Healthcare Improvement Scotland

NHS Grampian Responsive Diagnostic Review

November 2026

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Foreword

This diagnostic review was requested by Laura Skaife-Knight, Chief Executive, in response to growing and significant safety and quality of care concerns in NHS Grampian and to get an independent and external perspective on improvement opportunities.

These concerns were most apparent in the acute sector, particularly at Dr Gray's Hospital, but also at Aberdeen Royal Infirmary. The wide distribution of concerns indicated potential problems with NHS Grampian clinical governance systems, which include educational governance systems, that exist to ensure safe and effective care across the organisation. These considerations led to the request to undertake this diagnostic review, examining clinical governance within Dr Gray's Hospital and the wider NHS Grampian clinical governance systems that support it.

Although this review did not examine every aspect of NHS Grampian, it identified important and recurring weaknesses within elements of its clinical governance systems, leadership arrangements and organisational oversight.

Effective clinical governance is essential to the delivery of safe, high-quality healthcare. When governance arrangements do not operate as intended, there is a greater risk that concerns are not identified, escalated or addressed in a timely way, limiting an organisation's ability to provide assurance to patients, staff and the public about the safety and quality of care.

The findings set out in this review are supported by detailed and extensive evidence gathered throughout the review. Some of the observations and conclusions will be challenging to read. They describe significant failures in aspects of leadership and governance.

However, the purpose of this diagnostic exercise is to provide an honest and constructive assessment that can support meaningful and sustainable improvement. The safety and experience of patients must remain the primary consideration in responding to the issues identified.

This report is not intended as a further call for analysis, nor does it focus on isolated incidents. Rather, it highlights several systemic weaknesses that have affected NHS Grampian's ability to consistently demonstrate that risks to patients are being identified, managed and reduced effectively. It also describes recommendations for the future which are intended to provide clear and deliverable actions for improvement.

The challenge for NHS Grampian is not only to acknowledge these findings, but to show that concerns are translated into decisions, decisions into action, and action into measurable improvements.

The key test will be whether the organisation can, with appropriate support and challenge from partners and stakeholders, deliver the necessary changes with urgency, openness and sustained commitment. Doing so will provide an important opportunity to strengthen governance arrangements, improve patient safety and rebuild confidence among patients, the public and staff.

1. Introduction

1.1 In May 2026, Laura Skaife-Knight, the Chief Executive of NHS Grampian, invited Healthcare Improvement Scotland to undertake a diagnostic review of NHS Grampian. This was in response to a range of significant concerns relating to the quality and safety of care, clinical governance, educational governance, workforce sustainability, leadership, organisational culture and service sustainability. Whilst these concerns were prominent particularly in Dr Gray's Hospital, the importance of identifying underlying systemic issues was recognised from the outset of this review.

1.2 This approach is reflected in the terms of reference for the review which includes Dr Gray's Hospital and the wider system within which it operates. The overall objective of this review was to provide a clear, evidence-based diagnostic assessment of risks, strengths and improvement priorities in relation to safety, quality, governance and organisational culture and to present practical recommendations for the future.

1.3 The review has given careful attention to how governance systems operate in practice:

- how risks are escalated and managed
- how leaders respond when concerns are raised
- how assurance regarding quality and safety is obtained and tested
- whether learning and improvement activities result in demonstrable and sustained change.

1.4 A substantial body of evidence was drawn upon and evaluated against the agreed terms of reference, key lines of enquiry, and key national frameworks, including the Healthcare Improvement Scotland Clinical Governance Standards and the Blueprint for Good Governance in NHS Scotland

1.5 The review identified matters of concern regarding:

- leadership and accountability
- governance and assurance
- ability to implement improvements
- workforce
- culture
- service sustainability.

These concerns and findings related to them are considered in detail in the following sections.

1.6 Since February 2025, there have been a series of exchanges and escalation of matters of concern from Healthcare Improvement Scotland, and Public Services Delivery Scotland, to NHS Grampian and Scottish Government about individual services and aspects of leadership, culture, clinical and educational governance within the NHS board. In February 2025, the chief executives of Healthcare Improvement Scotland and Public Services Delivery Scotland (at that time NHS Education for Scotland) wrote to then interim chief executive of NHS Grampian expressing concerns about leadership, culture, medical education and aspects of workforce management particularly of the medical workforce[1].

1.7 The tables below detail which services had concerns raised about them by Healthcare Improvement Scotland to NHS Grampian. Where concerns were not adequately addressed by NHS Grampian, they were escalated by Healthcare Improvement Scotland to the Scottish Government. This follows the approach set out in the operating framework between Healthcare Improvement Scotland and the Scottish Government.

Escalation to NHS Grampian by Healthcare Improvement Scotland

Year	Service	Reason
2026	High Dependency Unit, Dr Gray's Hospital	Serious concerns about the adequacy of senior medical oversight of the unit
2026	Paediatric surgery, Dr Gray's Hospital	Concerns regarding the training of staff and skill mix

Escalation to the Scottish Government by Healthcare Improvement Scotland

Year	Service	Reason
2025	Cardiology, Dr Gray's Hospital	Concerns regarding waiting times and the co-ordination of care
2026	Hepatopancreatobiliary Surgery and Surgical High Dependency Unit, Aberdeen Royal Infirmary	Serious concerns related to clinical outcomes in hepatopancreatobiliary surgery and clinical oversight in surgical high dependency unit

[1] HIS/NES CEO Letter to NHS Grampian (25 February 2025)

2. Scope and methodology

Scope of the diagnostic review

2.1 The review considered services at Dr Gray's Hospital within the context of the wider acute sector of NHS Grampian up to and including board level. The relevant interactions with NHS Highland were also considered given the proximity of Moray to health services in Inverness.

2.2 Services managed through health and social care partnerships, integration joint board governance, primary care and community service delivery were not in scope. Where issues in those areas were identified during the review, they are mentioned in the report, but no definitive findings are made.

2.3 The review was undertaken over a relatively short period of time and provides a diagnostic assessment based on evidence available at the time. It was not intended to provide a comprehensive assessment of every service, professional group or aspect of NHS Grampian.

2.4 A previous KPMG Diagnostic Report published in 2025 identified that 'A consistent theme from our interviews was that NHS Grampian is generally good at identifying and describing issues facing services but that does not easily translate into deliverable actions which are tracked through to completion with the expected versus actual impact on performance being tracked'. While that report reviewed leadership and governance, it focused on financial and activity issues rather than clinical matters.

2.5 The review took place during a period of organisational change, when NHS Grampian was redesigning aspects of its governance arrangements and developing new reporting structures. Some of the systems considered by the review are therefore still evolving.

The method for this diagnostic review

2.6 The review was structured around five agreed key lines of enquiry, which provided the framework for evidence gathering, analysis and development of findings around:

- leadership and accountability
- governance and assurance
- improvement, capability and delivery
- workforce, culture and clinical engagement
- service sustainability and system working.

2.7 The review adopted a triangulated evidence-based approach. Findings and conclusions were based on the review team's assessment of multiple sources of evidence and the extent to which themes and findings were supported across those sources.

2.8 The evidence included:

- organisational documentation, governance reports and committee papers
- previous Healthcare Improvement Scotland inspection reports, external reviews and professional escalation processes
- Public Service Delivery Scotland quality management activity reports
- adverse event reviews
- workforce and educational governance reviews
- whistleblowing intelligence and concerns raised through professional channels
- interviews and meetings with board members, executive leaders and senior operational, professional and clinical leaders
- discussions with frontline staff
- site visits to Dr Gray's Hospital and Aberdeen Royal Infirmary
- direct observation of services, systems and governance arrangements in both sites.

What is clinical governance?

2.9 The diagnostic review has had a significant focus on clinical governance. Clinical governance is an integral and essential part of the delivery of high-quality, effective and safe clinical services. It is defined as 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'. Systemic approaches to clinical governance in the UK emerged after the Bristol heart scandal and were formally implemented in the NHS in Scotland in 1999. Healthcare Improvement Scotland has set out, in its standards published in February 2026, the essential elements of clinical governance.

2.10 Medical education governance is a key component of clinical governance. Effective medical education governance provides assurance regarding supervision, capability and training quality, whilst also generating important intelligence concerning patient safety, organisational culture, workforce sustainability and clinical risk. Concerns identified through medical education governance processes should therefore be regarded as part of an organization's wider clinical governance and patient safety assurance system.

2.11 Throughout this diagnostic review, we consider the standards and how they are being met by NHS Grampian, particularly regarding systems of governance.

2.12 In addition, we have applied the key aspects of the Essentials of Safe Care in considering how NHS Grampian is addressing the issues raised in this diagnostic review. The Essentials of Safe Care is the over-arching and practical framework of the Scottish Patient Safety Programme. It has four core drivers:

- a people-led approach
- effective and inclusive communication
- leadership at all levels
- safe clinical and care processes.

3. Diagnostic summary

Introduction

3.1 This diagnostic summary captures the key issues arising from this review. The key findings are:

- Dr Gray's Hospital is insufficiently integrated within NHS Grampian
- NHS Grampian has repeatedly failed to resolve clinical governance concerns effectively
- NHS Grampian's Board level scrutiny and oversight of clinical governance are inadequate
- NHS Grampian's leadership and management of the medical workforce are weak.

3.2 Our diagnostic review identified significant and inter-related weaknesses in NHS Grampian's leadership, organisational culture and clinical governance. These sit alongside long-standing concerns about organisational and financial performance and a marked recent increase in the significance and volume of clinical and medical educational governance concerns escalated by Healthcare Improvement Scotland and Public Services Delivery Scotland (formerly NHS Education Scotland until April 2026).

3.3 The concerns identified at Dr Gray's Hospital are not principally the result of local factors within Moray and are not isolated to that hospital. Instead, they highlight wider systemic shortcomings in NHS Grampian's clinical governance, medical educational governance and operating arrangements. The hospital's relative isolation has made it particularly vulnerable to those shortcomings and has brought some of them into sharper focus. However, this should not deflect attention from the wider deficiencies described in this report. They are material and need to be addressed with urgency.

Dr Gray's Hospital is insufficiently integrated within NHS Grampian

3.4 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.

3.5 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.

3.6 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.

NHS Grampian has repeatedly failed to resolve clinical governance concerns effectively

3.7 We 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.

3.8 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.

NHS Grampian's Board level scrutiny and oversight of clinical governance are inadequate

3.9 We 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.

NHS Grampian's leadership and management of the medical workforce are weak

3.10 We 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.

Overall conclusions

3.11 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.

