration.

Its purpose is not solely to support formal investigations, but to ensure that concerns are reviewed consistently, risks are identified at an early stage, and proportionate action is taken to support patient safety and system improvement.

Principles

The framework is founded upon the following principles:

- patient and family experience as a source of safety intelligence;
- independence and impartiality;
- proportionality;

- evidence-informed decision making;
- transparency and accountability; and
- system learning and improvement.

Investigations are intended to understand the causes of patient safety concerns and identify opportunities for learning and improvement across the healthcare system.

The framework is focused on learning rather than blame and seeks to understand the systemic factors that contribute to patient safety concerns, including policies, processes, governance arrangements and decision-making, in addition to opportunities for learning and improvement.

Approach

The framework establishes a structured process through which information is gathered, assessed and reviewed.

Information may be received from patients, families, healthcare professionals, public bodies, regulators, published evidence and other sources.

Concerns are assessed using a structured risk-based approach that considers:

- actual or potential patient harm;
- the severity and likelihood of risk;
- the number of patients potentially affected;
- impacts on vulnerable groups and health inequalities;
- evidence of systemic or recurring issues; and
- steps being taken by existing organisations to ensure the issue is being addressed.

Concerns are assessed according to their significance, potential impact on patients and the extent to which existing arrangements provide sufficient assurance that risks are being addressed.

Responses may include further engagement, information gathering, thematic work or, where appropriate, formal investigation.

Formal investigations will be undertaken where the Commissioner considers that additional scrutiny is necessary to understand a significant health care safety issue.

This approach ensures that formal investigation remains one of a number of available responses and that investigative resources are directed towards issues where the Commissioner can add greatest value.

Relationship with Existing Organisations

The framework has been designed to operate within Scotland's broader patient safety landscape.

The Commissioner intends to work constructively with healthcare providers, regulators, scrutiny organisations and improvement bodies. Consistent with Parliament's intention, the framework seeks to complement existing arrangements and promote coordination rather than duplicate functions undertaken elsewhere.

In deciding whether to undertake further work, the Commissioner will consider the extent to which other organisations are already investigating, regulating, reviewing or addressing a concern and whether additional independent scrutiny would contribute to learning or improvement.

Formal investigation is therefore one element of a wider approach which also includes engagement, information gathering, advocacy and collaboration with partner organisations.

Learning and Improvement

The framework extends beyond the completion of investigations.

The Commissioner wishes to monitor responses to recommendations, seek assurance regarding actions taken and identify learning that may have wider relevance across Scotland's healthcare system. Such findings can inform future priorities and contribute to continuous improvement activity.

The framework is intended to support a clear route from concern to action, ensuring that patient experiences, professional concerns and emerging intelligence can contribute to wider system learning and improvement.

Conclusion

The investigation framework provides a transparent and structured approach to the Commissioner's investigatory functions. It supports consistent decision-making, promotes learning and improvement, and establishes a clear route through which patient experiences and safety concerns can contribute to safer healthcare services across Scotland.

Paper 3

Purpose

This paper invites the Committee's reflections on the operating model and resourcing assumptions that informed establishment of the Patient Safety Commissioner for Scotland (PSCS). It draws upon the Office's experience during its first year of operation and considers whether the assumptions underpinning the original model remain aligned with the current operating environment.

The Original Operating Model

The Financial Memorandum accompanying the legislation envisaged a Commissioner supported by a small office. The model reflected Parliament's intention that the Commissioner would operate as part of a wider patient and health

care safety landscape, working alongside existing organisations involved in quality improvement, assurance, scrutiny and regulation.

The Office continues to support that approach. Scotland benefits from a range of organisations with responsibilities for patient and health care safety, and effective collaboration remains essential to avoiding duplication and making best use of available expertise and public resources.

Experience During the First Year

The first year of operation has provided an opportunity to test the assumptions underpinning the original model.

Alongside establishment of a new parliamentary office, the Commissioner has undertaken extensive engagement with patients, families, healthcare professionals, NHS organisations, regulators and policymakers. The Office has also developed governance arrangements, an investigation framework, a case management approach and the organisational systems required to support the Commissioner's statutory functions.

Experience has demonstrated significant willingness across the healthcare system to engage on patient safety issues. It has also highlighted the extent of demand facing many organisations involved in patient safety, assurance and improvement activity.

During its first year, the Office has established the foundations of a new parliamentary body whilst undertaking extensive engagement with patients, families, healthcare providers, regulators, professional bodies and policymakers. This work has demonstrated both strong support for the role and a shared commitment across the healthcare system to improving patient safety.

The Office has observed that many organisations operating within the patient safety landscape are themselves managing significant operational pressures. While expertise exists across the system, capacity to contribute to additional review, investigation or improvement activity is often limited by competing priorities and statutory responsibilities.

This experience has highlighted an important distinction between the availability of expertise and the availability of capacity. The original operating model assumed that the Commissioner would be able to draw upon both through collaborative working arrangements. Operational experience suggests that expertise remains available across the system; however, capacity to support additional work cannot always be assumed.

Independent Assurance

As set out in the Annual Report 2025-26, one of the recurring themes identified during the Commissioner's first year has been an assurance gap within parts of the healthcare system. Concerns may be recognised locally, reviews may be undertaken and actions identified, yet there can remain limited independent assurance regarding whether risks have been fully addressed, learning embedded and improvements sustained.

The Commissioner's Investigation Framework has been developed to assess concerns, identify emerging risks and consider the safety of health care. Formal investigation is one mechanism through which additional independent review may be obtained where health care safety concerns remain unresolved or where existing arrangements do not provide sufficient confidence on the safety of health care.

The Office has sought to focus its capacity on areas where independent scrutiny, assurance and investigation can add greatest value to the wider patient safety system.

Reflection on Parliamentary Expectations

As part of its planned scrutiny of the Commissioner, the Committee has an opportunity to consider how the operating model established by Parliament is functioning in practice.

The question is not whether collaboration remains the correct approach. The Office remains firmly committed to working alongside existing organisations and recognises the importance of avoiding duplication.

Rather, the question is whether Parliament's original assumptions regarding the availability of external support and capacity remain aligned with current circumstances, together with the demand and need for the Commissioner’s services, and whether any additional flexibility and support may be required to ensure the Commissioner can fulfil the role Parliament intended.

Emerging Considerations

The original model anticipated that the Commissioner would be able to draw upon expertise, evidence and capability available elsewhere within the healthcare system. Operational experience suggests that this remains an appropriate principle.

The Office has, however, observed that capacity is under pressure across a number of organisations involved in patient safety, quality improvement, assurance and scrutiny activity. As a result, opportunities to undertake additional work, thematic review or investigative activity may be constrained by factors beyond the Commissioner's control.

This creates an important question for Parliament. Where the Commissioner’s ability to obtain independent assurance and carry out her functions is dependent upon support from organisations that are themselves operating under significant pressure, what level of capability should be maintained within the Office to ensure Parliament's expectations can be met?

Potential Implications

The Committee may wish to consider the implications of maintaining the current model should pressures across the wider patient safety landscape continue.

Potential consequences include:

- reduced flexibility to respond to developing concerns;
- slower identification of emerging patient safety risks;
- reduced capacity for thematic review and system-wide learning;
- fewer opportunities to undertake independent investigation;
- greater reliance on assurance provided by other organisations; and
- delays in obtaining independent assurance regarding patient safety concerns.

Matters for Consideration

The Committee may wish to reflect on:

- whether the assumptions underpinning the original operating model remain consistent with the realities, demands and risks of the current patient and health care safety landscape;
- the distinction between access to expertise and access to operational capacity within partner organisations;
- the extent to which delivery of the Commissioner's functions should be dependent on the availability of external support;
- whether the current operating model remains sufficient to provide the level of independent assurance Parliament envisaged would be provided when creating the role; and
- whether it would now be appropriate to undertake the review of operating assumptions and resourcing anticipated during scrutiny of the legislation.

Conclusion

The Office remains committed to the collaborative approach envisaged during passage of the legislation.

Experience during the first year has provided an opportunity to consider how the operating model functions in practice. While the principles underpinning the original model remain sound, operational experience has highlighted the impact that wider system pressures can have on the availability of external capacity together with the demand for the Commissioner's services, and, consequently, the Commissioner's ability to obtain timely independent assurance regarding patient safety concerns.

The Committee's reflections would assist consideration of whether the assumptions informing the original model remain aligned with the current circumstances and how Parliament's original expectations can best be realised.

Paper 4

Purpose

This paper highlights observations arising from the practical operation of the Patient Safety Commissioner for Scotland Act 2023. It invites the Committee's reflections on whether operational experience to date provides further insight into implementing

Parliament's intentions when establishing the role and whether aspects of the legislative framework may warrant future review.

Background

The Act established an independent Commissioner with responsibility for promoting patient safety, amplifying patient voice and contributing to learning and improvement across Scotland's healthcare system. Parliamentary scrutiny placed particular emphasis on collaboration, complementarity and the avoidance of duplication with existing organisations.

