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

# NHS Grampian

At this week's meeting, the Committee will take evidence on the corporate and clinical governance issues within NHS Grampian.

The following witnesses will be in attendance:

**Panel 1 – Patient Safety Commissioner and whistleblowers**

- **Karen Titchener**, Patient Safety Commissioner for Scotland,
- **Gavin Bisset**, Policy and Investigations Manager, Patient Safety Commissioner for Scotland,
- **Dr Izhar Khan**, Consultant Nephrologist & General Physician, NHS Grampian,
- **Professor Zygmunt Krukowski** – retired Consultant Surgeon at Aberdeen Royal Infirmary.

**Panel 2 – Current and former representatives of NHS Grampian**

- **Laura Skaife-Knight**, Chief Executive, NHS Grampian (Sept 2025 – present),
- **Professor John Connaghan**, Interim Chair, NHS Grampian (10 October – present); also acted as interim Chief Executive of NHS Scotland between May 2020 and January 2021,
- **Professor Caroline Hiscox**, former Chief Executive, NHS Grampian (2020-2023) and current Chief Executive, NHS Lothian (August 2024 – present).

The following paper describes some of the background to the issues within NHS Grampian, as well as providing a broad overview of the key governance systems and processes in place for the NHS.

**Please note that some of the background in this paper has been gleaned from press reports and we have been unable to independently verify everything that has been reported within the time available. The information contained in this paper is, to the best of our knowledge, correct at the time of publication based on the information publicly available to us.**

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# Background

On 12 November 2026, Healthcare Improvement Scotland (HIS) published four reports into key services and systems within NHS Grampian. Two of these reports were critical of Dr Gray's and NHS Grampian and have led to wider scrutiny of patient safety and leadership within the board:

1. Dr Gray's Hospital, NHS Grampian – acute safe delivery of care inspection report
2. NHS Grampian Responsive Diagnostic Review

## HIS Report on Dr Gray's

The report on Dr Gray's 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.

HIS subsequently wrote to NHS Grampian on 1 May 2026, to formally escalate concerns related to the safe delivery of level 2 critical care within the high dependency unit at the hospital.

In addition, the report went on to highlight concerns around paediatric services and that HIS had:

> "…raised significant concerns with NHS Grampian in July 2026 about the delivery of safe and effective care for critically unwell paediatric patients. Concerns related to staff training levels to support the safe delivery of paediatric care across the hospital, and an increase in reported adverse events relating to the timely transfer of critically ill children." (Pg 8)

Further to this, a suspension of all elective paediatric surgery was put in place on 9 July 2026. This was alongside an existing suspension of emergency paediatric surgery.

However, it was later discovered that elective dental and ENT surgery had continued until 6 August 2026.

## HIS Responsive Diagnostic Review

The second of the HIS reports - the Responsive Diagnostic Review - was requested by the health board Chief Executive in May 2026 and was in response to persistent, serious concerns about safety, quality, clinical governance and leadership.

There were four main findings within the report and these are summarised below. The overall conclusion of the report included the following:

> "We found widespread evidence of passivity, limited constructive challenge and a reluctance to question established ways of working, even where concerns were well recognised. In some areas, this was accompanied by a lack of openness and a sense of fatalism about long-standing problems. Insufficiently effective executive leadership and oversight have allowed some unacceptable arrangements to become normalised, with concerns persisting despite repeated attempts to address them. At its most concerning, this culture can weaken accountability, inhibit organisational learning and reduce the likelihood that weak assurance, emerging risks and persistent problems will be robustly challenged and resolved." (Para 3.11)

The conclusion goes on to say that the cultural and leadership weaknesses in the board create conditions where risks to patient safety and the quality of care are not identified, escalated or addressed in a timely manner.

## Finding 1: Dr Gray's Hospital is insufficiently integrated within NHS Grampian

Dr Gray's Hospital is not sufficiently integrated into NHS Grampian's clinical, managerial and professional structures. The staff and other stakeholders at Dr Gray's Hospital do not consider that senior executives and clinical leaders of NHS Grampian are visible to them or engaged in the day-to-day realities that they face. They are concerned that the challenges and risks are not fully understood or addressed.

The review found that some of the key services at Dr Gray's Hospital are functioning in isolation rather than as part of a cohesive and resilient NHS Grampian model.