3.12 Ultimately, these cultural and leadership weaknesses create conditions in which risks to the quality and safety of patient care may not be identified, escalated or addressed in a timely and effective manner.

3.13 These findings are interconnected and should not be addressed in isolation. Dr Gray's Hospital is particularly exposed because of its geography, scale and insufficient integration, but the underlying weaknesses are systemic and require an NHS Grampian-wide response.

3.14 The necessary improvement will require clearer accountability, stronger board and executive oversight, better integration of services across NHS Grampian, stronger clinical and medical leadership, and a culture in which concerns are proactively identified and robustly acted upon. The central requirement is a shift from demonstrating activity has been initiated to demonstrating that risks have been understood, reduced and sustainably resolved. The risks are not hypothetical; they are real and create significant risks to patient safety and the quality of care.

4. Findings

4.1 In this section of the report we set out in more detail the key findings and have sought to triangulate this with the evidence gathered over the course of this diagnostic visit.

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

Operating context

4.2 Dr Gray's Hospital is the district general hospital in Elgin[2] and the principal acute hospital serving Moray. Founded in 1819 through a bequest from Dr Alexander Gray, an Elgin-born surgeon, it is one of Scotland's oldest hospitals still in operation. The original building remains a prominent feature of the site, which has evolved through successive phases of development, including a major £22 million redevelopment completed between 1993 and 1997.

4.3 Following the establishment of the NHS in 1948, Dr Gray's Hospital became part of the North-Eastern Regional Hospital Board before joining the Moray District of Grampian Health Board in 1974. It held NHS Trust status from the early 1990s until joining the acute sector of NHS Grampian in 2004, with the dissolution of NHS Trusts in Scotland. Between 2020 and 2025, responsibility for the hospital was delegated to the Moray Health and Social Care Partnership before returning to NHS Grampian's acute sector in 2025.

4.4 Today, Dr Gray's Hospital serves a population of approximately 130,000 people across Moray and surrounding areas. The hospital has around 140 in-patient beds and provides a broad range of services including emergency medicine, general medicine, surgery, orthopaedics, paediatrics, maternity and gynaecology, diagnostics and outpatient services. Many specialist services are delivered through networked arrangements principally with Aberdeen Royal Infirmary.

4.5 In recent years, Dr Gray's Hospital has been the subject of significant political, public and media attention. Concerns have focused on the sustainability of some services, the impact of long-term workforce shortages, the implications of the reduction of consultant-led maternity services implemented in 2018, challenges in maintaining resident specialist cover, and questions about the hospital's future role within NHS Grampian.

[2] Elgin is 67 miles from Aberdeen (approximately 1 hour 45 minutes by road and 1 hour 27 minutes by train) and 39 miles from Inverness (approximately 1 hour by road and 45 minutes by train).

4.6 More recently, concerns raised by doctors in training, through Public Services Delivery Scotland quality management processes, regarding aspects of clinical supervision, high dependency unit provision, service resilience and clinical governance have attracted national scrutiny and prompted review by external bodies. These issues have heightened public concern within Moray and reinforced the importance of ensuring that governance, workforce planning, adequate clinical and educational supervision of resident doctors in training and service arrangements are sufficient to support safe and sustainable care in a geographically isolated district general hospital.

4.7 Despite these challenges, Dr Gray's Hospital remains central to the delivery of acute healthcare in Moray. Making it safe and sustainable depends not only on maintaining individual clinical services but also on ensuring that governance, leadership and clinical pathways effectively support the delivery of high-quality care across organisational and geographical boundaries.

4.8 Maternity services represented a significant area of discussion throughout the review. The review recognised the complexity of providing safe and sustainable maternity services across a geographically diverse health system. It also recognised the importance of maintaining local access to services wherever this can be achieved safely and sustainably.

4.9 The review considered future maternity service provision at Dr Gray's Hospital to be a particularly important illustration of the wider challenges facing NHS Grampian. Discussions regarding future models of care highlighted the tension between workforce sustainability, service resilience, local access and patient safety. The review found evidence of significant planning activity; however, reviewers also heard concerns regarding the extent to which future service models can be consistently supported by sustainable workforce arrangements, robust governance systems and reliable assurance regarding safety.

4.10 The review makes no judgement regarding any individual proposed model, noting the intention for a review of rural maternity services recently announced in the 2026-2031 Programme for Government. However, it concludes that future decisions regarding maternity services must be supported by comprehensive clinical engagement, transparent risk assessment, robust workforce planning and ongoing assurance that patient safety can be maintained. These requirements mirror the wider organisational themes identified throughout the review.

Current services and leadership at Dr Gray's Hospital

4.11 Dr Gray's Hospital has its own triumvirate leadership team comprising a general manager, hospital clinical director and chief nurse. The general manager reports to the chief officer for acute, the hospital clinical director to the acute medical director and the chief nurse to the Moray Integration Joint Board chief officer. From November 2026 the chief nurse will report to the acute nurse director. The acute nurse director currently reports to the executive nurse director, the acute medical director to the executive medical director and the chief officer for acute reports directly to the chief executive.

4.12 Dr Gray's Hospital is one of six divisions within the acute sector. Some clinical services at Dr Gray's Hospital are managed by the Dr Gray's Hospital team, including emergency medicine, general medicine, anaesthetics and general surgery. Other services at Dr Gray's Hospital are managed by other divisions on a pan-NHS Grampian basis and are not under the direct management of Dr Gray's Hospital leadership team. These include paediatrics and gynaecology, imaging, laboratory and mental health. The clinical lead for orthopaedic surgical services within the division of surgery, works across the three sites of Dr Gray's Hospital, Woodend Hospital and Aberdeen Royal Infirmary. Some elements are integrated such as single vetting of referrals and a single waiting list.

Structural and geographical challenges

4.13 The services provided at Dr Gray's Hospital are important not only to the people of Moray but also to the sustainability of healthcare across the north of Scotland.

4.14 Many of these services operate at a relatively small scale and serve dispersed populations, making them particularly vulnerable to workforce and service pressures. Over a number of years, legitimate concerns have been raised regarding the safety, resilience and long-term sustainability of some services, most commonly arising from difficulties in recruiting and retaining enough senior medical staff. These challenges have at times affected service continuity and have required ongoing mitigation to maintain safe care. Given Dr Gray's Hospital's strategic role within the regional healthcare system, addressing these vulnerabilities is important both for local populations and for maintaining a sustainable model of care across the wider north of Scotland.

Failure to develop a strategy for Dr Gray's Hospital

4.15 We have seen evidence of considerable activity focused on the development of a strategy and implementation plan. However, we have not found evidence of the board asking what, how and why services are needed at Dr Gray's Hospital, nor of the management team providing clear answers to these questions.

4.16 There has been a challenging and protracted process for NHS Grampian in developing a clear, credible and sustainable long-term strategy for Dr Gray's Hospital between 2022 and 2024.

4.17 During this period, efforts to establish a widely supported vision for the hospital were affected by ongoing uncertainty regarding service configuration, workforce sustainability and the balance between local service provision and regional models of care. As a result, progress was often slow, with stakeholders expressing concerns about the pace of decision-making and the absence of a definitive direction for the hospital's future. This uncertainty contributed to a lack of confidence among staff, patients and local communities, while also making it more difficult to support effective workforce planning and service development.

4.18 The experience highlights the complexity of securing consensus on the future role of Dr Gray's Hospital and the importance of providing clear strategic leadership, meaningful engagement and realistic implementation plans to support sustainable change.

4.19 In December 2022, the board agreed the parameters for a plan related to Dr Gray's Hospital. The plan was submitted in February 2023, with an implementation plan containing 52 actions and associated governance arrangements. It was approved in April 2023. There is limited reference in that plan to sustainability, quality, safety or clinical governance.

4.20 At this stage, in April 2023, despite containing 52 actions, the implementation plan did not provide sufficient clarity regarding the scope and scale of services to be delivered at Dr Gray's Hospital. The plan was largely high-level in nature, focusing on processes rather than clearly defining service provision. While it recognised challenges relating to workforce recruitment and retention, it did not set out a sufficiently specific or credible approach to securing a sustainable workforce. In summary, although the plan articulated an ambitious vision, it lacked the precision and detail required to demonstrate how services, workforce capacity and infrastructure would be configured to achieve its objectives.

4.21 At its meeting on 14 March 2024, the board was advised that the worsening financial position of NHS Grampian, together with limited programme management capacity, was impeding delivery of the implementation plan. While the update paper presented progress in broadly positive terms, it simultaneously introduced three new priorities:

- redefining the range of surgical services and the associated workforce model
- reconfiguring the bed base and theatre model
- reimagining the front-door model and workforce plan.

In doing so, the board was asked to 're-centre programme implementation'.

4.22 In agreeing to 're-centre programme implementation' the board did not explore or ask about the progress against the actions agreed in the implementation plan from April 2023, such as:

- how these new three priorities aligned with the actions in the original implementation plan and the consequences for those actions

- the implications for delivery and the resources required
- whether these new priorities represented the most appropriate priorities in the circumstances.

At this stage, the board should have exercised far greater challenge and scrutiny to what was presented given the major shift from the implementation plan that had been previously agreed.

4.23 By December 2024, there was a recognition in NHS Grampian that the approach – approved in April 2023 – was not working. The then interim chief executive, stated:

'Despite the significant, focused and consistent effort by everyone involved, I believe our current planning and actions are not going to ultimately result in a safe, effective, high quality and sustainable model for the future of secondary care in Moray, as set out in the 2023-33 Dr Gray's Hospital Strategy: Defining the Role and Function of Dr Gray's Hospital, developed as part of the overarching NHS Grampian Plan for the Future.

'We are at a critical juncture and a radical re-think is required. However, I do not want this to be misinterpreted, so to be very clear, I remain absolutely and sincerely committed to Dr Gray's Hospital as a core part of NHS Grampian's infrastructure and services. Neither do I mean all that is contained in the current Dr Gray's Hospital Strategy will not be part of the future plan for Dr Gray's Hospital but that we need to reassess our approach.'

As a result, a different approach was adopted with a statement that an 'integrated service planning approach is used to develop a revised way of delivering the Dr Gray's Hospital Strategy. This approach, developed by the Planning, Innovation and Programmes Directorate, will ensure that all aspects of planning and engagement are completed in an integrated way, on a whole system basis.'

4.24 The argument offered by NHS Grampian for the shift was a statement about the change in the operating context including the financial position and concerns expressed by external bodies, including Healthcare Improvement Scotland, about patient safety. The basis of the paper presented in December 2024 was that the destination had not changed but that the approach to implementation was being revised. The paper makes very limited reference to the revised three priorities agreed in March 2024. There is a brief mention of theatres but no reference to any progress on the other two priorities.