These principles continue to guide the Office's work. During its first year, the Office has applied the framework established by the Act across a range of patient safety concerns involving healthcare providers, scrutiny bodies, regulators, professional organisations and policymakers. In doing so, a number of practical questions have emerged regarding how certain aspects of the framework operate in practice.

The observations set out below are not presented as concerns regarding the legislation itself. Rather, they reflect areas where operational experience has prompted consideration of how Parliament intended particular arrangements to function.

Coordination, Overlapping Responsibilities and Independent Assurance

Patient safety concerns frequently engage the responsibilities of multiple organisations.

Experience suggests the value of collaborative working across the healthcare system. It has also highlighted circumstances where a concern may potentially fall within the responsibilities and remit of healthcare providers, professional regulators, scrutiny bodies, government and the Commissioner simultaneously.

Examples include circumstances where issues may potentially fall within the responsibilities of multiple healthcare providers, regulators, scrutiny bodies, professional regulators or government. Whilst such arrangements are understandable within a complex patient safety landscape, questions can arise regarding leadership, coordination and escalation where multiple organisations become involved.

The Committee may wish to reflect on whether current arrangements operate in the manner Parliament originally intended and whether there may be ways in which coordination and collaboration in these situations can be better facilitated (noting the speed with which action may be needed) or whether lead responsibilities may be more clearly articulated.

Access to Information and Evidence

The Act provides the Commissioner with important investigatory functions.

Operational experience has highlighted the importance of timely access to information and evidence when examining systemic patient safety concerns.

The Office has reflected on the extent to which the current framework enables the Commissioner to gather evidence independently and efficiently where concerns involve multiple organisations or complex patient pathways.

In particular, experience has highlighted questions regarding how Parliament intended information-gathering functions to operate in practice and whether the current arrangements provide the level of access to information envisaged when the role was established.

The Office would welcome the Committee's views on whether current arrangements fully reflect Parliament's expectations when establishing the role.

Serious and Ongoing Patient Safety Risks

The Commissioner may receive information suggesting the existence of an ongoing or emerging patient safety risk.

In such circumstances, responsibility for immediate intervention is likely to rest with another organisation.

Operational experience has highlighted a distinction between the Commissioner's ability to investigate, advise, recommend and escalate concerns, and the ability of other organisations to take operational action in response, particularly with the speed which such a risk may require.

This has prompted reflection on Parliament's intentions regarding the Commissioner's role where concerns require urgent consideration and action by another body.

Experience has highlighted questions regarding the Commissioner's role in escalation, assurance and oversight where concerns require urgent attention. The Committee may wish to reflect on whether current arrangements provide sufficient clarity regarding how such concerns should be escalated and with whom, and how assurance should subsequently be obtained that these risks are quickly managed.

Powers the Commissioner HAS

Under the Act, the Commissioner can:

- Promote patient safety and advocate for systemic improvement.
- Gather information relating to healthcare safety issues.
- Receive concerns from patients, families, carers, professionals and organisations.
- Request and obtain information relevant to their functions
- Undertake formal investigations into healthcare safety issues.
- Determine the terms of reference for investigations.
- Publish reports, findings and recommendations.
- Require a person to respond to a recommendation made in a formal investigation report.

- Promote learning and improvement across healthcare systems.

The Commissioner can:

- Undertake announced or unannounced visits where necessary to support the Commissioner's investigations, where access is granted.
- Observe healthcare environments, where access is granted.
- Escalate safety concerns to providers, NHS Boards, Healthcare Improvement Scotland, Scottish Ministers or other relevant bodies if the Commissioner considers that necessary, such as to protect someone's life.
- Formally request urgent action or intervention from other organisations.

Specifically, the Commissioner can:

- Make recommendations intended to improve patient safety or the safety of health care.
- Publish recommendations and organisational responses.
- Highlight concerns about health care safety for public and parliamentary scrutiny.
- Trigger action by other organisations where risks are not being addressed.
- Influence improvement through investigation and transparent public reporting.

Powers the Commissioner DOES NOT HAVE

The Commissioner cannot:

- Direct or otherwise require NHS Boards to take action.
- Direct or otherwise mandate organisations to implement required safety measures.
- Impose or enforce conditions or limits on provision of health care services. There is no power for the Commissioner to close a ward, suspend or limit admissions, restrict services, stop or limit clinical activity.
- Require deployment of crisis or improvement teams.
- Enter and inspect/observe any health care settings unless by consent.

Whilst visits may be undertaken:

- The Commissioner has no statutory power of entry.
- The Commissioner cannot compel access to hospitals, wards or other health care facilities.
- Access depends upon cooperation from the organisation and persons concerned.
- The Commissioner does not possess powers equivalent to a regulator or inspectorate.
- The Commissioner has no Emergency Intervention Powers.

The Commissioner cannot:

- Issue emergency safety notices.
- Trigger statutory intervention arrangements.

- Require urgent service reviews.
- Mandate immediate mitigating actions.
- Direct operational responses during a live patient safety incident.
- Compel individuals or organisations to take specific actions, even if the Commissioner considers those actions necessary for health care safety.
- Require senior executives to attend meetings and give explanations or provide oral evidence as part of investigations beyond existing information requirements.
- Enforce recommendations

Organisations must respond to recommendations, but:

- They do not have to accept recommendations.
- They do not have to implement recommendations.
- The Commissioner cannot issue improvement notices.
- The Commissioner cannot issue compliance notices.
- The Commissioner cannot apply sanctions for non-compliance.

Recommendations and Follow-up

Parliament gave the Commissioner the ability to make recommendations intended to improve patient safety and the safety of health care.

As the Office develops its approach, consideration has been given to issues such as follow-up, assurance, implementation and public reporting.

Operational experience suggests that the effectiveness of recommendations depends not only on their publication, but also on understanding how they are considered, implemented and monitored over time.

Questions have therefore arisen regarding Parliament's expectations in relation to follow-up activity, assurance processes and the accountability of organisations to respond to and act upon recommendations by the Commissioner.

These matters featured prominently during scrutiny of the legislation and may benefit from further reflection in light of operational experience.

Information Sharing

The effectiveness of the wider patient safety landscape depends upon information sharing and cooperation between organisations.

Experience to date has highlighted operational questions regarding information sharing, coordination and the practical application of these arrangements across a complex landscape of providers, regulators and scrutiny bodies.

Questions for the Committee

The Committee may wish to consider:

- Does experience since commencement suggest that any aspect of Parliament's original intentions would benefit from clarification?

- Is the relationship between the Commissioner and other organisations involved in regulation, scrutiny, assurance and improvement sufficiently clear in practice?

- Do current arrangements provide the Commissioner with appropriate access to information and evidence when examining systemic patient safety concerns?

- Are arrangements relating to coordination, cooperation, information sharing, recommendations and follow-up operating as Parliament intended?

- Are escalation routes and responsibilities sufficiently clear and effective where concerns identified by the Commissioner relating to ongoing or emerging patient safety risks require action by another organisation?

- Are there aspects of the framework established by the Act which Parliament may wish to revisit in light of operational experience?

Conclusion

The Office remains committed to working within the framework established by Parliament and to maintaining constructive relationships across Scotland's patient safety landscape.

The first year of operation has demonstrated the value of the framework created by Parliament and the willingness of organisations across the system to engage constructively with patient safety concerns. It has also provided an opportunity to consider how certain aspects of the Act operate in practice when applied to complex, real-world circumstances.

Experience during the first year of operation has identified several areas where reflection on Parliament's original intentions may assist both the Commissioner and partner organisations. The Committee's views on these matters would be welcomed.

Dr Izhar Khan MBBS, MD (Abdn), FRCP (Edin)

Consultant Nephrologist and Hon Senior Lecturer NHS Grampian and University of Aberdeen.

Foundation Programme Director PSDS, ADME for IMGs NHS Grampian

On 19 November 2026 the Principal Clerk of the Health, Care and Sports Committee invited me to appear before the Committee to give evidence on Healthcare Improvement Scotland's NHS Grampian Responsive Diagnostic Review November 2026. I was also given the opportunity to make a submission setting out my views on the situation in NHS Grampian. The following account is for the benefit of the Committee and is factually correct to the best of my knowledge and recollection.

My background and role in NHS Grampian: I have had the great privilege to serve the people of Grampian and North East Scotland as Consultant Nephrologist and Honorary Senior Lecturer, University of Aberdeen since 1996. I am Associate Director for Medical Education for IMGS, NHSG and Foundation Programme Director for the North Deanery. I came to Aberdeen in 1991 as a research fellow at the Department of Medicine and Therapeutics Aberdeen University Medical School having worked in different regions in Scotland since 1987. I received many grants with my research colleagues, including a large grant from the EU to study outcomes in kidney disease in Scotland and Eastern and Western Europe. I have published extensively on renal disease and gained my MD with commendation by the University in 1996 and was appointed Consultant that year.