The review found that the acute sector triumvirate had failed to identify the longstanding clinical governance and workforce challenges at Dr Gray's Hospital and had not acted when those concerns were escalated to them. It also found that the board had failed to deliver the promised strategy for the hospital and an accompanying detailed description of the range of services to be provided from the site within NHS Grampian. (paras 3.4-3.6)

## Finding 2: NHS Grampian has repeatedly failed to resolve clinical governance concerns effectively

We [HIS] identified a recurring pattern in which concerns generate reviews, action plans, additional structures or workarounds but this has not successfully resolved underlying causes of difficulties. By workarounds, we mean that there are short term actions that, while attractive in resolving immediate difficulties, do not lead to sustainable solutions. They also avoid tackling challenging clinical governance issues and working relationships between individuals, teams and services.

Particularly concerning are major weaknesses in learning from significant adverse events and the failure to escalate patient safety issues. NHS Grampian must demonstrate not only that improvement actions have been implemented, but that they have resulted in effective and sustained resolution of identified risks, with clear evidence that improvements are embedded, consistently applied and capable of being maintained over time. (Paras 3.7-3.8)

## Finding 3: NHS Grampian's board scrutiny and oversight of clinical governance are inadequate

We [HIS] found that the scale of clinical governance risks is not reliably recognised and challenged by the NHS Grampian Board. At times, information given to the board as 'assurance' was difficult to reconcile with the sources of evidence that were available elsewhere. There was also concern about the adequacy of the level of information provided. The board, particularly the non-executive directors, needs to exercise greater curiosity, confidence and capability to test clinical governance

assurance and satisfy itself that significant risks to the safety and quality of care are being effectively managed. (Para 3.9)

**Finding 4: NHS Grampian's leadership and management of the medical workforce are weak**

We [HIS] identified serious weaknesses in all aspects of leadership and management of the medical workforce across the acute sector of NHS Grampian, not just Dr Gray's Hospital. The issues included lack of workforce plans, poor recruitment controls, failure of job planning, failure to engage with and deliver changes in clinical practice and interface working, and significant concerns in how doctors are managed. These failures are impacting on clinical governance, clinical supervision of resident doctors in training, patient care and patient safety. (Para 3.10)

The report contained 6 recommendations:

1. implement an integrated, respectful and sustainable plan for Dr Gray's hospital,
2. substantially increase organisational capability, oversight and accountability for assuring effective clinical governance,
3. establish effective organisational leadership and management of the medical workforce,
4. simplify governance and demonstrate that it works before introducing further structures,
5. establish outcome-based external oversight of improvement, and
6. strengthen board governance, decision making and collective accountability.

The Scottish Government has since sent in a team of senior managers from other NHS boards to help address the issues.

The Chief Executive, Laura Skaife-Knight, announced that NHS Grampian would set out improvement priorities at its 3 December 2026 Board meeting and provide further scrutiny through an extraordinary Board meeting on 21 January 2027.[1]

## Concerns of Dr Mohammed Habib

Since the publication of the HIS reports, Dr Mohammed Habib, a Hepato-biliary-pancreatic (HPB) consultant at Aberdeen Royal Infirmary, has gone public with his whistleblowing concerns. He has claimed that patient safety concerns within NHS Grampian were not adequately addressed and that opportunities to learn from adverse events were missed over several years.

[1] NHS Grampian (17 November 2026) Post Parliamentary Statement.

Dr Habib also made public a copy of a report from 2022 entitled 'Review of patient safety concerns within HPB services delivered within Aberdeen Royal Infirmary'.

This report is explored in more detail in the section on 'Governance Issues prior to 2026'. However, Dr Habib states the report details 19 avoidable deaths but was never made public.

He also says he raised concerns about excessive deaths in 2021 but failed to get action from the board and subsequently wrote to Police Scotland, the Crown Office and Scottish Government.

He then wrote to, then First Minister, Humza Yousaf in June 2023, and First Minister John Swinney in October 2024, November 2025 and May 2026.

Dr Habib has called for corporate manslaughter charges against the board and has argued that there should be further independent investigation of NHS Grampian's handling of patient safety concerns and governance arrangements.

Police Scotland has confirmed that it is carrying out enquiries following a report received in 2024 concerning several deaths associated with HPB services at Aberdeen Royal Infirmary. A situational report is to be submitted to the Crown Office and Procurator Fiscal Service, and the investigation remains ongoing.[2]

## Governance issues prior to 2026

The issues identified in recent reports are not entirely new to NHS Grampian and concerns reportedly date back to 2012.