4.25 Based on the minutes of the NHS Grampian Board meeting in December 2024, and like the position at the March 2024 board meeting, there appears to have been limited critical questioning about why the original approach agreed in April 2023 had been rejected for an alternative course. The main concerns drawn from the recording of the meeting in December 2024 were:

- the realism of an ambitious timescale for producing a plan with options by April 2025
- the importance of ensuring Dr Gray's Hospital was an integral part of a system of care in NHS Grampian and not isolated to the population of Moray
- the need to address the lack of staff confidence from previous approaches to planning.

4.26 Irrespective of the changing context being the rationale for the development of a new implementation plan, there was insufficient focus, drive and traction to advance the original proposals as set out in 2023. Arguably, the position reached by December 2024 describes, to some extent, a pattern as reflected in the diagnosis by KPMG, of insufficient follow through on commitments.

The recent approach and integrated care pathways

4.27 A revised strategic plan for Dr Gray's Hospital was presented at the April 2025 board meeting which proposed 'to incorporate the Dr Gray's Hospital strategy implementation as part of the whole system integration of acute pathways programme of work'.

4.28 The paper in December 2024 had described the commitment that the new planning approach will 'build on the significant commitment and efforts already undertaken, that will achieve the strategic vision for the hospital, and will result in safe, effective, high-quality care at Dr Gray's Hospital in a long-term model that is sustainable and affordable'.

4.29 However, the approach in the April 2025 paper appears far narrower than might have been anticipated in the paper presented and agreed by the NHS Grampian Board in December 2024. The focus instead is concentrated on cardiology, orthopaedics and endoscopy, with a commitment that the key aspects of the integrated models for those three services would be implemented by the end of June 2025.

4.30 There is reference to this work in the KPMG report published in October 2025 and in which significant aspects of the integration work is described as being 'at risk' or 'not on track'.

4.31 The NHS Grampian chief executive supplied an update in April 2026 on the integrated acute pathways work which signalled the significant cultural and relational difficulties in building a cohesive approach across NHS Grampian between Dr Gray's Hospital and Aberdeen Royal Infirmary. The most serious challenges were encountered in respect of cardiology services. The following table, provided by NHS Grampian, describes the key challenges and risks across all the services in the integrated acute care pathways programme. We note that the document does not include any actions to manage the issues or risks listed, and this is a serious omission.

Theme	Issues (currently impacting the ability to deliver change)	Risks (could impact delivery in future if not mitigated)
Culture	Variation between Dr Gray's Hospital, Aberdeen Royal Infirmary and Woodend in working practices and context.	Ongoing cultural and relational aspects within the services need to be acknowledged as putting at risk timescales and general progress.
Lack of integrated leadership and management structure	Services which have integrated their vetting and merged waiting lists, are experiencing delays in BAU where there is a lack of integrated leadership and management. Relevant discussions are progressing to address this.	Good work of the programme to date may not be fully embedded as business as usual without clear integrated leadership and management, with accountability and responsibility.
Operational pressures	Available capacity with the service and operational staff to engage with the IAP decreased in some workstreams over winter due to system pressures and other change priorities.	Risk to required pace and connection to the wider system when workstream leads are not available to provide decision making and direction.
Emerging clarity of Dr Gray's service model	Future Dr Gray's Hospital model will influence overall service and pathway model, and vice versa but not yet clear.	Deliverable of providing an integrated service model will be delayed while awaiting clarity on future Dr Gray's Hospital model.
IAP programme and wider organisational priorities	Clarity of exit point of IAP programme is still under discussion. Resources and transferable tools, lessons learned may be called upon in the future. Yet to be determined.	Risk that the programme fails in completing all deliverables with limited time for completion. The opportunity cost to follow through on redesign opportunities identified during the programme.

4.32 The area medical committee (AMC) repeatedly expressed concerns from 2024-26[3] about both the lack of a clear strategic vision and delivery plan for Dr Gray's Hospital and the pathway redesign work undertaken through the Integration of Acute Pathways (IAP) programme.

The most recent letter includes the following paragraph:

[3]AMC DR GRAY'S HOSPITAL Concerns 12 September 24, AMC NHS Grampian Performance Concerns 13 December 24; AMC Ongoing Concerns DR GRAY'S HOSPITAL 14_February 25; AMC Ongoing Concerns DR GRAY'S HOSPITAL 2 8_April 26

'However, the AMC remains concerned that the IAP work, by its own description and scope, has not resolved the core issues that prompted the original letters of concern regarding Dr Gray's Hospital. In particular, the programme documentation explicitly notes that immediate clinical risks and wider service sustainability issues sit outwith the IAP scope. It is precisely these unresolved issues – many of which are strongly influenced by organisational culture and behaviours – that continue to cause concern among clinicians working at Dr Gray's Hospital and across the wider system.'

The AMC continues to note the absence of a clearly articulated and shared view from the board and the chief executive team on the future role of Dr Gray's Hospital within the NHS Grampian system.

The closure report on the IAP, dated June 2026, makes clear both the highly limited scope of the work undertaken and its failure to deliver the strategic framework for Dr Gray's Hospital that the board had been advised would form a central component of the programme at its April 2025 meeting.

A lack of a clear and sustainable vision for Dr Gray's Hospital

4.33 The approach taken from the development of a strategic plan in 2022 through to a much narrower approach built around a small number of acute integrated care pathways means there is no comprehensive detailed plan for how Dr Gray's Hospital will provide a range of safe, high-quality and sustainable services for the people of Moray and beyond.

4.34 This lack of strategic clarity has made it more difficult to build confidence among staff, partners and the local community, and has limited opportunities to align investment, workforce planning and service development around a shared set of objectives. There is a need for a framework within which realistic and deliverable decisions about service configuration, clinical networks and workforce models could be understood as part of a coherent long-term strategy rather than as a series of isolated, and sometimes reactive operational changes.

Clinical governance of Dr Gray's Hospital

4.35 While monthly clinical governance meetings were held at Dr Gray's Hospital and chaired by the site chief nurse, we do not consider these arrangements to have been effective. Meeting minutes indicate that attendance was largely limited to managers. The meetings were primarily focused on information sharing rather than the critical functions of effective governance, namely scrutinising performance data, providing challenge, holding individuals and teams to account, and driving problem-solving and improvement. This assessment is reinforced by accountability and assurance report findings, which demonstrate persistent failures to meet fundamental clinical and staff governance standards over a prolonged period[4].

4.36 Recent work undertaken by the new deputy medical director for clinical governance has further highlighted a lack of understanding of governance processes at Dr Gray's Hospital, and more widely across several divisions. While they described the current position as improving, they also noted that improvements are not yet embedded. This suggests that the shortcomings identified were not isolated issues but reflected more systemic weaknesses in the organisation's approach to governance.

4.37 We found no evidence that the acute services triumvirate took effective action to intervene and address these governance failures. Whether this reflected a lack of awareness of the scale and significance of the issues, inadequate prioritisation of those issues once identified, or a failure to act effectively, each possibility represents a serious leadership and governance concern. This lack of effective intervention is particularly difficult to reconcile with the range of concerns that had been raised through multiple sources, including Healthcare Improvement Scotland and Public Services Delivery Scotland quality management reviews, the area medical committee, the external orthopaedic review and a particularly severe adverse event associated with major harm in 2025. The over-reliance on external scrutiny and assurance signals, rather than insights from internal assurance systems, is concerning.

[4] AA Adverse Events Report - Dr Gray's May 2026; AA Audits Report - Dr Gray's October 2025; AA Clinical Outcomes & Access Performance Report - Dr Gray's January 2026; AA Risk report- Dr Gray's January 2025; AA Staffing Division of Dr Gray's Report April 2026

Specific service concerns

General medicine

4.38 General medicine at Dr Gray's Hospital remains vulnerable, with ongoing challenges relating to workforce sustainability and the resilience of the medical rota. Some historical workforce and job-planning decisions have contributed to the current position. Over time, four consultants who had previously participated in the general medical take and on-call rota moved to roles focused solely on their specialist practice and no longer undertook acute general medical duties. Two of these consultants have since retired, while two remain in post.

4.39 In addition, the substantive geriatric medicine consultants do not currently participate in the general medical take or on-call arrangements. A further consultant post is being recruited to on a similar basis. While these arrangements may have reflected legitimate service and workforce considerations at the time, they have had the effect of reducing the pool of consultants available to support acute general medicine. Consequently, there has been an increased reliance on locum consultants to provide cover for medical receiving and out-of-hours on-call commitments.

4.40 Taken together, these factors have reduced the flexibility and resilience of the medical workforce and have made it more challenging to maintain a sustainable model for the delivery of acute general medical services.

4.41 As part of the Public Services Delivery Scotland quality management processes, a triggered visit to the medical unit, where resident doctors in training rotate on placement from Aberdeen Royal Infirmary, was undertaken in May 2025. The visit team highlighted significant concerns and had eight requirements for improvement. Quality management processes have been in place since then, however four requirements remain outstanding at the time of writing.

4.42 In addition to the quality management activity being undertaken in the medical unit, quality management of medical education activity is currently being undertaken by Public Services Delivery Scotland within Dr Gray's Hospital in the departments of anaesthesia, general surgery, trauma and orthopaedics and the high dependency unit due to areas of concern being identified by Public Services Delivery Scotland quality management processes including the General Medical Council and Scottish Trainees Survey (STS) annual training reports.

4.43 In February 2026, Dr Gray's Hospital leadership explicitly escalated the concerns about the safety of the medical unit and asked the acute sector triumvirate to arrange a fundamental review of the medical staffing model across general medicine in NHS Grampian. There is no evidence that the acute sector triumvirate took any action on this matter, despite informing the chief executive team. In short, there was insufficient support offered.

4.44 While concerns about workforce, sustainability and clinical safety were raised by the area medical committee on three separate occasions in 2024, 2025 and 2026 to the chair, chief executive, executive medical and nurse directors there has been limited action but no visible improvement[5].

4.45 The general manager for Dr Gray's Hospital has also raised these issues in 2024[6], in 2025[7] and February 2026[8]. In February 2026 the concerns were raised to the acute sector triumvirate and to the executive medical and nurse directors. It was raised by Dr Gray's Hospital general manager at the acute sector governance meeting with the acute sector triumvirate on 26 February 2026[9]. The minutes say:

'The group questioned the sustainability of the current model and discussed the need for a structured review of acute and general medicine services, including workforce planning.'

'The group agreed on the need to evaluate options beyond repeated unsuccessful recruitment.'