My Role in NHSG Clinical Advisory Structure: Between circa 2011-2015 I was Chair of the Consultants' Subcommittee (CSC) and Chair of the Area Medical Committee (AMC). The latter comprised the CSC and GP Subcommittee and provided clinical advice to the Board. I have never held any Managerial position in NHSG and currently work as a consultant Nephrologist in ARI.

The roots of the problem: It would be remiss of me not to bring to the attention of the Committee that the current problems faced by NHSG are not recent. The roots of the current situation lie in Management not listening to clinicians for many years, which has resulted in the damning report by Healthcare Improvement Scotland (HIS). In this part of my submission I would like to highlight a few significant events during and subsequent to my role in the advisory structure in NHS Grampian, which are germane to the current situation

1. In 2012 I and my colleagues from the CSC approached the then CEO in our advisory capacity, regarding the role of the Executive Medical Director in the Hewage v NHS Grampian case of racial and sexual discrimination which was won by Miss Hewage. NHSG had lost in the Employment Appeals Tribunal and yet pursued the case up to the Supreme Court. The Medical Director had been declared an 'unreliable witness' at tribunal. The CSC demanded that the Medical Director be held accountable for his actions but no action was taken.

2. In 2013-14 concern was raised by some colleagues about management disengagement with advisory committees with the then minister and a HIS investigation was initiated in June 2014. In an extra-ordinary meeting of

consultants on 7 October 2014 around 35 consultants signed a letter sent to Mr Alex Neil, Cabinet Secretary of Health and Wellbeing expressing concerns around disengagement of Senior Management from clinicians. The review made 13 recommendations and highlighted serious concerns around leadership, governance, culture and inappropriate behaviour that could impact quality of care. The review highlighted failures in leadership and governance by the Health Board, Executive Team and ARI senior management and that a minority of senior doctors in general surgery and emergency care exhibited disruptive behaviour. The publication of the HIS report in December 2014 coincided with a Royal College of Surgeons report regarding HPB surgery in NHS Grampian. A number of colleagues were referred to the GMC. There was an atmosphere of fear of retribution among colleagues who had raised concerns about senior NHSG management.

3. Before the report was published the Medical Director left NHSG and an interim MD was brought in from Tayside. A new MD was appointed from the same senior management team. As Chair of AMC I was on the panel but was excluded from the shortlisting process and subjected to intimidation by the Director of Workforce before the interview. I informed the then CMO Dr Aileen Keel of this by email.

4. One of the first acts of the new Executive MD was to abolish an advisory body of peers who advised the MD on cases of poor performance of individual clinicians or departments. This gave immense power to the MD who was also the Responsible officer at executive level without advisory oversight. The recent 2026 HIS report also acknowledges that advisory structures have been side lined.

5. Another example of management ignoring clinical advice was when the new Emergency Care Centre for unplanned medical admissions was created. We were informed that there would be the loss of dozens of acute medical beds but that something they called ‘Intermediate Care’ would alleviate pressures and compensate for the loss of 60-80 beds. I and other colleagues in the advisory structure warned NHSG that this loss of beds would come back to haunt us. I believe that we would not have patients in corridors had our advice be heeded by the then CEO and MD. I demitted office from the AMC in 2015.

My observations on the NHS Grampian Responsive Diagnostic Review In May 2026 the current CEO invited HIS to undertake a diagnostic review of NHSG. It was in response to concerns relating to quality, safety of care, clinical governance, workforce sustainability, leadership, organisational culture and service sustainability. The review mostly covers failings at Dr Grays Hospital Elgin but also covers some areas more widely related to NHS Grampian such as SAER reports and clinical appraisal.

Many months before the diagnostic review was requested by NHSG I raised my concerns as a practising consultant nephrologist with HIS, following a meeting with the Chairs of the AMC and CSC in late 2024, and was interviewed in early 2025 by Dr Simon Weston. The concerns I raised at the time were mainly about poor delivery of acute services, in particular unselected acute medical admissions, corridor care and inappropriate patient admissions to specialty wards. I have received

communication from the current AMC Chair about a number of letters to the CEO regarding Dr Grays expressing concerns about the Integrated Acute Pathways and Enhanced GP Services.

The Chair of Dr Grays Senior Medical Staff Committee wrote to the CEO and Chair of Health Board on 6 September 2024 about the state of Dr Grays highlighting 'progressive degradation in the quality and safety of services' warning that there would be 'ongoing deterioration without urgent intervention'. He wrote 'inpatient services are struggling to provide safe and effective care' in many specialties'. He asked for 'urgent and co-ordinated response'. The letter was copied to Mr. Neil Gray, the then Cabinet Secretary for Health and Social care

The committee should be reminded that the Report is limited in scope and does not cover issues relating to General Practice contracted by NHSG and the acute services delivered in Aberdeen Royal Infirmary. Many colleagues are dissatisfied by management by edict, more recently the plans to move a specialty ward to create a facility for patients with fragility has caused uncertainty among a number of specialties currently housed in the Emergency Care Centre. Patient flow is at times inadequate and corridor care is the norm. Clinicians are not consulted before transfer of patients to specialty wards. Concern has also been raised about lack of workforce planning, for example in dermatology where there is a deficit of many FTE consultant posts resulting in pressure to deliver a timely and safe service for melanoma and skin cancer patients.

The November 2026 Diagnostic HIS Report is a damning indictment of how services at Dr Grays Hospital have been managed. The Committee should note the main findings of the report include:

1. Insufficient integration of Dr Grays within NHS Grampian.

2. NHS Grampian has repeatedly failed to resolve clinical Governance concerns.

3. NHSG Board failed at scrutiny and oversight of clinical governance.

4. NHSG's leadership and management of the medical workforce is weak.

5. Staff feel that senior executives and leaders of NHSG are not visible to them and have not fully understood the challenges and risks faced in Dr Grays.

6. General medicine is vulnerable.

7. Trauma and orthopaedics have ceased since 2024. Patients with trauma related fractures wait for hours before being transferred to ARI by long ambulance journeys. This has a knock-on effect for Aberdeen patients.

8. Resident Doctors in Training have raised concern about quality of care and consultant led care in High Dependency Unit to Public Service Delivery Scotland.

9. Paediatrics emergency surgery was unsafe and was suspended in June 2026, and elective surgery was also suspended in July 2026 after concerns were raised with HIS.

10. The IAP is a narrow, limited integration of services and there is no comprehensive detailed plan for Dr Grays.

11. Concerns raised by advisory committee (AMC) about workforce, sustainability and clinical safety raised in 2024, 2025 and 2026 to the Executive Medical Director, Chair of the Board, Nursing director and CEO resulted in limited action without visible improvement.

12. Wider problems within NHSG included concern about HPB surgery have been noted and since the report there has been further discussion about this specialty.

13. The report noted that approaches to quality assurance and improvement and inadequate SAER investigation were a Grampian wide problem. Concerns about SAERs were raised with NHSG in 2024. The Scottish Public Services Ombudsman criticised the quality and content of SAER reports and an internal review of quality took many months. Many SAERs are overdue and 76 have breached the 140-day timescale.

    The case reported by HIS in sections 4.141-4.155 of the Report is worth noting.

14. The report noted the delayed response by NHSG regarding a query about at risk services and the lack of a formal report on potentially high risk specialties (section 4.194).

15. The report criticises NHSG for poor medical workforce management and failure on the part of the Responsible Officer (Executive Medical Director) to ensure appraisal for all doctors.

Concluding remarks

The HIS Diagnostic Review is one of the most damning reviews I have come across and anyone who has read all 74 pages cannot but fail to conclude that there are huge safety, governance, workforce, service sustainability and leadership problems in NHS Grampian and I believe Dr Grays is not fit for purpose to deliver acute services for the people of Moray.

This is a view shared by the current AMC Chair.

For years Senior Management has not listened to clinical advice and on occasions when advice was given, often it was ignored. In the past the Board had representation from clinicians and the Chair of the AMC sat on the Board in advisory capacity. That was replaced by the Chair of the Area Clinical Forum which does not always have a clinician as Chair. I would advise the Board to invite the AMC chair who represents GPs and Consultants in addition to the ACF Chair. In order to solve

the problems we face it is imperative that clinical advice is taken and listened to by the Board.

I and my many colleagues have been deeply affected by this report and the subsequent, sometimes cruel and unfair media coverage has cast a pall over hard working and dedicated staff. A crisis can be disruptive and painful. However, it can also serve as a catalyst for change and improvement. NHS Grampian should set clear, measurable goals for recovery.

We need strong and resilient leadership that listens to clinicians and staff.

The greatest satisfaction that a clinician derives is from their interaction with patients. I recall the pride we felt when Aberdeen Royal Infirmary came top in Scotland in The Sunday Times Good Hospital Guide in April 2003. With good management and redressing the chronic underfunding of NHS Grampian, we can make it the best again. Through this committee I would like to assure the public that Aberdeen Royal Infirmary is safe and encourage patients to continue attending their appointments.