The following sections provide a summary of previous concerns, reviews and actions taken.

### 2014 Short Life Review of Quality and Safety at Aberdeen Royal Infirmary

In March 2014, the then Cabinet Secretary for Health, Alex Neil, was made aware of concerns at Aberdeen Royal Infirmary by several consultants and subsequently instructed Healthcare Improvement Scotland (HIS) to investigate.

In December 2014, HIS published Aberdeen Royal Infirmary: Short-Life Review of Quality and Safety. The review examined:

- the culture, leadership, values and behaviours in operation at the board, and
- the quality and safety of care in a focused number of specialties and services, including the emergency department, general surgery and care of the elderly.

[2] Scottish News (20 November 2026) Police probe into NHS Grampian deaths after surgeon claims patients died needlessly.

The report concluded that there was no evidence of widespread, unsafe clinical care and confirmed that patients achieved broadly similar outcomes in Aberdeen Royal Infirmary compared to similar patients in other Scottish hospitals.

However, it did identify concerns about:

- serious breakdowns in relationships between management and clinicians,
- weak leadership and governance arrangements,
- poor organisational culture and low staff morale,
- concerns about team-working within surgical services,
- a lack of effective clinical engagement in decision-making.

In response, NHS Grampian published an Improvement Programme and Immediate Action Plan. This set out actions to be taken within the following 30 days and over the longer term. Key commitments included:

- strengthening executive and clinical leadership,
- improving engagement between the Board and frontline staff,
- clarifying management responsibilities and governance structures,
- improving workforce planning and staff support.

The board had also invited a separate Royal College of Surgeons of England review of surgical services.

## 2014 Invited Review of Surgery

The Royal College of Surgeons for England and the Association of Surgeons of Great Britain and Ireland were invited by the board, in June 2014, to conduct a review of General Surgical Services.

This was following the previous HIS review and because of concerns about outcomes from Hepato-Pancreato-Biliary (HPB) services at Aberdeen Royal Infirmary. It also looked at concerns around wider team-working and individual behaviours.

The full version of the final report does not seem to be available online but a section including the recommendations was released via an FOI response and is available via the NHS Grampian website.

This excerpt shows that the review team found no information which suggested that the General Surgical service at Aberdeen Royal Infirmary was unsafe. However, it went on to make 29 recommendations which alluded to significant interpersonal conflict, poor team-working, behavioural concerns, and weaknesses in governance within the service. These appeared to create risks to service quality and undermine confidence within the surgical department.

The Cabinet Secretary for Health (now Shona Robison) made a ministerial statement to the Scottish Parliament on 3 December 2014 and NHS Grampian published an immediate action plan in response to both the reports.

## Patient safety concerns within Hepato-Pancreato-Biliary services delivered at Aberdeen Royal Infirmary

As covered previously, Dr Mohammed Habib, a Hepato-biliary-pancreatic (HPB) consultant at Aberdeen Royal Infirmary, has gone public with his whistleblowing concerns that patient safety issues, including excess deaths, were not adequately addressed and that opportunities to learn from adverse events were missed over a number of years.

As part of this, Dr Habib also made public a copy of a previously unpublished report from 2022 entitled 'Review of patient safety concerns within HPB services delivered within Aberdeen Royal Infirmary'.

To date, this report has not been made public. However, details reported in the media[3] indicate that the 2022 review examined 45 patients who underwent liver or pancreatic surgery by NHS Grampian's HPB service between 2015 and 2021.

The review was led by Professor Stephen Wigmore of the University of Edinburgh and Professor Giles Toogood of the University of Leeds. It considered the medical records of 28 men and 17 women and assessed both clinical documentation and staff evidence.

Of the 45 cases reviewed, 31 patients had died. The reviewers reportedly concluded that 19 of those deaths were attributable to avoidable consequences of surgery or intervention, including:

- 5 deaths judged to be 'definitely avoidable',
- 8 where there was strong evidence of 'avoidability', and
- 6 where there was slight evidence of 'avoidability'.

A further 12 patients were found to have experienced harmful or negative outcomes linked to the care they received.

HPB surgery in Aberdeen was suspended in 2022 and patients were redirected to NHS Lothian.

A copy of the review report was requested from NHS Grampian and the Scottish Government on behalf of the Committee but, at time of writing, this has not been made available.