'The need to develop clear action plans with deliverable, evidence and timelines and monitor progress through regular reporting.'

4.46 Despite this there is no action recorded in the minutes. In a separate assurance report to the chief executive team from the acute sector triumvirate, they say:

'Major actions underway – Agreement to undertake a structured review of acute and general medicine service models at Dr Gray's Hospital, including consideration of alternative workforce and service configurations'[10].

4.47 It does not say who is doing this or to what timescale. The acute sector triumvirate should have been clear about this. There has been no such review to date.

4.48 General medicine is a key service for Dr Gray's Hospital and the people of Moray, and any failure would have significant impact across the north of Scotland. The local management team and the area medical committee have both repeatedly raised concerns about the safety and sustainability of the service, but NHS Grampian acute sector triumvirate and executive team have not taken any action to address the issues. If the executive medical director was genuinely unaware of these concerns, this represents a serious failure of the governance processes for which they are accountable.

[5] AMC DR GRAY'S HOSPITAL Concerns 12 September 24; AMC NHSG Performance Concerns 13 December 24; AMC Ongoing Concerns DR GRAY'S HOSPITAL 14_February_25; AMC Ongoing Concerns DR GRAY'S HOSPITAL 8_April_26
[6] Dr Gray's Hospital Recovery Planning Presentation to Executive Team 9 July 2024
[7] Acute Sector Governance November 2025 - 3 MINUTE BRIEF –Medical Workforce Dr Grays November 2025
[8] Dr Gray's Hospital Medicine Service & Workforce Redesign email 03 February 2026
[9] Acute & General Medicine Service Model and Workforce Redesign Proposal February 2026
[10] Acute Sector Governance Meeting Minutes 26 February 2026; Acute Sector Governance Report Dr Gray's Hospital 26 February 2026

Trauma and orthopaedics including the management of hip fractures

4.49 There are significant concerns in relation to the trauma and orthopaedics service.

4.50 Since orthopaedic operations at Dr Gray's Hospital were stopped in 2024, all patients requiring surgery for a hip fracture have to be transferred to Aberdeen Royal Infirmary. The rationale for this was set out in the integrated model planning in 2025[11]:

'Historically orthopaedic services in Aberdeen (Woodend/ARI) and Elgin (Dr Gray's) have been run and managed as separate services. During 2024, a number of risks emerged to the service in Elgin, mainly around changes to workforce due to a combination of long-term leave in the consultant body and removal of medical trainees. In response to this, to maintain continuity of service for the population of Moray, immediate changes to the emergency pathway were made to enable all emergency activity to be transferred to Aberdeen'.

4.51 It is of serious concern that patients are suffering long waits (average 10 hours) in pain in the Dr Gray's Hospital emergency department before a long ambulance journey, further waiting at Aberdeen Royal Infirmary and only 40% are meeting the standard of surgery within 36 hours – half the number who were in 2023. They also have an average additional five days stay in hospital[12]. This is poor care for the individual patients and impairs care for others as emergency department trolleys and ward beds are then unavailable.

4.52 There are further adverse consequences with reduced capacity for Aberdeen patients at Aberdeen Royal Infirmary and the impact on their care. Other patients needing more minor surgery that should be possible as day cases have to travel to Aberdeen and possibly stay overnight.

4.53 On 22 January 2026, the NHS Grampian closed board[13] was told verbally under any other business that an external review of orthopaedics at Dr Gray's Hospital had been received, was being considered and would be reported to the clinical governance committee.

4.54 The Orthopaedic Service Review, Dr Gray's Hospital, NHS Grampian[14] made 13 recommendations covering the period 1 January 2020 to 31 March 2024. It found significant concerns regarding clinical care and surgical competence in 56% of cases. There were communication issues in 43% that impacted patient care and behavioural concerns in 34%.

4.55 The review identified that clinical governance processes were insufficient, cases were not discussed at morbidity and mortality meetings and formal adverse event reviews were not commissioned.

[11] Orthopaedics Integration Commission 2025
[12] Hip fracture Performance Update 2025
[13] NHS Grampian Closed Board Minutes 22 January 2026
[14] Final Orthopaedic Service Review Report

4.56 The Orthopaedic Service Review was on the agenda for the closed meeting on 17 February 2026[15]. The paper said that the review had considered 71 cases and that there had been further local review which had concluded that:

- eight cases required Level 1 significant adverse event reviews
- four cases required Level 2 significant adverse event reviews
- five cases required consideration of individual practice.

4.57 The paper from the acute medical director and Dr Gray's Hospital clinical director did not list the 13 recommendations, whether NHS Grampian accepted them or how they would be implemented. In an appendix it summarised what the paper said were the 'key recommendations'.

4.58 The minutes contained in the papers for the May 2026 meeting of the clinical governance committee state that the committee asked the executive nurse director to escalate the matter to the chief executive team and provide a further update on 4 August 2026[16]. This is an encouraging response from the clinical governance committee but the following questions should have been highlighted:

a) Why were the problems not recognised earlier?

b) Why was SAER not initiated at the time?

c) What was the root cause of multiple problems with multiple clinicians?

d) What does this failure say about clinical governance at Dr Gray's Hospital and in the acute sector, and have they been addressed?

4.59 It is not clear whether the external report's recommendations have been accepted or implemented. This example reflects wider concerns set out later in this report regarding the systems and processes of clinical governance and the management of adverse events. Had these systems been operating effectively then the problems would have been identified earlier and patient harm potentially prevented.

4.60 We were concerned to see a deterioration in the management of hip fractures. This is an important measure of wider quality of care, and the evidence suggests a deterioration in services since 2021, when Dr Gray's Hospital was nationally recognised for excellence as the recipient of a "Golden Hip" award.

[15] (REVISED) Combined Papers for Clinical Governance Committee Closed Session 17 February 2026
[16] Combined Papers Clinical Governance Committee Meeting 26 May 2026

4.61 Patients now typically face a longer wait in the emergency department at Dr Gray's Hospital before being transferred by ambulance to Aberdeen Royal Infirmary, where they may then experience a further delay before receiving definitive surgical treatment. This extended and more complex care pathway can be particularly challenging for frail and elderly patients, increasing discomfort, anxiety and the risk of serious complications associated with delays in treatment.

4.62 Clinical staff have expressed concerns that, in addition to adversely affecting patient experience, these arrangements may also be having a detrimental impact on clinical outcomes. These concerns are supported by research evidence that early surgery followed by early orthogeriatrician assessment improves outcomes.

4.63 Although the review team obtained this information without difficulty, some executive leaders appeared unclear on the extent of the issue. This raises important questions about:

- the effectiveness of organisational oversight
- the use of clinical intelligence in decision-making
- the extent to which patient experience and outcomes are informing strategic and operational decisions.

The evidence presented to the review team was from the orthopaedic team in Dr Gray's Hospital, and this is in line with the information available from the Scottish Hip Fracture Audit[17].

Management of patients in the high dependency unit (HDU)

4.64 Concerns have been raised by Healthcare Improvement Scotland and Public Services Delivery Scotland about the care of patients in the high dependency unit (HDU) at Dr Gray's Hospital, where the sickest patients within the hospital receive care. The unit follows an 'open' model, in which patients remain under the care of their referring consultant rather than critical care specialist.

4.65 Resident doctors in training (RDIT) raised concerns with Public Services Delivery Scotland about the quality and consistency of consultant led care in the unit. NHS Grampian has responded by appointing two locum consultants to provide weekday daytime cover. While this meets an immediate need, and welcomed by the RDITs, it is not a sustainable model for safe patient care 24 hours a day seven days a week. Out-of-hour consultant cover remains, as before, through the locum consultant physician on call for Dr Gray's Hospital medical service. It is important that this workaround does not become normalised and we were concerned that the second post had been advertised for a further year without discussion with the clinical director leading the HDU review.

[17] Slides from the SHFA Peer review data pack- NHS Grampian Peer Review 2026

4.66 NHS Grampian is now developing a plan for a sustained and integrated model of HDU care. This is welcome, but it is concerning that the safety issues required escalation by resident doctors and national bodies rather than being identified and addressed through clinical governance systems within NHS Grampian.

Children's surgery

4.67 Concerns have recently been raised about the safety of children's surgery at Dr Gray's Hospital. These arose from incidents involving both intraoperative and perioperative care. NHS Grampian shared further details with us, but we have excluded the details from this report for reasons of patient confidentiality. NHS Grampian is providing alternative arrangements in the short term and has committed to restoring services by December 2026.

4.68 The patient safety concerns identified led to NHS Grampian deciding to suspend paediatric emergency surgery in June 2026. Following escalation of concerns by Healthcare Improvement Scotland in July 2026 (arising from an inspection) NHS Grampian extended this suspension to elective surgery as well. NHS Grampian senior management discovered in August 2026, that the suspension had not been fully enacted and took action to ensure that it was applied consistently. We have not seen evidence of further harm to individual patients as a result of this delay, but the inability to implement a patient safety measure as intended is itself concerning.

Senior leadership management and support

4.69 We heard repeated concerns about the lack of visibility of, and support from, senior system leaders based in Aberdeen for Dr Gray's Hospital. The presence of such executive and senior clinical leaders at Dr Gray's Hospital was felt to be infrequent, insufficiently visible and inadequate. We saw and heard more positive evidence of meaningful presence from the chief executive, who we were told, engages meaningfully with staff and patients during these visits.

4.70 The impact of these infrequent visits was felt to extend beyond simple visibility or 'presenteeism' by senior leadership. We saw evidence in written documents, supported by testimony from staff, that executive and senior clinical leaders were often unaware of important clinical governance issues at Dr Gray's Hospital. We also heard from senior leaders that there was uncertainty about ownership and accountability for important clinical risks, and about the escalation of those risks where they "crossed boundaries" between services or management structures.

4.71 As mentioned earlier, we heard first-hand about changes made to the pathway for patients with fractured neck of femur diagnosis and how they had not been successfully implemented, leading to delays in clinical management at both Dr Gray's Hospital and Aberdeen Royal Infirmary. We saw the delay of an actual patient and heard of the challenges of transferring these patients for appropriate management. There was a lack of awareness of the failure of this pathway amongst the local management team and we were concerned about the lack of urgency in managing these issues from more senior team members.

Dr Gray's Hospital as part of the corporate family

4.72 Hospitals in Scotland do not operate in isolation from other services, including other hospitals. Safe and effective care depends on common standards, described in shared guidelines and supported by integrated systems, combined training and related measures designed to ensure that care is provided to a consistently high standard with minimal unwarranted variation.