Professor Zygmunt Krukowski, former consultant general surgeon at ARI

Career synopsis:

Professor Z H Krukowski LVO MB ChB PhD FRCS(Ed) FRCP(Ed) Hon FRCS(Glas) was a consultant surgeon in Aberdeen Royal Infirmary, Professor of Clinical Surgery in the University of Aberdeen and Surgeon to HMQ Elizabeth II until he resigned in 2016. A master surgeon and pioneer of laparoscopic surgery he was awarded an A+ merit award. He was frequently invited to teach and lecture internationally. He served on and chaired a variety of bodies including Surgical Colleges and Associations, Research Councils and Health Service organisations. He pioneered prospective computerised audit including codeveloping the Scottish national surgical mortality audit. He regularly published original research and contributed to standard surgical texts His publications on surgical outcomes as quality indicators have been cited more than 2000 times.

It is distressing to observe the reputation of the hospital where I worked for more than 40 years damaged by inept management, ineffectual clinical quality assurance and clinical governance.

Developments in Aberdeen Royal Infirmary post 2010

After the appointment in 2010 of general surgeons with an interest in HPB surgery complication rates and mortality increased.

Interventions to salvage patients generated complaints of “disrespect” and offers of assistance to address issues were rebuffed.

Non-participation in established data collection meant that accurate data was not collected or analysed.

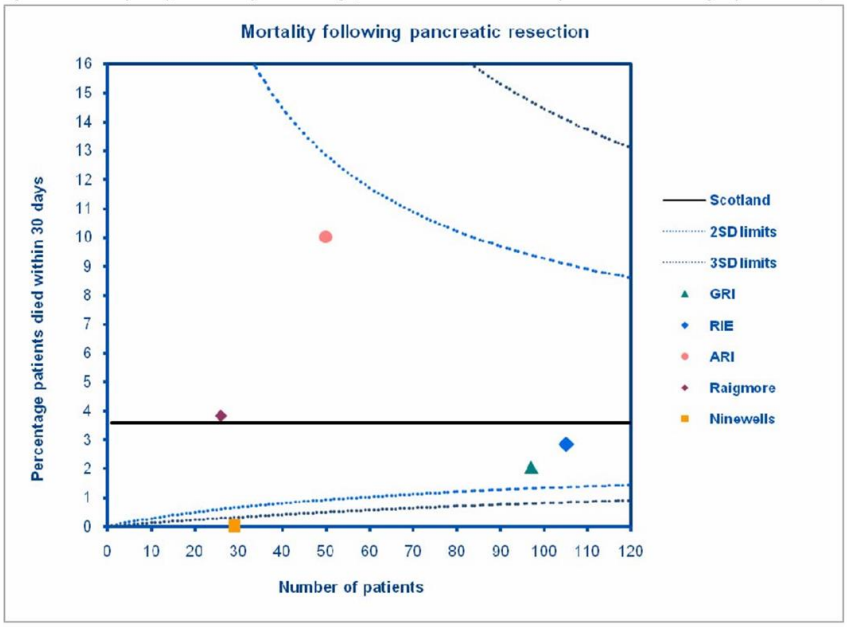
Concerns were repeatedly raised with line managers and assurances given that a new quality assurance system would address these issues.

The system based on DATIX, a management incident reporting system proved inadequate due to non-compliance, analytical failures, downgrading of concerns and inaction.

In 2014 as a result of the publication of the first Scottish National HPB Audit report (Figure 1) and apparent inaction by local senior management I raised concerns with Dr Andrew Russell, NHS Tayside Clinical Director, seconded to NHS Grampian.

Figure 1

Figure 8: Thirty-day mortality following pancreatic resection by location of surgery: funnel plot of 2009-2011 data[4,5]



This report confirmed a high mortality following pancreatectomy and was excused by being within two standard deviations which is statistically illiterate.

Scottish HepatoPancreatoBiliary Cancer Network
Final - Published HepatoPancreatoBiliary Cancer Audit Report 15/03/13 16

NHSG management received the HPB Audit and Dr R Dijhuizen, medical director NHSG, through Mr T O'Kelly the Associate Medical Director, commissioned Mr P M King, clinical lead general surgery, to review and report.

Mr King's report confirmed issues with patient selection and poor care. The report was not shared with the general surgeons.

This failure of the commitment to candour and transparency constantly espoused at all levels of management and government is a recurring theme over the next decade.

On three previous occasions, as a clinical manager and national audit assessor I identified similar serious safety issues. The then NHSG medical directors, Dr J Hern and Dr D Ross, met relevant parties and constructively addressed the concerns. However, after informing the NHS Tayside medical director, Dr Andrew Russell, of concerns there was no positive engagement only the initiation of a sequence of events resulting in my resignation and constructive dismissal in 2016.

Since 1999 chief executives of Scottish NHS boards have had the statutory duty to maintain and monitor the quality of care provided.

For this to happen they require accurate, honest and timely clinical information delivered without bias. They need to exercise the same balance in interpretation and reaction. Recent revelations indicate there have been failures in both areas extending back over many years.

There have been very successful clinically led surgical audits in Scotland most notably the Lothian Surgical Audit, EMAS in Grampian and the Scottish Audit of Surgical Mortality SASM. These all fell into disuse and the systems intended to replace their functions have not been effective.

Mortality and Morbidity (M&M) meetings were historically frank confidential exchanges but have been replaced by no blame, anonymised Team Based Quality Reviews (TBQR) to support staff and protect institutions rather than address issues.

The replacement system, in 2014, for mortality and morbidity quality assurance based on DATIX, a management incident reporting tool was intended to provide quality assurance.

This has manifestly proved illusory. How did the system fail to identify and initiate remedial action in response to the many avoidable deaths obvious to the Wigmore Report?

Contributory factors are the voluntary nature of participation and the inefficiency of the system. It is also possible to game the system by delayed and inaccurate data entry such that the window for early review is missed.

There was also evidence of downgrading of severity on final review by management and failure to follow actions.

That these failures occurred in Aberdeen Royal Infirmary is disconcerting. Mr Manoj Kumar, a consultant general surgeon introduced the current system and is responsible for its implementation throughout Scotland as the National Clinical Lead for Mortality and Morbidity Quality Assurance in Health Improvement Scotland.

HIS guidance to NHS Scotland on implementing quality assurance viz:

- Mortality and Morbidity Reviews: Practice Guide 2017. 38 pages M Kumar & P Bowie

- A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland 2025. 77 pages Anonymous

describe detailed, idealistic but manifestly impractical advice. If the system was operating as envisaged the current situation could not have developed.

My concerns about timeliness, accuracy and rigour were echoed in a recent internal NHSG Report on Serious Adverse Event Reviews.

The failure of the clinical M&M system is mirrored in the Management handling of SAERs as documented in sections 4.141 - 4.184 of the 2026 HIS report. Simply following a bureaucratic process with no critical analysis or constructive output is pointless.

Deficiencies in data collection and analysis are not confined to NHSG. The Scottish National HPB audit has been publishing, albeit two years in arrears, a

comprehensive annual review of HPB surgery. Buried within the audit is evidence of excess mortality in line with the recent and undisclosed Wigmore report. (Figure 2)

Figure 2

90 Day Mortality after potentially curative pancreaticoduodenectomy from Annual SHPBN Audit

	Grampian			Scotland			NON NHSG		
YEAR	No	Died 90	%	No	Died 90	%	No	Died 90	%
2009	16	4	25.0%	94	6	6.4%	78	2	2.6%
2010	14	1	7.1%	95	1	1.1%	81	0	0.0%
2011	20	1	5.0%	118	6	5.1%	98	5	5.1%
2012	14	0	0.0%	89	3	3.4%	75	3	4.0%
2013	11	1	9.1%	69	6	8.7%	58	5	8.6%
2014	15	0	0.0%	99	5	5.1%	84	5	6.0%
2015	19	2	10.5%	108	4	3.7%	89	2	2.2%
2016	13	4	30.8%	75	11	14.7%	62	7	11.3%
2017	12	1	8.3%	63	1	1.6%	51	0	0.0%
2018	11	1	9.1%	82	4	4.9%	71	3	4.2%
2019	16	3	18.8%	95	5	5.3%	79	2	2.5%
2020	4	3	75.0%	92	7	7.6%	88	4	4.5%
TOTAL	**165**	**21**	**12.7%**	**1079**	**59**	**5.5%**	**914**	**38**	**4.2%**

Excess mortality of (12.7 v 4.2)8.5% equivalent to 14 deaths

One patient who died in 2009 after surgery for neuroendocrine pancreatic rumour was removed from the 2013 report
One patient who died in 2010 after surgery for a duodenal tumour was removed from 2014 report
Both meet the criteria for inclusion adopted after 2015 and the statement that "this death should not be counted as a death" no longer applies
2020 report for 2018 data did not include numbers only percentages but derived from 2021 report

HIS Reviews

The HIS Report on NHS Grampian of December 2014 itemised twenty-three failings of management.