In her recent statement to Parliament, the Cabinet Secretary said the report had been withheld due to concerns about patient confidentiality. However, she did make

[3] For example, see the Press & Journal (19 November 2026) Key findings from bombshell investigation into 19 'avoidable' deaths at Aberdeen Royal Infirmary.

available a letter from Prof Wigmore to NHS Grampian in May 2023, in which he states he is ‘confident to endorse a resumption of normal activity in NHS [Grampian]’.

## Concerns of Dr Izhar Khan and Prof Zygmunt Krukowski

Dr Izhar Khan and Professor Zygmunt Krukowski have recently been reported in the media claiming that longstanding problems at NHS Grampian stem from failures of leadership, governance, and organisational culture rather than isolated operational issues.

In a recent TV interview, Dr Khan expressed concern that senior management has become disconnected from frontline clinicians, resulting in important clinical concerns being insufficiently heard or acted upon. They also contend that recommendations from previous reviews have not been implemented effectively, leading to repeated findings over many years and a failure to learn lessons from earlier investigations.

Specific allegations made by the doctors include:

- A perceived disconnect between senior management and clinical staff, with service changes being implemented without meaningful consultation with the clinicians expected to deliver them.
- Organisational decision-making being carried out in "silos", limiting effective communication and engagement across the health board.
- Pressures on bed management and patient flow that can compromise patient care, including patients being treated in wards that are not aligned with their clinical needs and the use of corridor spaces for patient care.
- A focus on rapid discharge and operational targets that can distract clinical teams from providing safe and appropriate care.
- Concerns that staff who raise issues are not always listened to and that opportunities to address problems are missed.
- A belief that recurring concerns about patient safety, leadership and governance identified in reviews over more than a decade have not been adequately addressed, despite repeated commitments that lessons would be learned.

Professor Zygmunt Krukowski reportedly raised concerns at the time of the 2014 reviews and was quoted recently as saying:

> “Deeply depressing that very little has changed. I mean, there has been the usual merry-go-round amongst senior management over the last ten or 15 years. The response is always ‘lessons will be learned’. It’s manifestly not the case, so lessons aren’t learned.

> Either they get moved on, or they don't stay to see the consequences of their actions.
>
> This mantra that lessons will be learned. Well, they can't be learned, because if you look at the disasters reported in this report from the surgical area, they clearly have not been learned, and this is ten years or more that these concerns have been aired."[4]

Professor Krukowski left NHS Grampian in 2015.

### Concerns of Jason Donnelly

Following public reporting of Dr Habib's concerns, a further whistleblower emerged in the media.[5]

Mr Jason Donnelly runs a business which is involved in the quality assurance of medical equipment. Press reports detail that he alleges he repeatedly contacted the First Minister with concerns about the risk from changes to cleaning chemicals.

Mr Donnelly claims he lost a contract in 2018 after he raised concerns and is reported to have said there is a culture of 'institutional protection' at the health board.

He reportedly wrote again to the First Minister recently stating:

> "For me, these reports bring renewed anger and distress. Since 2018, I have repeatedly warned you about wrongdoing, patient-safety risks and what I maintain was the covering up and whitewashing of serious concerns within this health board.
>
> "I warned you that, without meaningful intervention and independent scrutiny, the failures would continue."

## Governance Overview

In order to scrutinise what has happened within NHS Grampian, it is important to understand the main systems of governance in the NHS.

Governance has been defined as:

> "...the means by which NHS boards direct and control the healthcare system to deliver Scottish Government policies and strategies and to ensure the long-term success of the organisation. It is the ability to ask questions and make decisions to improve population health and address health inequalities, while delivering safe, effective and high-quality healthcare services. It is to be distinguished from executive-led operational management."

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[4] STV News (17 November 2026) NHS Grampian whistleblowers warn 'lessons not learned' by 'merry-go-round' management.
[5] The Press and Journal (23 November 2026) Second NHS Grampian safety whistleblower warned John Swinney for years about crisis.

The Blueprint for Good Governance provides guidance to boards on how to deliver and sustain good governance. It sets out five functions of governance:

- setting direction,
- holding to account,
- assessing risk,
- engaging stakeholders,
- influencing culture.

The issues around NHS Grampian are largely to do with two key strands of governance:

1. **Corporate governance** - the systems, processes and accountabilities through which an organisation is directed, controlled and held responsible for its performance and decision-making.

2. **Clinical governance** - the systems through which healthcare organisations ensure the quality, safety and effectiveness of the care they provide.