4.73 We saw evidence of services that were well integrated within NHS Grampian. However, we also found evidence that vital services – notably cardiology, critical care and orthopaedics –were fragmented. These concerns were escalated to NHS Grampian by Healthcare Improvement Scotland and Public Services Delivery Scotland as patient safety and educational governance issues.

4.74 Integration challenges are visible in in-patient pathways, transfer arrangements and continuity of care. Problems were identified with referrals, transfers, communication and continuity between services and sites. We received evidence that local general practitioners and others working in primary care have had similar concerns and have raised these at various times without resolution.

4.75 We found evidence of a "them and us" culture between Dr Gray's Hospital and Aberdeen Royal Infirmary. We recognise that tensions can arise within regional organisations between larger and smaller institutions. However, well-functioning organisations take active measures to strengthen service integration, mutual understanding, shared practice, staffing and wider organisational integration.

4.76 It would be wrong to suggest that there was no evidence of aspects of service integration within NHS Grampian. However, we were concerned by several instances in which the "them and us" culture appeared to be reinforced by those in leadership positions. It is essential that those in the most senior positions, including the acute sector triumvirate and chief executive team, act effectively to ensure that such behaviours are challenged and do not adversely affect patient care.

4.77 We heard that concerns raised by management and leadership at Dr Gray's Hospital to more senior levels were often met with an unhelpful response. We were told that this was most apparent when attempting to resolve complex issues such as the provision of high-dependency care. Reaching out to senior leadership in Aberdeen was, we heard, sometimes met with a response that implied a failure by local services to solve their own problems. This inhibited collaborative working and supportive, compassionate leadership.

4.78 Staff at Dr Gray's Hospital, in an open meeting with the review team, described feeling like the "poor relation" and that when they raised issues for assistance, they were told to "consume their own smoke."

4.79 Many of the system leaders, including some board members, appeared perhaps unconsciously to use the words "they" and "them" when describing Dr Gray's Hospital.

4.80 Phrases such as the "Kingdom of Moray" were used in formal meetings with the review team. We understood these comments to imply shortcomings in compliance and team working on the part of colleagues in Moray. We were also aware of instances where staff at Dr Gray's Hospital expressed views that appeared protective of local arrangements and resistant to wider integration. While we do not assume any deliberate intent to offend or diminish others, such language, especially when used by senior leaders, is unhelpful. It can reinforce divisions, weaken shared identity, and impede the collaboration and cooperation needed to deliver effective services.

The relationship of this to safety and quality

4.81 The concerns identified in this review should be considered in the context of the Clinical Governance Standards published by Healthcare Improvement Scotland in 2026. While not confined to any single service, they raise issues across several domains, particularly leadership and staffing, clinical supervision of RDITs, quality improvement, clinical safety and risk management, education and training, and the use of data and information.

4.82 Persistent consultant vacancies, reliance on locums and individual clinicians, limited senior leadership presence, unclear ownership of risks, and fragmented working arrangements are relevant to both leadership and staffing and clinical safety and risk management. Concerns about high dependency unit care, and the need for resident doctors and national bodies to escalate significant safety issues also raise questions about the effectiveness of local systems for identifying, escalating and managing clinical risk.

4.83 These findings should also be considered against Healthcare Improvement Scotland's Essentials of Safe Care Framework. Problems with referrals, transfers, communication and continuity of care highlight challenges in safe communication and consistent clinical processes, while concerns about leadership visibility, responses to concerns raised from Dr Gray's Hospital, and a perceived "them and us" culture raise wider questions about leadership and organisational safety culture. They are also reflected in the Sharing Intelligence for Health and Care Network Analytical Framework of Warning Signs. These cover warning signs of matters of concern such as matters of leadership, culture and governance.

4.84 The vulnerabilities identified at Dr Gray's Hospital cannot be explained solely by geography, service scale or workforce shortages. While these factors increase risk, effective clinical governance requires organisations to manage such risks through strong leadership, clear accountability, effective communication and robust governance arrangements, particularly where services operate across organisational or geographical boundaries.

4.85 Improvement at Dr Gray's Hospital therefore requires more than stabilising individual services. NHS Grampian must demonstrate:

- clear oversight of frontline risks
- clear accountability for cross-boundary issues
- effective escalation and learning processes
- strong communication between teams and sites
- consistent standards of care across the organisation.

The risks we have seen in Dr Gray's Hospital have the potential not only to impact on Moray and Grampian but also NHS Highland. It reinforces the need for a clear and well-defined strategy for Dr Gray's Hospital which is integral to the whole system of care in NHS Grampian.

Summary of findings: Dr Gray's Hospital is insufficiently integrated within NHS Grampian

4.86 Dr Gray's Hospital faces significant and, in some respects, extreme challenges arising from its size, geography and physical separation from other sites. However, we believe these challenges are amplified by poor working relationships between senior clinical leaders, largely based in Aberdeen, and local leaders and clinicians at Dr Gray's Hospital.

4.87 We believe these problems are visible not only to those working within the hospital but also to colleagues in general practice and primary care across Moray. We have not seen evidence of effective engagement with general practice to resolve these issues, although a proper assessment of this would require a more in-depth review than was possible during our work.

4.88 Concerns about poorly integrated services have been raised internally and externally for several years without yet achieving sustainable solutions. Too often, the stimulus for improvement has been external scrutiny or whistleblowing by staff, including doctors in training. We recognise and commend the efforts of the chief executive to visit and engage personally with Dr Gray's Hospital on a regular basis. However, this alone will not resolve the problems we have identified.

4.89 It is our observation that Dr Gray's Hospital is too often seen as "the problem" for NHS Grampian rather than as a vulnerable institution whose difficulties are amplified by deficiencies in leadership, system working, wider organisational culture, and collective Grampian board ownership. The absence of a robust and credible plan for Dr Gray's Hospital as part of an integrated system of care has created a strategic void.

4.90 These problems are further exacerbated by wider failings in key elements of NHS Grampian's management, leadership and governance of patient safety and clinical quality. These failings not only create risks for patients at Dr Gray's Hospital but also have the potential to create risks for patient care more widely across NHS Grampian.

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

Operating framework for clinical governance

Board level governance

4.91 Like all NHS boards, NHS Grampian is expected to have a robust and integrated clinical governance system. This is intended to ensure a line of sight for the safety and quality of care from the frontline to the board[18].

4.92 The Healthcare Improvement Scotland Clinical Governance Standards set out the expectations of what an effective system should look like. In the previous section of this report, we set out concerns in aspects of clinical governance in the delivery of some services at Dr Gray's Hospital. These findings consider the wider approach to clinical governance in Dr Gray's Hospital and the wider system.

[18] Clinical governance has evolved since its first introduction in UK in 1998 following the Bristol inquiry and is enshrined in a legal duty on all NHS Boards to assure the quality of care to patients, under section 12H of the 1978 NHS Scotland Act.

4.93 At the pinnacle of the system of assurance for clinical governance in NHS Grampian is the board. It has a statutory duty to ensure there are robust systems for ensuring the quality of care for patients and, of which, clinical governance is an important dimension.

4.94 The board is supported in this by a clinical governance committee. The clinical governance committee, like all other NHS boards, has a role in providing assurance that the systems and processes for clinical governance work effectively and reports on such to the board. The executive medical director and the executive nurse director are responsible for clinical governance at an executive level.

4.95 Underneath the over-arching governance arrangements is a set of executive and managerial arrangements. Some are focused exclusively on quality and safety while others incorporate aspects of quality and safety within their role.

4.96 Prompted by Healthcare Improvement Scotland and Public Services Delivery Scotland concerns, as expressed in section 1, the board agreed, at its meeting in June 2026, for quality and safety to be incorporated as a priority into the strategic plan. The earlier version, agreed in March 2026, had excluded quality and safety as a priority.

Clinical Quality and Safety Improvement Board

4.97 NHS Grampian committed to establish a clinical quality and safety improvement board. The purpose of the board is to:

"Provide assurance to the executive team and the clinical governance committee that necessary improvements to NHS Grampian's clinical governance arrangements are being identified, implemented and formally assessed to ensure they are effective, aligned to relevant national standards (including Healthcare Improvement Scotland Clinical Governance Standards published February 2026 and SPSP Essentials of Safe Care), and that agreed improvements are prioritised, delivered and sustained".[19]

4.98 This board is co-chaired by the executive nurse director and executive medical director. In addition, an executive management group has been established.

4.99 NHS Grampian intends that the establishment of the clinical quality and safety improvement board will strengthen organisational focus, oversight and leadership for quality and patient safety. However, we are concerned that this represents an additional layer of management without clear added value to existing structures that remain in place. NHS Grampian should clarify how it will be assured that the clinical quality and safety improvement board will add appropriate value, clarity of purpose and avoid duplicating the existing operational management arrangements.

[19] Chief Executive response to Formal escalation of patient safety concern – Dr Gray's Hospital 15 May 2026

The concerns about clinical governance are not confined to Dr Gray's Hospital

4.100 This review identifies the concerns about clinical governance as not being isolated to Dr Gray's Hospital. The concerns this review has surfaced are multi-dimensional and systemic.

4.101 Both executive and non-executive directors expressed significant concerns regarding the effectiveness of the current clinical governance arrangements. Feedback consistently highlighted a lack of confidence in the organisation's escalation processes, leadership oversight, management grip on quality and patient safety issues, and clarity around accountability at all levels of the system.

4.102 A recurring theme that the review team identified from interviews was concern about the extent to which staff across the organisation understand the purpose and operation of clinical governance, as well as their own responsibilities within it. Several participants described a culture that appeared focused on the collection and reporting of data rather than using information to gain insight, identify emerging risks, or understand underlying causes of problems. One interviewee summarised this issue by observing that staff were "not professionally curious", reflecting a perception that governance processes often lack sufficient challenge, enquiry, and critical analysis.

4.103 We frequently heard senior leaders describe the current system as fragmented and inconsistent, with variation in approach and effectiveness across services and partnerships. There was a strong view that a revised governance framework is required to provide greater consistency, clearer expectations, more robust accountability, and stronger organisational oversight. It was also emphasised that clinical governance must become a central element of organisational decision-making and more prominent in the deliberations of the NHS Grampian Board.