The current HIS Report of 2026 acknowledges that there have been several (11) reviews since then but chose not to rehearse all the previous recommendations preferring to concentrate on six areas one of which is patient safety.

It is remarkable that the 2026 HIS Report should still include the directive that the board should establish routine, integrated oversight of quality and safety, including:

- clinical outcomes
- significant adverse events

Observations

It is both depressing and demoralising that NHS Grampian and indeed NHS Scotland does not have a clinically based, and led, integrated system for data collection and analysis in surgery which facilitates accurate documentation of, for example, operation notes and discharge documents without duplicate data capture.

If the obligation to capture accurate data is not a feature of contemporary consultant job plans consideration should be given to making it so.

Review of adverse outcomes should be less about protecting individuals and institutions. Even when patients and relatives are informed about adverse outcomes these are explained by having gone through due process including multi-disciplinary team meetings and quality assurance review.

Candour and transparency must include accountability and honesty. If a pattern is identified personal sensitivity should be subordinated to considerations of patient safety.

If there had been effective clinical leadership and management the pattern of poor care which was clinically obvious as early as 2010 would have been addressed.

Z H Krukowski LVO
26 November 2026

NHS Grampian

Submission 1: Healthcare Improvement Scotland Diagnostic – commissioned by NHS Grampian and our response

Background and context

NHS Grampian has been operating within Stage 4 of the NHS Scotland Support and Intervention Framework since 12 May 2025, in relation to financial sustainability, leadership and governance, with rising concerns about operational performance against national standards and local services and standards, including some concerns from regulatory bodies. A Scottish-Government chaired Assurance Board is in place to oversee delivery of the required improvements.

In May 2026, the Chief Executive asked Healthcare Improvement Scotland (HIS) to undertake an independent diagnostic review to provide external scrutiny and identify any wider or systemic issues requiring improvement, against a backdrop of an increasing number of quality and safety concerns from Regulators, which were cause for concern.

The review considered Dr Gray's Hospital and Aberdeen Royal Infirmary within the wider NHS Grampian Clinical Governance system. It examined how risks are escalated and managed, how concerns are responded to, how assurance on quality and safety is obtained and tested, and whether learning and improvement result in demonstrable and sustained change. It did not include Primary Care, Mental Health, Integration Joint Boards and Health and Social Care Partnerships though work is underway by responsible leaders in these areas to assess if there is any transferable learning opportunities.

The Diagnostic was framed in reference to the HIS Clinical Governance Standards, the Essentials of Safe Care Framework and it followed key lines of enquiry which included: clinical and educational governance, service models and patient pathways, workforce and staffing, operational delivery and management oversight, workplace culture, teamworking and organisational learning and leadership and accountability.

Formal Terms of Reference were agreed by the Clinical Governance Committee and NHS Grampian Board.

The Diagnostic Review was published on 12 November 2026, alongside three HIS Safe Delivery of Care inspection reports. NHS Grampian has accepted the findings on publication and committed to responding openly and at the required pace, with clear accountability for improvement and transparent measurement of progress It included four main findings, as follows:

1. Dr Gray's Hospital is insufficiently integrated within NHS Grampian
2. NHS Grampian has repeatedly failed to resolve Clinical Governance concerns effectively
3. Board level scrutiny and oversight of Clinical Governance are inadequate
4. Leadership and management of the medical workforce are weak

There are six key recommendations, as follows:

1. Implement an integrated, respectful and sustainable plan for Dr Gray's Hospital
2. Sustainably increase organisational capacity, oversight and accountability for assuring effective Clinical Governance
3. Establish effective organisational leadership and management of the medical workforce
4. Simplify governance and evidence it works before introducing new structures
5. Establish outcome-based external oversight of improvement
6. Strengthen Board governance, decision-making and collective accountability

As an important feature of our response, we have made a strong commitment to maximise engagement and involvement of our staff, ACF, GAPF and our clinical advisory groups from the start of the process so that we widen engagement opportunities and give more staff and clinical teams the opportunity to shape our response. We are giving careful thought to how we ensure our patient and community voice is also heard and influences our response.

Recognising and anticipating the concern the publication of the HIS Diagnostic has caused our patients and local community, we immediately set up a patient helpline. At the time of drafting this paper, the helpline remains in place (see below).

We have engaged proactively with the Patient Safety Commissioner also who is visiting Aberdeen Royal Infirmary on 24 November 2026 and Dr Gray's Hospital on 25 November 2026 to hear about NHS Grampian's immediate response and importantly to speak and hear the views of frontline staff.

The Diagnostic findings have implications for NHS Grampian's existing Stage 4 escalation arrangements. In her statement to the Scottish Parliament on 17 November 2026, the Cabinet Secretary for Health and Care confirmed that NHS Grampian would remain within a strengthened Stage 4 framework. An external Intervention Support Team, comprising experienced executive and clinical leaders and led by an Interim Turnaround Director, with experience in Clinical Governance, Patient Safety, Performance Improvement and Organisational and Operational Recovery, will work alongside NHS Grampian for a period of six months. The escalation position will be reviewed by the end of December 2026. Healthcare Improvement Scotland will undertake an independent assessment of progress within three months.

NHS Grampian's response

Gaining wider system ownership of the report and the required changes

We heard views from over 1,000 staff and engaged constructively with our Area Clinical Forum (ACF) and the Grampian Area Partnership Forum (GAPF) ahead of the Diagnostic Report being published. We have committed to involving our staff and ACF and GAPF in our response from the start of the process. We have also taken a broader approach to engagement as we develop and shape the Action Plans in response to our three Safe Delivery of Care Reports published the same day (12 November 2026) by inviting staff at service and ward level to shape the Version to our Action Plans which are a more granular Action Plan to the usual HIS Inspection Report Action Plans, presenting a novel approach in Scotland.

Our staff, including many clinical colleagues, have begun sharing with us their ideas for what needs to be different moving forward and have expressed their personal commitment to being part of the change we all need to see. We are giving careful thought also to how we ensure there is strong patient voice and input into our response.

Fostering a system of openness and transparency

We have taken initial steps to strengthen our work in relation to Speak Up and Whistleblowing, including with a new Executive Director Lead (our Director of Public Health), strengthened governance arrangements which are more closely aligned to our organisation-wide Culture Programme and better evidence of 'closing the loop' when people do speak up to strengthen confidence in our systems and processes. We have at the moment appointed seventeen Speak Up Ambassadors who will provide confidential support and advice to staff and the recent "Speak Up Week" provided a focal point for our ongoing commitment to fostering an open and transparent culture.

Creating a positive and safe Speak Up culture remains a priority for us, including recruiting more medical and clinical colleagues as Speak Up Ambassadors in the weeks and months to come.

Immediate response to the HIS Diagnostic Report

Recognising and anticipating the concern the publication of the Healthcare Improvement Scotland Report has caused our patients and local community, we immediately set up a patient helpline which remains open Monday-Friday between 8am and 6pm. We are closely monitoring calls, themes and ensuring timely responses with daily updates to Scottish Government on this. At the time of writing (23 November 2026) this helpline remains in place.

We have proactively made contact with the Patient Safety Commissioner in the last couple of days and have arranged for her to visit Aberdeen Royal Infirmary on 24 November 2026 and Dr Gray's Hospital on 25 November 2026 such that we can get an external viewpoint on how we can best respond to the safety and Clinical Governance concerns in the Healthcare Improvement Scotland Diagnostic Report.

We have changed our senior Medical Leadership arrangements, with the substantive Medical Director and Acute Medical Director stepping aside from their clinical leadership roles with immediate effect and an Interim Medical Director, Professor Graham Ellis, commencing in post on 16 November 2026. Professor Ellis will appoint an Interim Acute Medical Director in the coming weeks.

We have made a number of important changes to strengthen leadership in key areas in 2026. These include a new Deputy Medical Director for Clinical Governance and a Deputy Medical Director for Unscheduled Care and an Improvement Director for Unscheduled Care for the Grampian system, including Aberdeen Royal Infirmary and Dr Gray's Hospital.

We have refreshed and strengthened senior leadership arrangements at Dr Gray's Hospital, with a new General Manager already in post and a new Chief Nurse commencing in post this month. We are out to external advert for a new Medical Director for Dr Gray's Hospital with interviews later this month, which will mean we aim to go into January 2027 with a new senior team for Dr Gray's Hospital.

We have appointed an Interim Director of Patient Safety and Quality as a Board-level post to oversee and drive the improvements that are necessary, with effect from 30 November 2026.

We are introducing Performance Review Meetings this month for Divisional Leadership Teams and Corporate Services so that we can hold teams to account for performance, spanning quality and safety, operational performance, workforce and people and financial performance. These will be attended by the full Executive Team and chaired by the Chief Executive.