NHS Boards are central to corporate governance and executive directors are accountable to the rest of the board which is made up of the Chair, non-executive lay members (appointed by Ministers) and non-executive stakeholder members (representatives of specific interests that must be represented on the Board e.g. Chair of the area clinical forum).

It is the role of boards to hold the executive to account, approve decisions, have oversight of what is happening in the board, and receive reports from committees such as the clinical governance committee.

In terms of clinical governance, the systems and processes are wide-ranging and complex but the following sections detail the key mechanisms used within NHS boards and those that are external to the boards.

## Governance Systems Within NHS Boards

### Governance Committees

NHS Boards have a number of standing committees which are intended to provide assurance to the board. These typically include audit and risk, clinical governance, staff governance, finance and performance, and remuneration committees.

In terms of clinical governance specifically, clinical governance committees provide oversight of patient safety, quality of care and clinical risk, seeking assurance that healthcare services are safe, effective and continuously improving.

Their core functions include:

- monitoring patient safety, quality of care and clinical outcomes,

- overseeing clinical risks, incidents and adverse events,
- reviewing audits, inspections and investigations to identify areas for improvement, and
- seeking assurance that lessons are learned and improvements are implemented.

The committee reports to the board on these matters and should also escalate concerns where there are serious incidents or recurring problems.

**Morbidity and Mortality Monitoring**

Concerns about surgical mortality and patient outcomes have been a key feature of the issues within NHS Grampian. Surgical outcomes, including mortality, are monitored locally and boards are expected to have systems of risk-adjusted mortality monitoring, morbidity surveillance, clinical audit, governance review and benchmarking that identify when outcomes move beyond expected variation and trigger investigation.

Historically, Scotland also had national mortality review programmes. The Scottish Audit of Surgical Mortality (SASM) operated from 1994 to 2015 and reviewed deaths occurring under the care of surgeons through a peer-review process. In 2015 it was replaced by the Scottish Morbidity and Mortality Programme (SMMP), which broadened the focus beyond surgery and operated until 2018. Responsibility for mortality and morbidity review now rests primarily within local NHS board governance arrangements.

**Duty of Candour**

The organisational duty of candour in Scotland requires health, care, and social work providers to be open and honest when an unexpected or unintended incident causes harm or death. The affected person (or someone acting on their behalf) must be informed as soon as possible and have the known facts and planned next steps shared with them.

In addition, boards are required to conduct a review into what happened, offer a written report within 3 months and share improvement actions. Boards must also publish an annual report of incidents and learning.

NHS Grampian's latest report on Duty of Candour was published on 25 November 2025. This showed that there was a total of 62 duty of candour incidents in 2024/25, including 8 deaths.

**Serious Adverse Event Reviews**

Serious Adverse Event Reviews (SAERs) are a process used when things go wrong in healthcare. They are used to establish what happened, why it happened, and what actions are needed to prevent recurrence.

Each NHS board is expected to implement the revised National Framework for Reviewing and Learning from Adverse Events in NHS Scotland which was updated

and published by HIS in 2025. The framework aims to achieve consistency in how boards identify, define and respond to adverse events

In 2019, the then Cabinet Secretary for Health and Sport, Jeane Freeman, instructed HIS to take forward actions that require all NHS boards to notify HIS when they have commissioned a Significant Adverse Event Review (SAER) for a Category 1 adverse event.

Category 1 events are events that resulted in unexpected or avoidable death or severe harm to one or more people.

Data on the commissioning of SAERs is reported to HIS by boards on a monthly basis but a revised notification system is being tested during 2026.[6]

The most recent publicly available data on the number of category 1 SAERs commissioned by each NHS board was published in August 2025 in a written PQ (S6W-39813). This showed the following number of SAERs in Grampian since 2021:

| | Category 1 SAERs commissioned from Jan 2021 - Jun 2025 | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| NHS Grampian | 23 | 21 | 21 | 31 | 20 |

## Governance Systems External to NHS Boards

### Escalation Policy

Where there are concerns about a board, the Scottish Government uses the NHS Scotland Support and Intervention Framework. This is often referred to as the 'escalation policy'.