Safety concerns about hepatopancreatobiliary surgery

4.104 There have been longstanding concerns about the safety and sustainability of specialist hepatopancreatobiliary surgery in Grampian, with reviews and support from eminent surgeons and professional bodies and discontinuation of the most complex procedures in Aberdeen Royal Infirmary. Despite these efforts, further concerns were raised by individuals within NHS Grampian to Healthcare Improvement Scotland. Healthcare Improvement Scotland reviewed these concerns, with expert clinical support, and raised urgent concerns about the safety of the continuation of even the scaled-back remaining specialist procedures. This triggered a decision by NHS Grampian to immediately cease their remaining complex hepatopancreatobiliary procedures in January 2026 and to seek support from specialist centres elsewhere in Scotland. This service was escalated to Scottish Government by Healthcare Improvement Scotland, as a matter of concern earlier this year, at level 2 under the Healthcare Improvement Scotland-Scottish Government Operating Framework.

Weak approaches to quality assurance and improvement

4.105 NHS Grampian does not respond effectively when informed of concerns about quality and safety of care. The repeated identification of concerns by Healthcare Improvement Scotland and Public Service Delivery Scotland, together with the consequent need for external scrutiny and intervention, points to a systemic weakness in NHS Grampian's internal governance, assurance and escalation arrangements. Effective organisations should be able to identify emerging risks, respond to concerns promptly, and provide assurance that remedial action is being taken. The persistence of these issues, and the extent to which they have required external attention, suggests that existing mechanisms have not consistently provided this level of assurance.

4.106 As early as March 2025, Healthcare Improvement Scotland and Public Services Delivery Scotland (then NHS Education for Scotland) warned that problems in Grampian's Hospitals were not restricted to Dr Gray's Hospital but represented wider organisational challenges. The subsequent significant, ongoing level of engagement required by Healthcare Improvement Scotland (both independently and jointly with Public Services Delivery Scotland) points to persistent concerns, repeated requests for improvement and a failure to deliver progress at the pace and scale required.

4.107 The volume and nature of this engagement indicate that external bodies often had greater visibility of risks and performance concerns than was evident through NHS Grampian's own governance structures, despite the information being readily available to them. The problem is not lack of information; the problem is failure to access and act on it. This raises concerns about the readiness of NHS Grampian to anticipate, understand and act on risks.

4.108 This raises important questions about the effectiveness of reporting, oversight and accountability arrangements within the organisation. It is not acceptable for concerns to be identified repeatedly by external agencies. Robust governance requires leaders at every level to seek assurance actively, challenge constructively, and intervene decisively where improvement is not being achieved. The fact that concerns continued to require escalation beyond NHS Grampian suggests that assurance processes were not operating with the necessary rigour, transparency or sense of urgency.

4.109 We note that this pattern of clinical issues being repeatedly identified but not sustainably resolved has been identified by the Scottish Government's Assurance Board. We found evidence that NHS Grampian's response to clinical governance concerns too often is to launch reviews, redesign governance and add new layers of governance to existing structures, without delivering actual improvement. The new clinical quality and safety improvement board risks becoming another case in point.

4.110 NHS Grampian needs a much better led, streamlined and effective system of clinical management to deliver continuous quality management and effect change for improvement.

4.111 There appeared to be a broad awareness of these issues at executive and senior leadership levels, as well as amongst a number of board members. However, there was less clarity and consensus regarding the most effective route to resolution. Many interviewees expressed genuine frustration about the persistence of the challenges and barriers to improvement. While there was recognition of the need for change, discussions about potential actions often focused on the obstacles perceived by leaders, including longstanding cultural challenges, resource pressures and operational demands. These conversations gave us little confidence that they believed change was achievable.

4.112 The NHS Grampian closed board paper 7 May 2026[20] describes the need for improvement in clinical governance arrangements at Dr Gray's Hospital. It does not indicate why improvement is needed except that 'In recent meetings, the NHS Grampian Assurance Board has started to focus on the board's arrangements for clinical governance with a particular focus on Dr Gray's Hospital.'

4.113 The minutes[21] of the meeting show that the board found that the paper 'provides limited assurance that improvement to policies and processes are being made.' It noted that cultural change was required and that leaders needed to be held to account. This was the correct response rather than accepting the paper. The review team considered that this paper should have been taken in a board meeting open to the public.

4.114 A senior clinical governance leadership role has recently been established, initially focusing on Dr Gray's Hospital. This is a positive development and reflects recognition of the need to strengthen governance arrangements. We were told that early work has highlighted the scale of the challenge across all domains of clinical governance and that this is not confined to Dr Gray's Hospital.

4.115 The work remains at an early stage and is not yet embedded. Achieving sustainable change will require time, consistent leadership and stronger medical engagement. The aim is to create a culture in which governance, patient safety and quality improvement are regarded as core leadership responsibilities. Concerns have also been identified regarding escalation pathways and decision-making for deteriorating patients, highlighting the need for clearer and more consistent arrangements between Dr Gray's Hospital and Aberdeen Royal Infirmary to ensure patient safety.

Inadequate management of significant adverse event reviews

Framework for the management of adverse events

4.116 Some of the most concerning findings in the diagnostic review relate to the management of Significant Adverse Event Reviews (SAER).

[20] Strengthening Clinical Governance Arrangements Dr Gray's Hospital 7 May 2026
[21] NHS Grampian Closed Session Minutes 7 May 2026

4.117 Modern healthcare relies on increasingly complex treatments and interventions delivered by multidisciplinary teams operating within highly interconnected systems. While this complexity enables significant advances in patient care, it is unfortunately inevitable that adverse events will, at times, occur.

4.118 It is essential that incidents are reliably identified, recorded, appropriately investigated and used as opportunities for learning and improvement. This learning is fundamental to effective clinical governance and to ensuring the safety of patients receiving care. The management of and learning from adverse events is a core component of patient safety and an essential element of clinical governance. The entire process must be as swift as possible to minimise the risk of recurrence and harm to other patients.

4.119 Healthcare Improvement Scotland published the National Framework for Reviewing and Learning from Adverse Events in NHS Scotland in February 2025. The framework requires the most serious adverse events, including those resulting in significant harm, to be subject to a Level 1 review, commonly referred to as a significant adverse event review. NHS Grampian also had a local policy governing the management of and learning from adverse events during the period covered by this review.

4.120 Effective SAER arrangements require:

- reliable identification and reporting of serious incidents
- timely commissioning and completion of reviews
- rigorous and objective investigation
- implementation of recommendations
- effective organisational learning which demonstrably improves patient safety

4.121 Our review identified significant weaknesses across each of these areas within NHS Grampian.

Concerns were raised about SAERs with NHS Grampian in 2024

4.122 Concerns regarding the quality and effectiveness of SAERs within NHS Grampian pre-date this review.

4.123 In 2024, the Scottish Public Services Ombudsman raised concerns regarding the quality and content of SAER reports submitted by NHS Grampian. In response, the executive nurse director and executive medical director commissioned an internal review of SAER quality in December 2024.

4.124 The internal review did not report until September 2025. It took nine months to examine seven Level 1 SAER reports. Two were assessed as being of an acceptable standard. The remaining five lacked sufficient detail, depth of investigation and analytical rigour to provide adequate assurance regarding the circumstances of the adverse events reviewed. The review made approximately twenty recommendations for improvement.

4.125 During the same period, NHS Grampian received the previously mentioned KPMG report commissioned as part of Scottish Government performance management arrangements. This report identified an increasing number of overdue Level 1 investigations, inadequate feedback mechanisms for staff reporting incidents and a lack of evidence that learning was being translated into improvement actions.

Improvement actions advanced by NHS Grampian

4.126 NHS Grampian established a short life working group in December 2025 to oversee implementation of recommendations arising from both the internal SAER Quality Review and the KPMG review. The group's remit was to deliver, oversee implementation of, gather evidence relating to, and evaluate the impact of improvement actions relating to SAERs.

The single improvement plan developed following the KPMG review included three actions relating specifically to SAERs:

- CLG11: Ensure there is a clear escalation process for overdue Level 1 adverse event reviews
- CLG12: Establish communication mechanisms to provide feedback to staff regarding learning from adverse events
- CLG16: Undertake a deeper review of how serious adverse events are identified, classified, investigated and reported.

4.127 On 26 May 2026, the executive nurse director provided a paper to the NHS Grampian clinical governance committee reporting that CLG11 and CLG16 were complete and that CLG12 was substantively complete.

4.128 The NHS Grampian Board was subsequently advised that the clinical governance committee had endorsed closure of these actions. However, the recommendations made in September 2025 had not been implemented and the number of open Level 1 events awaiting investigation or overdue was increasing, suggesting that these assurances may not have accurately reflected the position

4.129 On 13 August 2026, the NHS Grampian Board did not accept the position related to CLG 16 (i.e. could be recognised as ‘closed’) because of the correspondence that had recently been received from Healthcare Improvement Scotland, and there was a need for ‘further and future examination’.

4.130 In interviews with Healthcare Improvement Scotland, members of the clinical governance committee described ongoing concerns regarding SAERs and reported difficulties reconciling assurances received from executives with their experience of operational practice.

4.131 The most recent data available to the review demonstrated a substantial backlog of Level 1 reviews:

Level 1 adverse events (Datix, 5 August 2026)

- 104 open adverse events requiring a Level 1 review
- 76 beyond the national 140-day timescale
- 39 awaiting commission, of which 33 were overdue
- 50 currently in progress, of which 20 were overdue
- 10 awaiting sign-off, of which nine were overdue
- requiring resolution of data-quality issues
- 10 with a recorded closure date within Datix but still visible within reporting systems.

4.132 On 12 August 2026 the short life working group, established to implement recommendations eight months earlier, advised the Clinical Quality and Safety Improvement Board that a new adverse event review improvement implementation group should be established with a further implementation programme extending from August 2026 to July 2027. Although NHS Grampian knew of concerns from 2024, it had made no significant change by August 2026.

Wider internal concerns regarding management of SAERs

4.133 Evidence provided to the review indicated that serious incidents are not always recorded promptly within Datix and that escalation routes to executive leaders are inconsistent. Senior leaders themselves described examples where serious incidents did not come to executive attention for a considerable period following occurrence.

4.134 We also heard evidence that some incidents requiring a Level 1 review were only identified after a long delay and only then because of a complaint or external review. Morbidity and mortality meetings were, at times, regarded as substitutes for formal SAER processes despite serving a different purpose.

4.135 The primary routine executive oversight mechanism is a weekly clinical risk management meeting. Senior leaders and members of the quality improvement and assurance team identified this process as a point of weakness given the volume and breadth of business considered during the meeting. Executive oversight focuses on review timescales. There is no routine review of the quality, findings and outcomes of investigations.

4.136 The quality and safety team also highlighted:

- variation in commissioning arrangements across divisions
- variation in review thresholds and review quality
- substantial numbers of overdue Level 1 and Level 2 reviews
- inconsistent sharing of learning
- poor tracking of recommendations
- limited feedback to reviewers
- inadequate organisational identification of recurring themes and trends.