We are determined to ensure this pivotal moment is a catalyst for much-needed change at NHS Grampian, and with it the requirement to have an unrelenting focus on improving patient safety, experience and outcomes led by the Board but cascaded and owned by the organisation.

At our 3 December 2026 public Board meeting, which will now be in-person for Board members, we will bring our initial and immediate response to the Healthcare Improvement Scotland Diagnostic Report. The public and media will be able to access the meeting in the usual way. At this meeting we will set out our broad strategy of response and what we will deliver by the end of December 2026 and end of March 2027.

By the end of December 2026 the high-level actions we expect to complete are:

1. Complete our immediate response to the HIS Diagnostic (3 December 2026 Board meeting). This will be further developed for the 21 January 2027 extraordinary public Board meeting where a comprehensive Improvement Plan will be presented, with specific timetabled actions with clear accountabilities, measurement and risk mitigation. This will be linked to corporate, Executive and senior manager objectives and our appraisal system

2. Complete the by end of December 2026 actions from the three recently published Safe Delivery of Care Action Plans, following HIS inspections into Maternity at Dr Gray's Hospital, Maternity at Aberdeen Maternity Hospital and Acute and Mental Health Services at Dr Gray's Hospita

3. Evidence of further performance improvements, including in Planned Care (improved year-end landing position and 2027/28 programme planning to further reduce long wait patients), Unscheduled Care (including opening additional acute frailty capacity and trialling the Timely Handover Process and maximum 90-minute ambulance handover period at Aberdeen Royal Infirmary and Dr Gray's Hospital) and developing a Recovery Plan to improve cancer performance and waiting times

4. Further strengthening leadership arrangements – including appointing a new Medical Director at Dr Gray's Hospital, an Interim Acute Medical Director and an Interim Director of Patient Safety and Quality for NHS Grampian

5. Measurable improvements to the timely resolution of complaints, including backlog reductions for the most overdue complaints

6. Measurable improvements to Significant Adverse Event Reviews, including reductions to Level 1 backlog

7. Evidence of broadened staff engagement and involvement, including with Grampian Area Partnership Forum

8. Strengthened engagement with our Clinical Advisory Groups and in turn clinical engagement in the organisation, including ACF, Area Medical Committee, GP Sub Committee and Consultant Sub Committee

9. Improved Board governance and effectiveness – including moving to open only sessions for Clinical Governance Committee, in-person Board meetings from December 2026, the development of a Board Improvement Plan that will come to our 21 January 2026 public Board meeting for approval and scoping of a year-long training programme for Non-Executive Directors in Clinical Governance

10. Safe restoration of Paediatric Surgery at Dr Gray's Hospital subject to support and the necessary assurance from HIS and the NHS Grampian Board

Improving Board effectiveness and scrutiny

For the additional public Board meeting in January 2027, we will also consider our immediate response to the review on Board effectiveness and scrutiny which was facilitated through external support from Neena Mahal, Chair of NHS Forth Valley. Our immediate aim for the early part of 2027 is to ensure we absolutely improve Board Committee scrutiny, improve the information that comes to the Board and integrate Quality and Patient Safety into an Integrated Performance Board report that provides robust assurance through our Clinical Governance Committee and other Board Committees. Our self-assessment against the Healthcare Improvement Scotland Standards for Clinical Governance show that in many aspects we fall short.

We will want to show by the end of March 2027 that we have made substantial progress in establishing a robust Clinical Governance system. Early 2027, we will be introducing a formal training programme for Non-Executive Directors in Clinical Governance at NHS Grampian as a pilot for Scotland, supported by Scottish Government and Public Services Delivery Scotland, which will be a one year intensive process and a points based system.

The work of the Assurance Board

Our work with the Scottish-Government Chaired Assurance Board continues. We have agreed the agendas for the remainder of this calendar year, and these include updates on Paediatric Surgery at Dr Gray's Hospital, specifying what Clinical

Governance improvements we want to make over the period to end March 2027 and our immediate response to the Diagnostic Report as well as updates on Unscheduled Care and Planned Care and Cancer Wait performance and our associated recovery plans. The minutes of the Assurance Board continue to be published for openness and transparency.

In the last month we have very significantly improved our projected March 2027 year-end position for elective care by several thousands of patients and we continue to do all we can to go further still. Revised trajectories have been submitted to Scottish Government. We will work with the additional support from Scottish Government to improve our general operational performance over the course of the coming months, and we welcome the additional support as nothing other than necessary and welcome.

We have taken immediate steps to start to improve our system of overseeing Significant Adverse Event Reviews (SAER). This includes from August 2026, our Executive Nurse and Medical Directors signing-off commissions and Terms of Reference and the final reports for all Level 1 SAERs. With regard to the Level 1 SAER that is featured in a heavily redacted way in the Diagnostic Report, we have reopened the SAER, we are engaging with the family, Healthcare Improvement Scotland and Royal College of Surgeons on the revised Terms of Reference and an external review team will lead the reopened review progress of this SAER to ensure independence to the process. The NHS Lanarkshire Medical Director is overseeing the full process.

We have agreed recovery plans to address the backlog of Level 1 SAERs and very overdue complaints, with trajectories for immediate improvement in place. Progress will be tracked by regular updates to the Executive Team as well as via the Clinical Governance Committee and NHS Grampian Board and the Assurance Board. We are also keeping Healthcare Improvement Scotland regularly updated and we look forward to welcoming them back in the next few months to satisfy themselves that appropriate action has been taken and that improvement is both measurable and sustainable. Additionally, we will continue to provide evidence of measurable improvements and progress to the Scottish Government Assurance Board and our patients, partners, communities and staff so that there is confidence that the actions we are taking are leading to the sustained changes that the people of Grampian deserve.

Laura Skaife-Knight, NHS Grampian Chief Executive
26 November 2026

Submission 2: Re: Hepato-Pancreato-Biliary (HPB) Surgical Services

Purpose

This briefing provides a factual summary of NHS Grampian's hepatopancreato-biliary (HPB) surgical services, including the 2022 external review, the actions and governance arrangements established in response, subsequent service developments, the decision in January 2026 to cease HPB resectional surgery within NHS Grampian, and the current position. It also outlines NHS Grampian's response to recent developments and its commitment to co-operate fully, openly and transparently with the further independent review.

Background

NHS Grampian has undertaken a series of reviews and actions relating to HPB surgery over a number of years. Complex HPB surgery was paused in March 2020, with patients referred to other centres. A limited service recommenced in April 2021, involving two designated surgeons and enhanced patient selection and governance arrangements.

In 2022, NHS Grampian commissioned an external review led by Professor Stephen Wigmore and Professor Connor Toogood. The review considered the care of 45 patients who had undergone complex HPB surgery between 2015 and 2021. NHS Grampian received the report on 29 September 2022 and its findings were formally considered and accepted by the Clinical Governance Committee on 27 October 2022. At that point, complex HPB surgery was paused, with these procedures being undertaken elsewhere, while other non-cancer liver, gallbladder and pancreatic surgery continued locally.

The findings led to two programmes of work, addressing both future service provision and previous adverse events. This included external expert input; engagement with affected patients and families; Duty of Candour processes; independent review of adverse cases; review of the governance arrangements operating between 2015 and 2020; and changes to clinical practice and governance arrangements.

Professor Wigmore continued to provide external review and support to the service. Following changes to the service arrangements and further review of patient outcomes, on 3 May 2023 he reported that the service in its then configuration provided safe, contemporary care and supported a resumption of normal activity.

Further independent review and organisational learning continued through 2024 and 2025, including review of 16 adverse event cases and consideration of patient records, external expert reports, adverse event information and the experiences of affected families. This work identified learning relating to clinical practice and governance, informed consent and communication with patients and families, documentation and continuity of support.

Subsequent Review, Assurance and Service Developments

The cessation of complex (resectional) HPB surgery at Aberdeen Royal Infirmary from 21 January 2026 was on patient safety grounds and followed previous external expert and regulatory input. Patients requiring complex HPB surgery are now managed through regional pathways, principally with NHS Lothian for HPB resection.

The Board was verbally informed at its closed meeting on 22 January 2026 and subsequently received a written confidential briefing on 23 January 2026. The decision was not proactively communicated publicly at that time which NHS Grampian apologises for, recognising this does not evidence openness and transparency.

Since then, work has focused on ensuring strong regional pathways and arrangements for Grampian patients requiring HPB surgery are in place, alongside ongoing NHS Grampian Clinical Governance Committee oversight. The Committee has received updates covering service safety, external expertise, engagement with affected families, adverse event and governance reviews, organisational learning and the resilience and sustainability of regional arrangements.

All HPB cancer surgery and complex benign HPB surgery remains ceased and is no longer undertaken within NHS Grampian, with patients requiring resection referred through regional or national pathways.