The framework is overseen by the National Planning and Performance Oversight Group (NPPOG). It has five stages, which are summarised below.

| Stage | Description | Support and Intervention(s) | Decision taken by |
|---|---|---|---|
| 1 – Steady state | NHS boards are delivering in line with agreed plans. Normal reporting arrangements in place. | The annual delivery plans, produced by all boards, form the basis against which performance is assessed throughout the year. | Scottish Government policy leads |

[6] Personal communication with Healthcare Improvement Scotland.

| Stage | Description | Support and Intervention(s) | Decision taken by |
|---|---|---|---|
| | | Surveillance through official statistics published by Public Health Scotland and scheduled engagement of NHS board annual reviews/mid-year reviews | |
| 2 – Enhanced monitoring | Some variation from agreed plan (s), possible delivery risk if no remedial action is taken | A NHS board-led support package or recovery programme agreed and implemented. Increased surveillance and monitoring by Scottish Government. Scottish Government Directors aware. | Scottish Government policy leads |
| 3 – Enhanced monitoring and support | Significant variation from plan, risks materialising, Scottish Government commissioned tailored support package is required | Formal approach incorporating significantly enhanced support and scrutiny and likely to include a level of external support. Relevant Scottish Government Directors engaged with NHS Board Chief Executive Officer and top team. Director General Health and Social Care aware. | Health and Social Care Management Board |
| 4 – Senior external support and monitoring | Significant risks to delivery and tailored support is not producing the required improvements. Senior level external support required. | Senior level external support reporting to an Assurance Board chaired by Scottish Government. Assurance Board reports direct to the Chief Operating Officer for NHS Scotland and Director General Health and Social Care.<br><br>Onus remains on the NHS board to deliver the required improvements. | Director General for Health and Social Care |

| Stage | Description | Support and Intervention(s) | Decision taken by |
|---|---|---|---|
| 5 – Statutory intervention | The level of risk and organisational dysfunction is so significant that the NHS Board requires direct intervention using statutory powers of direction. | Ministerial powers of Intervention. | Cabinet Secretary for Health and Social Care |

A board can be at different stages for different issues. Stage 5 is only used in exceptional circumstances.

As of 3 November 2026, NHS Grampian was at level 4 in the framework on the grounds of "financial sustainability and the deterioration of the Board's financial position during 2024/25 and leadership and governance".

**Healthcare Improvement Scotland**

Although NHS boards are responsible for their own clinical governance arrangements, Healthcare Improvement Scotland (HIS) provides independent scrutiny, assurance and improvement support, helping to identify risks to patient safety and monitor the effectiveness of governance and quality systems.

HIS describes itself as an 'improvement body' rather than an external regulator and it works with boards to bring about improvements. It is constituted as a special health board of the NHS.

Inspections of services are programmed by HIS but it can respond to requests from Ministers (and sometimes boards) to undertake extraordinary investigations where there is cause for concern. It does not respond to complaints or concerns from individuals and it has limited enforcement powers.

**Annual Accountability Reviews**

Each board also undergoes an annual accountability review. These are formal discussions held in public between NHS boards and the Cabinet Secretary for Health (or a Minister). They are used to assess performance, governance, quality of care, workforce issues and financial management. They also identify areas where improvement or additional support may be required.

NHS Grampian's accountability review was held on 13 November 2026 and the annual review webpage provides the public session recording.

**Patient Safety Commissioner for Scotland**

The Patient Safety Commissioner for Scotland (PSCS), Karen Titchener, is an independent statutory officeholder whose role is to advocate for patients' safety and promote improvements in the safety of healthcare in Scotland.

The PSCS described the HIS review as "one of the most serious patient safety reports Scotland has seen" and said patients and families deserve honest answers about what happened.[7]

She also highlighted that the central issue was not a lack of warning signs but a failure to act on concerns that had already been raised, noting that staff had repeatedly voiced concerns.

She has called for wider reforms, including:

- greater transparency around Significant Adverse Event Reviews (SAERs),
- independent verification of improvement actions rather than reliance on self-reporting by health boards,
- a national grading system for hospitals to allow the public to compare performance and identify areas requiring improvement,
- stronger regulatory powers, arguing that there is a gap in the current system because Healthcare Improvement Scotland can identify problems but has limited powers to compel boards to act.