4.137 NHS Grampian has responded to ongoing concerns regarding SAERs with multiple reviews, meetings and improvement plans but has failed to deliver the fundamental changes required to establish an effective and sustainable system for the management of serious adverse events.

4.138 The organisation continues to hold a substantial backlog of Level 1 reviews, many of which are significantly overdue. Those reviews which are being completed are not of an acceptable standard, something known by NHS Grampian since 2025. This has clear implications for organisational learning, clinical governance and patient safety.

4.139 The failure to make significant improvements on a known issue in two years suggests that NHS Grampian is still not able to make timely improvements. One of the September 2025 recommendations was that Level 1 reports be signed off by the executive nurse and executive medical directors. This was implemented by email on 3 August 2026, shortly after Healthcare Improvement Scotland raised serious questions about the SAER referenced later in this section. It seems unlikely that this straightforward action would have been taken without that external intervention.

4.140 We have concerns about the effectiveness of board oversight given the lack of progress and the acceptance of information which was not correct and with no challenge as to what actual performance was.

Serious concerns regarding an individual SAER

4.141 As part of our assessment of NHS Grampian's approach to learning from adverse events, Healthcare Improvement Scotland examined two recently completed SAERs relating to high-profile incidents. Both reviews raised concerns about the quality of the investigations. One case generated particularly significant concerns due to major shortcomings identified within the review process of a particularly serious event.

4.142 This case involved the death of a patient during surgery, as a result of an operative complication. Although NHS Grampian undertook a SAER, Healthcare Improvement Scotland found that the final SAER report contained a major omission by not meaningfully examining the actions, clinical decision-making, operative techniques or judgements of the operating surgeons involved.

4.143 This was inconsistent with the purpose of a Level 1 review, the central objective of which is to establish a comprehensive understanding of the factors that contributed to an adverse event and to identify any lessons for improvement. In effect, the most critical aspect of the incident was left unexplored.

4.144 Given the nature of the incident, this omission represented a notable, concerning and unjustifiable failure of governance and a missed opportunity to improve patient safety.

4.145 The case was discussed as part of a wider consideration of surgical safety at a closed session of the NHS Grampian Board in early 2026.

4.146 Several other concerns regarding the conduct of the investigation and the quality of the SAER report further undermined confidence in its robustness, independence and completeness. On that basis, Healthcare Improvement Scotland requested that NHS Grampian commission a new Level 1 review, undertaken independently and with internal and external expert support, to ensure a thorough, objective and credible examination of the circumstances surrounding the event. This was agreed by NHS Grampian.

4.147 In July 2026, Healthcare Improvement Scotland sought further information from the NHS Grampian chief executive regarding the commissioning, governance oversight, executive involvement and sign-off arrangements associated with the original review. The written response received in August stated that the SAER report had not been approved in accordance with organisational policy and that the executive nurse and medical directors had not had sight of the SAER report prior to it being shared with Healthcare Improvement Scotland.

4.148 Healthcare Improvement Scotland subsequently obtained information which contradicted the response from NHS Grampian. Healthcare Improvement Scotland was provided with evidence that the final report had been sent to the executive and acute medical directors for discussion at a meeting of the responsible officer's advisory group which they both attended. Furthermore, Healthcare Improvement Scotland was also provided with evidence that the report had been signed off in accordance with the NHS Grampian policy.

4.149 Healthcare Improvement Scotland therefore had serious concerns about the apparent inaccuracy of the information provided by the NHS Grampian chief executive's letter. When these concerns were shared, NHS Grampian acknowledged that these aspects of the earlier correspondence were incorrect. The chief executive formally withdrew the assertion that the report approval process had breached policy. Healthcare Improvement Scotland was later informed that the executive medical director accepted that the report had been sent to him but had no recollection of receiving or reviewing it and similarly had no recollection of discussion of the case at a responsible officer's advisory group[22] meeting which the SAER had been intended to support discussion. The NHS Grampian chief executive has subsequently confirmed that the executive medical director was involved in discussions regarding the SAER report as the responsible officer.

4.150 NHS Grampian also advised that no formal records or minutes existed for the relevant responsible officer's advisory group meeting. Consequently, though it was possible to independently verify attendance, it was not possible to establish the extent of any discussion or confirm key aspects of the governance and decision-making process. Healthcare Improvement Scotland regard this as concerning due to the lack of clarity regarding senior oversight given the seriousness of the circumstances and significance of the adverse event.

4.151 NHS Grampian accepted that the original assertions were incorrect, confirming that the SAER report was indeed shared by leaders in the surgical division with their superior medical leaders and was signed off in accordance with the NHS Grampian policy at that time. Unfortunately, we learned that NHS Grampian's misinforming Healthcare Improvement Scotland on these key facts caused significant distress to some clinical leaders in roles subordinate to the chief executive team. We understand that this distress arose from a perception of attempted wrongful displacement of culpability from NHS Grampian executives to their subordinates.

4.152 The NHS Grampian chief executive accepted responsibility for the letter she signed that included these incorrect assertions and apologised to Healthcare Improvement Scotland for them. She made efforts to correct the error, apologised to affected NHS Grampian staff and took steps intended to rebuild trust.

[22] The responsible officer advisory group is chaired by the medical director of NHS Grampian (as the responsible officer) and has oversight of the appraisal of doctors in the health board, their fitness to practice and the cycle of five yearly revalidation with the General Medical Council

4.153 This particular SAER, and the related events described above, highlight the following significant concerns:

- The investigation did not examine several key clinical issues, including surgical actions, decision-making, operative technique and clinical judgement. As a result, it did not provide the comprehensive analysis expected of a Level 1 SAER review
- Similar concerns regarding learning, investigation quality and governance arrangements had previously been identified through external and internal review processes, such as by the Scottish Public Services Ombudsman. This raises questions about whether lessons had been effectively implemented and sustained
- The documentation available to the review team was inadequate and did not provide a clear audit trail of decision-making, actions taken, or governance oversight
- Given the seriousness of the incident and the extent of senior-level consideration, stronger evidence of executive oversight and challenge should have been evident. The material reviewed did not provide assurance that sufficient scrutiny had taken place
- These shortcomings were not identified through NHS Grampian's own governance arrangements. Had they not been highlighted through external review, it is uncertain whether further investigation or corrective action would have occurred
- Most significantly, we remain extremely concerned that Healthcare Improvement Scotland received inaccurate information which had the potential to divert attention away from executive leadership and governance accountabilities.

4.154 Healthcare Improvement Scotland has not received a satisfactory explanation for how NHS Grampian came to provide inaccurate information. Given the seriousness of these concerns, Healthcare Improvement Scotland has initiated a separate review of the quality of NHS Grampian’s processes for undertaking SAERs, including its handling of the case highlighted in this report.

4.155 Taken together, these findings indicate systemic weaknesses in investigation practice, governance oversight, executive accountability and organisational learning in relation to learning from significant adverse events in NHS Grampian.

Assessment against the HIS Clinical Governance Standards and the Essentials of Safe Care

4.156 The findings in this section should be considered in relation to Healthcare Improvement Scotland's Clinical Governance Standards, published in February 2026. The standards apply across clinical services in Scotland and set expectations for:

- leadership and staffing
- quality management and continuous improvement
- clinical effectiveness; clinical safety and risk management
- education and training
- service user and patient involvement
- data and information.

The evidence identified in this section of the diagnostic review is particularly relevant to Standards 1, 2, 4 and 7.

4.157 Standard 1 – **leadership and staffing**. The repeated escalation of concerns by staff and external bodies, the gap between executive assurances and operational experience, and weaknesses in clear accountability and escalation indicate significant concerns about the effectiveness of executive leadership and oversight. Workforce fragility, locum dependence and service sustainability concerns also align directly with the standard's expectations for safe and sustainable staffing, clear management structures and effective escalation of staffing and clinical risk.

4.158 Standard 2 – **quality management and continuous improvement**. The review found that there was a pattern of concerns not being recognised by NHS Grampian until they were raised by external bodies. This indicates that NHS Grampian did not have an accurate assessment of the quality and safety of care it was providing. There was also a pattern of failing to respond to concerns by delivery of timely, effective and evidenced improvement.

4.159 Standard 4 – **clinical safety and risk management**. The most direct alignment is with the requirements for effective management of clinical risks, safety concerns, adverse events and near misses. The SAER findings demonstrate weaknesses in incident identification, escalation, commissioning, timeliness, investigative quality, action tracking, organisational learning and assurance. The evidence that some serious incidents were identified only through complaints or external review, together with inconsistent escalation and limited routine scrutiny of the quality and outcomes of investigations, indicates that systems for recognising, responding to and learning from risk were not operating reliably. Concerns about the accuracy of information provided to Healthcare Improvement Scotland also have implications for the openness, transparency and integrity required within an effective safety culture. As mentioned regarding Standard 1, the insufficiency of executive oversight is critical in relation to the management of safety and risk.

4.160 Standard 7 – **data and information.** The performance division of the acute sector produces and circulates regular data reports, but this does not lead to action where improvement is required. We did not identify concerns about the data quality, but we did about the failure to act. There is a problem with flow of information through the organisation, including delays in recording serious incidents, inconsistent escalation to senior leaders, and a failure of those leaders to ask the right questions. Escalation is perceived by some senior leaders as failure, therefore no escalation takes place, the situation is unresolved and those accountable are unaware. There are discrepancies between narrative reports suggesting that issues have been resolved and data which shows that they have not. The failure to use data and information undermines the organisation's ability to identify and manage risk and to provide meaningful assurance.

4.161 The findings also align closely with the Healthcare Improvement Scotland Essentials of Safe Care Framework. In particular, they raise concerns about:

- leadership to promote a culture of safety, including whether staff concerns are consistently heard and acted upon
- safe communication within and between teams, including the reliability of escalation, feedback and information provided for governance and assurance
- safe and consistent clinical and care processes, including the reliable identification, investigation and learning from serious adverse events.

Although this section contains less direct evidence about the framework's person-centred systems and behaviours theme, weaknesses in learning from adverse events and in responding to concerns have clear implications for the experience of patients and families when harm occurs.

Summary of findings: NHS Grampian has repeatedly failed to resolve clinical governance concerns effectively

4.162 NHS Grampian has received repeated warnings from external organisations, clinical leaders and frontline staff about patient safety, governance failures, workforce fragility and service sustainability between 2024 and 2026. Despite this, there was a lack of timely or effective action to address many of the concerns.