Work is ongoing to ensure that regional arrangements are resilient, timely and sustainable, with appropriate arrangements for referral, capacity, escalation, transfer, repatriation and ongoing patient care. NHS Grampian's Clinical Governance Committee Governance Committee is receiving regular updates on progress including as recently as 24 November 2026.

Organisational Response

NHS Grampian has established a co-ordinated organisational response to the recent developments, bringing together relevant clinical, operational, governance, information governance, people and communications expertise. This includes arrangements to preserve relevant records and information, coordinate communications and information requests, support affected patients, families and staff, and ensure the organisation is able to cooperate fully and openly with the independent review.

Patients, families and staff

NHS Grampian recognises the impact that the issues relating to HPB surgery, and the recent public and media attention, may have on patients, families and staff. A dedicated telephone line is available for patients and families who have concerns or require further information, with arrangements in place to ensure that any clinical concerns raised are appropriately followed up. Support is also available for staff, with particular attention being given to teams most directly affected by the continuing scrutiny and media interest including Chief Executive and Executive Directors engaging directly with affected teams.

NHS Grampian plans to write to all families to offer support and to determine if these families wish to re-engage by week ending 4 December 2026.

Decision to Cease HPB Surgery at Aberdeen Royal Infirmary

Following further external clinical advice and consideration of the sustainability and resilience of the service, including patient-safety risks, the decision was taken on 21 January 2026 to cease the remaining HPB resectional surgery within NHS Grampian. Patients requiring these procedures were thereafter referred through regional and national pathways, principally to NHS Lothian and NHS Tayside.

The NHS Grampian Board was verbally informed of the decision at its closed meeting on 22 January 2026 and received a written confidential briefing on 23 January 2026.

The decision to cease the service was not proactively communicated publicly at that time. NHS Grampian has acknowledged that this did not demonstrate the openness and transparency that patients, the public and staff should expect, and has apologised for this.

Current Position and Arrangements for Patients

HPB resectional surgery is no longer undertaken within NHS Grampian, with patients requiring these procedures referred through established regional and national pathways, principally to NHS Lothian and NHS Tayside.

NHS Grampian continues to provide the local elements of patients' care and works with receiving specialist centres to support arrangements for referral, treatment, transfer, repatriation and ongoing care. Work continues to ensure that these pathways are resilient, timely and sustainable, with appropriate arrangements for capacity and escalation.

There is no plan to reinstate HPB resectional surgery within NHS Grampian.

Recent Developments

On 19 November 2026, concerns relating to hepato-pancreato-biliary (HPB) surgery at NHS Grampian were raised publicly by Mr Habib at a press conference. The concerns have attracted significant national media and political attention and included questions about the handling of previous concerns regarding the HPB service in Grampian, adverse patient outcomes and the organisational response to the independent review undertaken in 2022. NHS Grampian issued an initial media response that day, recognising the seriousness of the allegations and confirming that any new evidence or information would be carefully considered through the appropriate clinical, governance and legal processes.

In the days that followed, NHS Grampian considered the issues raised alongside the previous reviews, investigations and governance arrangements relating to HPB surgery.

On 21 November 2026, the Scottish Government announced an urgent, fully independent review into how concerns about HPB surgery at NHS Grampian, including those raised by Mr Habib, had been handled by NHS Grampian and the Scottish Government. The review will examine the period 2012 - 2026 and is intended to establish the facts, including how concerns were handled, whether there were missed opportunities or unreasonable delays, and whether there were weaknesses in governance or accountability. NHS Grampian has welcomed the announcement, considering it the best way forward, and has confirmed that it will co-operate fully, openly and transparently.

On 24 November 2026, the Cabinet Secretary for Health and Care provided further information to the Scottish Parliament on the independent review, including its leadership and the approach to developing the Terms of Reference. NHS Grampian subsequently reiterated its commitment to co-operate fully with the review and to provide the access, information, files and records required.

A co-ordinated organisational response has been established to manage the immediate actions arising from these developments. This includes the preservation of relevant records and information; the co-ordination of communications, information requests and correspondence; support for affected patients, families and staff; and putting in place arrangements to facilitate NHS Grampian's full and open co-operation with the independent review.

A dedicated patient telephone line remains in place, and additional staff briefings, listening and wellbeing arrangements have been put in place in recognition of the impact of the continuing public and media attention.

On 25 November 2026, Healthcare Improvement Scotland publicly clarified that the patient death referred to in the Responsive Diagnostic Report’s section concerning a Level 1 Significant Adverse Event Review occurred during HPB surgery at Aberdeen Royal Infirmary. The clarification was made with the agreement of the patient's family and asked that their wellbeing and privacy be respected. NHS Grampian issued a corresponding media statement, acknowledging shortcomings in the original review of the patient's death and associated governance arrangements. The patient's next of kin had been contacted in advance of the publication of the HIS Diagnostic Report by NHS Grampian to apologise for these shortcomings and to explain that the Significant Adverse Event Review would be reopened with external support. The Chief Executive met the family in person on 25 November 2026 to reiterate that apology, answer their questions and confirm NHS Grampian's commitment to involve them fully in the reopened review, including the development of the new scope (Terms of Reference).

Independent Review and Next Steps

NHS Grampian welcomes the further independent review and is committed to cooperating fully, openly and transparently with it. NHS Grampian will provide the reviewer with access to the information, files and records necessary to establish the facts, consider how concerns were identified and addressed, and identify any further learning or action required. Arrangements are in place to ensure that potentially relevant records and information are secured and preserved, while continuing to support affected patients, families and staff. NHS Grampian will consider and

respond to the findings and recommendations of the review when these are available.

Healthcare Improvement Scotland Diagnostic

The Healthcare Improvement Scotland Responsive Diagnostic Review also considered issues relating to the governance, safety and sustainability of HPB services within NHS Grampian and references the decision to cease HPB resectional surgery in January 2026. NHS Grampian is responding to the findings and recommendations of the Diagnostic through its wider improvement programme. A separate briefing on the Diagnostic has been provided to the Committee and a full discussion about NHS Grampian's response will take place at its 3 December 2026 public Board meeting.

Laura Skaife-Knight, NHS Grampian Chief Executive
26 November 2026

Professor Caroline Hiscox, former Chief Executive, NHS Grampian and current Chief Executive, NHS Lothian

NHS Grampian Hepatobiliary and Pancreatic (HPB) Service 2020 – 2023

Professor Caroline Hiscox – NHS Grampian Accountable Officer November 2020 – November 2023

PURPOSE OF THIS NOTE

To provide members of the Health and Social Care Committee with factual information about events concerning the receipt, communication and response to the 2022 independent external report 'Review of Patient Safety Concerns within HPB Services delivered at Aberdeen Royal Infirmary' prepared by Professor Stephen Wigmore Regius Chair of Clinical Surgery, University of Edinburgh and Professor Giles Toogood, Professor of HPB Surgery, Leeds University.

The Clerk to the Committee has informed Professor Hiscox that the Committee members expect to cover this report in their questions to witnesses attending the second panel session on 2 December 2026.

Professor Hiscox wishes to assist the Committee in gaining a deeper understanding of events surrounding the HPB service, but Committee members will appreciate that she must not prejudice the work of the recently announced KC-led inquiry in the Grampian HPB service. Also, Professor Hiscox is providing information voluntarily to the Committee, and therefore cannot disregard confidentiality and GDPR obligations, in particular as they refer to patient, staff or whistleblowing confidentiality.

BACKGROUND

Events prior to Professor Hiscox's period as Accountable Officer:

Concerns had been raised about the NHS Grampian HPB service from 2010, with Health Improvement Scotland (HIS) and Royal College of Surgeons England (RCSE) examining the service in 2014.

2014: The RCSE review did not identify an overall safety issue with the HPB service but identified significant areas for improvement. The General Medical Council (GMC) also investigated individual surgeon concerns but closed these cases with no action.

NHS Grampian accepted the HIS and RCSE recommendations and developed an improvement plan including a specific focus on the HPB service.

March 2020 - further local concerns were identified. The Grampian HPB complex surgery service was paused with urgent patients referred to other units in Scotland. There were 4 HPB surgeons at this point. NB All elective services were paused from late March 2020 due to the Covid 19 pandemic

Events during Professor Hiscox's period as Accountable Officer:

November 2020 - Aberdeen University was asked for support to validate outcomes data collected by the HPB surgical team and a summary was received in April 2021. There was also intervention to support team working from NHS Resolution England.

April 2021 - the service was restarted on a limited basis, with no complex surgery performed in Grampian. Two designated surgeons used an enhanced patient selection process, referred complex cases to other North of Scotland centres, and there was dual person operating and enhanced multi-disciplinary team oversight of the service.

Between April and June 2021 two separate whistleblowing disclosures about the care of patients within the HPB team were received. These included specific concerns about the management of 45 cases which were operated on over a six year period between 2015 and 2021. The whistleblowing process recommended an independent review of the 45 cases, and this was commissioned from Professor Steve Wigmore and Professor Giles Toogood in May 2022.