She has also called for better support for whistleblowers and was quoted in the press as saying:

> “We should be grading hospitals so everyone can see exactly what is going on and what needs to improve. We need that transparency, and right now there is none because currently health boards all carry out Significant Adverse Event Reviews differently.
>
> Healthcare Improvement Scotland (HIS) has drawn up a framework that is not mandatory, however all NHS boards are required to report to HIS when they commission an SAER.
>
> However, despite having more than 600 staff the watchdog has no power to compel health boards to act. HIS has been described by campaigners as “toothless”.[8]

[7] Patient Safety Commissioner for Scotland (14 November 2026) NHS Grampian Review: Patient safety concerns must lead to real change.
[8] Sunday Post (22 November 2026) NHS Inspectors ‘toothless because of gap in rules that must be addressed’.

# Recent Developments

## Ministerial Statement

On 24 November 2026, the Cabinet Secretary for Health made a statement to the Scottish Parliament on the concerns regarding HPB services at NHS Grampian. In the statement she said that the concerns were extremely serious and acknowledged the impact on patients and families affected.

The Cabinet Secretary referred to the 2022 review which identified 19 potentially avoidable deaths and confirmed it led to the temporary suspension of complex HPB surgery in 2022. She detailed that, following a period of oversight and improvement work, the service resumed in 2023 after the author of the review, Prof Wigmore, concluded that it was safe to do so.

However, the Cabinet Secretary stated that significant questions remain about the period between 2023 and 2026, including whether concerns were appropriately identified, escalated and acted upon, and whether adequate assurance was provided to the Scottish Government and ministers.

She also highlighted concerns about the handling of correspondence and issues raised by Dr Mohammed Habib, including whether existing processes for escalating patient safety concerns operated effectively.

In order to establish a clear account of events, the Cabinet Secretary announced an independent review, led by an external King's Counsel, which will examine the management of concerns relating to HPB services from 2012 to 2026, including the actions of both NHS Grampian and the Scottish Government. The review will seek to determine who knew what, when they knew it, what action was taken, and whether opportunities to address concerns were missed. Its findings will be published in full.

# Key Themes

### Board Oversight and Accountability

A recurring issue across the HIS reports and previous reviews is whether the NHS Grampian Board received sufficient information to understand the scale of the risks facing the organisation and whether it provided effective challenge and scrutiny. This includes the role of non-executive board members, the adequacy of assurance provided to the board, and the effectiveness of board committees, particularly the Clinical Governance Committee.

### Persistent Governance and Cultural Failings

Many of the concerns identified in the 2026 HIS reviews echo themes raised in reviews dating back to 2014, including problems with leadership, organisational culture, interpersonal conflict between clinical staff, clinical engagement and governance. Members may wish to explore why concerns appear to have recurred

over a prolonged period despite multiple reviews, recommendations and improvement programmes.

**Effectiveness of Clinical Governance Systems**

The issues identified in Grampian raise broader questions about the effectiveness of clinical governance arrangements, both within NHS Grampian and across NHS Scotland. This includes the identification and escalation of patient safety risks, learning from adverse events, mortality monitoring, whistleblowing arrangements, and the extent to which governance systems are capable of identifying and addressing emerging concerns before they become systemic problems. Members may wish to explore to what extent the issues emphasise problems with clinical governance systems more generally, or whether these are problems specific to Grampian.

**Escalation of Concerns and the Role of the Scottish Government**

Recent events have focused attention on how significant patient safety concerns are escalated beyond health boards and the extent to which existing oversight arrangements enable Ministers and the Scottish Government to identify and respond to emerging risks. This includes consideration of the support and intervention framework, the handling of correspondence from whistleblowers, and the circumstances in which additional intervention is triggered.

**National Assurance and Independent Scrutiny**

The issues within NHS Grampian have prompted wider discussion about the role of national bodies in assuring patient safety. This includes the powers and effectiveness of Healthcare Improvement Scotland, arrangements for monitoring serious adverse events and mortality, and whether existing mechanisms provide sufficient independent scrutiny and assurance.

**Leadership, Workforce Management and Organisational Learning**

The HIS review identified significant weaknesses in the board leadership and management of the medical workforce. It also highlighted concerns about a culture in which longstanding problems were not effectively challenged or resolved. Members may wish to explore issues of leadership accountability, organisational learning, workforce culture and the extent to which concerns raised by staff are heard and acted upon.

**Transparency, Openness and Whistleblowing**

A common theme running through recent evidence is the importance of transparency in responding to patient safety concerns. Issues include the publication of key monitoring data, reviews, support for whistleblowers, communication with affected patients and families, and whether healthcare organisations create an environment in which concerns can be raised and acted upon without fear of detriment.

**Kathleen Robson, Senior Researcher, SPICe**

**Date: 26/11/2026**

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