The Wigmore/Toogood report used the Structured Judgement Review methodology developed by the Royal College of Physicians to do a table-top review of the case notes of 45 cases over 2 days.

NHS Grampian received the report on 29 September 2022.

Key findings from the report:

- A serious adverse event was identified in 19 of 45 cases
- An adverse event was identified in 12 of 45 cases
- No adverse event identified in 14 cases

Of the 45 cases, 31 patients were deceased. For the 31 cases where the patient was deceased an analysis of avoidability was conducted using the structured judgment approach:

    - 5 cases were classified as definitely avoidable
    - 8 cases were classified as strong evidence of avoidability
    - 4 cases were classified as probably avoidable (more than 50:50)

2 further cases of avoidable harm were identified through the second review of cases from 2021 - 2022 conducted by Professor Wigmore (see below) and added to the group of cases that would be further examined.

14 cases of the 31 cases where the patient was deceased had no avoidable harm identified and therefore were not considered for further review.

SPECIFIC ACTIONS TAKEN

A. Report Recommendations and immediate actions to protect patient safety

All complex HPB surgery was stopped in NHS Grampian from October 2022 and patients were referred to NHS Lothian. All of the recommendations in the Wigmore/Toogood Report were implemented.

B. Communications

The immediate priority was to support affected patients, families and staff using the Duty of Candour framework as guidance.

Duty of Candour framework:

The Scottish Duty of Candour framework is a patient-centred statutory duty designed to promote trust through openness and learning. The Duty of Candour is fundamentally about the relationship between the organisation and the patient, service user, or family affected by an incident.

NHS Scotland Boards must activate the Duty of Candour procedure as soon as reasonably practicable when:

- An unintended or unexpected incident occurs during the provision of a health service.
- In the reasonable opinion of a registered health professional who was not involved in the incident, the incident appears to have caused, or could cause, one of the statutory Duty of Candour outcomes.
- The outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

The statutory outcomes include:

- Death.
- Permanent lessening of bodily, sensory, motor, physiological or intellectual functions.
- Harm which has lasted, or is likely to last, for a continuous period of at least 28 days.
- Pain or psychological harm which has lasted, or is likely to last, for a continuous period of at least 28 days.
- An increase in treatment requirements.
- A shortening of life expectancy.

Once the Duty of Candour procedure applies, the organisation must:

1. Notify the patient or relevant person as soon as reasonably practicable.
2. Offer an apology.
3. Provide an opportunity for discussion and questions.
4. Carry out a review of the circumstances.
5. Share the findings of that review and any learning identified.

6. Keep the required records and include relevant information in its annual Duty of Candour report.

There is an important principle of openness and respect that patients and families should, wherever reasonably practicable, be informed directly about a Duty of Candour incident before learning about it through media reporting or other public communications. Direct communication with those affected should therefore be prioritised.

Duty of Candour obligations do not override or displace other legal duties owed by organisations. Information sharing must continue to comply with data protection legislation including the UK GDPR and Data Protection Act 2018 obligations, as well as duties of confidentiality owed to patients, staff and others. Information should therefore be disclosed only to the extent necessary and appropriate in all the circumstances.

Immediate handling of the Wigmore/Toogood Report in October 2022

The Chief Executive and the Chair of NHS Grampian considered it appropriate to provide a full briefing to the whole NHS Grampian Board in an extraordinary minuted meeting of the Clinical Governance Committee on 27 October 2022. This would protect patient and staff confidentiality and provide time for individual patients and families to be contacted; enable full and frank discussion of the issues and avoid causing undue public alarm that could potentially increase the likelihood of late presentation and possibly lead to poorer health outcomes. The primary consideration was to prioritise a trauma-informed, family-centred approach and protect the integrity of further reviews recommended by the Wigmore/Toogood Report.

Prior to the 27 October 2022 Clinical Governance Committee meeting, non executive members of the NHS Grampian Board were briefed by the Medical Director at the monthly non executive informal session on 20 October 2022 on the conclusions of the Wigmore Report and the immediate actions being taken in response. This was an informal briefing and non executives were encouraged to attend the Clinical Governance Committee meeting the following week, for which detailed briefing papers were provided in advance.

This communications approach was shared with relevant officials at Scottish Government.

C. Family contact process for NHSG HPB cases – initial contact in 2022

An experienced family contact team (Chief Nurse, Lead Consultant Surgeon and Clinical Psychologist) began work in October 2022 and support was provided to the families affected until the conclusion of the adverse event review process in late 2025.

All 19 (17 +2) cases meeting the criteria for a serious adverse event in the Wigmore/Toogood report were recorded with a ‘Duty of Candour’ trigger. Contact details could not be identified for 2 families. Of the remaining 17 families:

- all received letters
- 16 had telephone contact by end of November 2022
- 13 of those 16 families requested and had a face-to-face meeting with the team by May 2023.

In respect of the whole group of 45 cases examined by Professors Wigmore and Toogood, for the 26 cases where no harm had by identified by them 14 of these families were contacted by end of November 2022 with 2 requesting a follow up meeting.

D. Review of HPB cases 2021 – 2022 (since service restarted April 2021)

Professor Wigmore was asked to review all HPB cases which had been undertaken since the restart of the service in April 2021 to the Autumn of 2022 and had not been in scope for his first report. His report is dated 22 November 2022.

60 cases were reviewed and the key findings were that mortality was high for liver surgery but within the accepted upper limit of the National HPB Network, but mortality for pancreatic head resections remained unacceptably high.

Professor Wigmore also noted that blood loss in a number of pancreas and liver resections was extremely high and case volume for NHS Grampian was low, which he stated impacts negatively on surgeons' technical experience, as well as team management of patients and recognition and intervention for complications.

Professor Wigmore offered to support the two remaining surgeons and until May 2023 joined weekly planning meetings and travelled up to Aberdeen on a number of occasions to support the two remaining surgeons, including joining them in theatre, and talk to the HPB team including anaesthetists.

Professor Wigmore recommended that the NHS Grampian HPB service could undertake low risk HPB resections, with the limitations previously agreed after his first report to stay in place.

Professor Wigmore provided a letter in May 2023 which has been made available to MSPs by the Cabinet Secretary for Health and Social Care. The letter stated that

- he believed the HPB service was providing a high standard of patient care which was safe and contemporary with current practice
- the service was operating differently from previous practices.
- The standard of preparation, surgery and post-operative care was very high
- the decision-making regarding suitability for surgery, intraoperative choices and in response to postoperative problems was excellent and likely to continue in his absence since it was based on good teamworking and dedication from the HPB team.

He endorsed a resumption of normal activity for the HPB service in NHS Grampian.

A review of Clinical Governance processes for the HPB service was completed by May 2023. Changes were made to clinical governance processes, including

revisions to the Mortality & Morbidity meetings and Quality Assurance meetings. This was reported to the NHS Grampian Clinical Governance Committee in May 2023.

E. Detailed external expert review of Adverse Event cases 2022 - 2024

The Central Legal Office (CLO) was asked to identify an expert to conduct an external expert review of cases involving 13 patients who died with a likelihood of avoidability of harm score of above 50:50. NHS Grampian provided case notes on the 13 cases via CLO to the expert, who completed the reviews by November 2024 and made the records available to NHS Grampian.

F. Further contact with families during Adverse Event Review process 2022-2025

NB: This information is taken from a report provided to the NHS Grampian Clinical Governance Committee in August 2025, 2 years after Professor Hiscox left NHS Grampian. It is provided in this note to give a more complete picture of the family contact during the extended period when cases were being reviewed, and questions on these matters are for the current NHS Grampian Chief Executive to respond to.

After the detailed review reports were received in 2024, NHS Grampian conducted their own Level 1 Adverse Event Reviews (AER) on these cases. All these cases triggered the NHS Scotland organisational Duty of Candour procedure.

As reported to the NHS Grampian Clinical Governance Committee in August 2025, contact with the families of these cases was attempted. Contact was established with eleven families. These families were invited to meet with NHS Grampian staff to share their experiences of the care their relatives had received. These experience narratives formed a vital part of the information reviewed during the Level 1 Adverse Event Review process.

The families were kept up to date with the progress of the AERs by letter. They were given the contact details of a Family Liaison Manager so that they had a single point of contact for communication with NHS Grampian.

It took approximately six months from receipt of the external reviews to completion of all eleven AERs where there was contact with families.

On completion of the AER process, the Level 1 AER reports were shared with the families by recorded delivery mail along with a covering letter. The families also received an official apology signed by the Acute Services Medical Director in line with NHS Scotland Duty of Candour procedures. Six families took up the offer to meet with NHS Grampian staff following receipt of the review reports. Psychological support was available at the meetings bar on one occasion.

The family experience was included in the final AER reports, and a report on the AER process was provided to the NHS Grampian Clinical Governance Committee in August 2025.