4.163 We identified weaknesses in NHS Grampian's approach to quality improvement. Concerns were frequently met with further reviews, restructuring and additional governance groups rather than sustained operational change and measurable improvement.

4.164 Particularly serious concerns were identified in the management of SAERs. There was a substantial backlog of overdue reviews, variable quality of investigations, weak oversight, poor organisational learning and limited implementation of recommendations. Assurances that improvement actions had been completed were not always supported by the underlying evidence.

4.165 This diagnostic review focused on Dr Gray's Hospital as part of a wider system of clinical governance. We have not examined the whole of NHS Grampian's clinical governance system in detail but the executive nurse director and deputy medical director for clinical governance both expressed concerns about other parts of the system. We are not concluding that every part of NHS Grampian has weak clinical governance, nor that every patient being treated in Grampian is at higher risk of harm. Nevertheless, the weaknesses and failures that we have found in the central, core systems of clinical governance point to wider systemic concerns.

4.166 The review team was left with the impression that those in the most senior positions felt unable or insufficiently empowered to address concerns and did not recognise their accountability to ensure effective action.

4.167 Experience from past challenges in healthcare tells us that the consequences of weak systems of clinical governance are often most apparent in those parts of the system with additional vulnerabilities. The local challenges of Dr Gray's Hospital are well known and covered in the earlier section of our report. We have concluded that a significant proportion of the challenges manifest in Dr Gray's Hospital are the result of weaknesses in the chain of clinical governance leadership, management and systems, and which extend to the top of the organisation. NHS Grampian should address these systematically rather than as an exclusive focus on Dr Gray's Hospital.

4.168 Taken together, the findings suggest that the issues described are not isolated failures of individual processes. They represent weaknesses across several interdependent components of the clinical governance and patient safety system. The principal requirement is therefore not simply to add further governance structures, but to demonstrate that leadership, risk management, quality management, communication, data and learning processes operate reliably as an integrated system and result in measurable, sustained improvements in the safety and quality of care.

4.169 The major change required to provide NHS Grampian with effective clinical governance is a change in the behaviours of senior executives. They need to demonstrate the leadership, accountability and commitment necessary to deliver improvement.

4.170 This section has focused on the management and operation of clinical governance systems within NHS Grampian. The next section considers the board's governance role in this area.

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

Sufficiency of information provided to the board

4.171 A consistent and significant concern throughout this review is the apparent disconnect between leaders' awareness of issues and their acceptance of responsibility for addressing them. Ultimately, accountability rests at the top of the organisation. If the board is not receiving the information it needs, it must insist on obtaining it. Equally, when executive leaders are aware of weaknesses, their role is not simply to observe or comment; they have a responsibility to ensure those issues are resolved.

4.172 This principle applies regardless of the issue or location. Where there are concerns relating to infection prevention and control, or any other area of performance at Dr Gray's Hospital or elsewhere, the acute sector triumvirate should have robust mechanisms to ensure they are aware of the issues, that credible improvement plans are in place, and that delivery against those plans is actively monitored. In turn, executive directors must assure themselves that the acute sector triumvirate is exercising effective oversight and management.

4.173 Meetings should primarily serve as forums for decision-making, accountability and performance monitoring. Too often within NHS Grampian, however, meetings appear to be focused on discussion and information sharing rather than driving action, ensuring delivery and holding to account.

4.174 Board members reported difficulty in understanding the true quality and safety position within NHS Grampian. Non-executive directors and the board chair described limitations in the quality, depth and usefulness of the information available to support effective scrutiny and challenge. Board members said they were not consistently provided with the information required to discharge their responsibilities effectively. Some non-executive directors felt that they were expected to critique performance while lacking sufficient information and being held at arm's length from operational realities.

4.175 Some non-executive directors felt that important information was withheld because it was categorised as operational rather than strategic. Concerns were raised that matters carrying significant clinical governance and patient safety implications were therefore not routinely visible to board members.

4.176 We explored with the executive nurse director and executive medical director the relative paucity of clinical governance discussions at the board level. We heard a view that the board had traditionally relied on its committee structures for assurance rather than undertaking direct scrutiny of clinical governance issues. Matters considered by committees were not routinely regarded as requiring wider discussion by the board. This approach risks creating a gap between delegated committee oversight and the board's collective understanding of the quality and safety of clinical services.

4.177 Executives expressed differing views differed regarding the limited visibility of clinical governance matters at board level. Some respondents considered the current arrangements adequate, noting that any non-executive director has the opportunity to attend the clinical governance committee if they wished. However, we do not agree that this provides sufficient assurance. Clinical governance risks and performance issues should be routinely visible to, and actively scrutinised by, the full board to ensure collective responsibility for the quality and safety of services.

4.178 Concerns were also raised about the quality, relevance and volume of information presented to the clinical governance committee. Several respondents described committee papers as providing reassurance rather than genuine assurance, with reports frequently focusing on describing activity rather than evidencing outcomes, improvement or effective risk management. Non-executives described reports that repeatedly provided the same information at successive meetings. As one example, members highlighted that a report on other potentially vulnerable services, which had been promised in January 2026, had still not been provided at the time of our review.

4.179 We also heard concerns that NHS Grampian has not consistently demonstrated openness and transparency when discussing patient safety issues. A frequently cited example related to changes made to maternity services at Dr Gray's Hospital in 2018, where respondents felt the changes were presented primarily as a workforce challenge, despite significant underlying concerns about service sustainability and patient safety. The review considered that some of the matters considered at closed board meetings were neither commercially sensitive nor about individuals and would have been more appropriate in the open meeting.

The challenge role of the non-executive directors

4.180 During interviews with executive team members and board members, the review team identified differing understandings of the board's role in decision-making and how governance arrangements operate in practice. Several participants described NHS Grampian's approach as being different from that of other NHS Scotland boards, suggesting that decisions were ordinarily reached within executive team meetings before being presented to the board for endorsement.

4.181 When the review team explored this further, it was asserted that papers setting out multiple options and associated considerations were not routinely presented to the board, with board papers principally focused on the recommended option for approval. Some interviewees described this as a longstanding approach, reflecting a view that the board's role is primarily strategic and that it should not become involved in operational decision-making.

4.182 The review team challenged this interpretation, including through discussion of the roles and responsibilities set out in the NHS Scotland Blueprint for Good Governance. However, some participants maintained that this reflected the way governance arrangements had historically operated within NHS Grampian and saw no need for change.

4.183 Given the significance of these observations, the review team discussed them directly with the NHS Grampian chief executive. The chief executive did not support this characterisation of board governance, stating that the board fulfils its responsibilities in line with the NHS Scotland framework, considers matters collectively, and makes decisions rather than simply endorsing recommendations previously agreed by the executive team.

4.184 Irrespective of which interpretation most accurately reflects practice, the existence of such markedly different perceptions among executive and board members is itself significant. The review team considers that a shared understanding of the board's statutory responsibilities, its role in assurance and scrutiny, and the respective responsibilities of executive and non-executive members is fundamental to effective governance. Divergent views in these areas risk undermining collective accountability, board cohesion and the board's ability to ensure, assure and provide confidence regarding the safety, quality, effectiveness and responsiveness of services.

Educational governance

4.185 We learned that concerns identified through educational governance, workforce governance and service reviews rarely reached the board. We also heard concern within NHS Grampian's clinical leadership that reports relating to medical educational governance issues involving clinicians were produced but were not always progressed through the routes expected by professional regulators. This raises significant questions about whether mandatory medical educational governance requirements are being applied reliably. It also limits board visibility of concerns about clinical training and of concerns raised by clinicians in training, both of which are important sources of intelligence about the wider safety and quality of care. There are many recent and historical examples across healthcare systems of clinicians in training providing invaluable early warning of emerging risks, when their concerns are heard and acted upon.

4.186 Resident doctors in training (RDIT) account for around 40% of the medical workforce. RDITs are key to patient safety and their education, training and supervision must be seen by senior leaders as a core role.

4.187 An example of failure of medical educational governance escalation for board oversight is the General Medical Council (GMC) enhanced monitoring status of trauma and orthopaedics at Aberdeen Royal Infirmary. This unit was placed on enhanced monitoring by the GMC due to patient and resident doctors in training safety concerns being raised by Public Services Delivery Scotland quality management processes. The terms of reference for the staff governance committee state that reports are received from medical education. No report has been received this year and neither the chair nor the committee were aware of the GMC enhanced monitoring status of trauma and orthopaedics at Aberdeen Royal Infirmary.

Reassurance, not assurance

4.188 We found that assurance was frequently based on evidence of process and activity rather than demonstrable impact. The NHS board and committee papers, in general, appeared to focus on structures, actions and activity rather than providing evidence that quality or safety had improved or that risks had reduced. Non-executive directors told us that board papers often lacked analysis of trends, triangulation of different sources of intelligence and the patient perspective. Senior board participants described receiving raw data and descriptive reporting with limited interpretation or insight. There was also evidence of over-reliance on a small number of non-executive directors to interpret quantitative data when it was presented.

4.189 Board participants described difficulty in obtaining evidence that actions had resulted in measurable improvement or a reduction in risk. Non-executive directors were not always equipped with sufficient information to challenge effectively, and several described difficulties in obtaining meaningful assurance or understanding the true position in relation to quality and safety. Although we did note, in more recent board papers, that non-executive directors had become more assertive in asking for additional evidence[23]

4.190 Too often, executive reassurance appeared to be offered in place of evidence-based assurance on matters of clinical governance. The distinction is important: assurance requires evidence that demonstrates that the controls are effective and that intended outcomes are being achieved, rather than confirmation that processes, meetings or actions have taken place.

[23] 04.00StrengtheningClinicalGovernancearrangementsDGH.pdf

Awareness and curiosity about quality and safety issues

4.191 Non-executive board members were not always aware of formal escalations of concern by Healthcare Improvement Scotland, Public Services Delivery Scotland and other external agencies. The chief executive and directors had provided copies of letters and briefings in private (closed) sessions. However, matters related to the General Medical Council enhanced monitoring status of trauma and orthopaedics at Aberdeen Royal Infirmary due to patient and resident doctors in training safety concerns were not brought to the attention of the staff governance committee or the board.

4.192 We heard, and found little written evidence of, meaningful accompanying analysis or discussion of the potential systemic issues underlying these individual concerns. There was also little evidence of active exploration or curiosity to establish whether similar issues were occurring elsewhere in Scotland and whether relevant learning could therefore be applied within NHS Grampian.

4.193 When board members were informed at the closed board meeting on 22 January 2026 of the death of a patient, the need to suspend major hepatopancreatobiliary surgery, and the serious failings in orthopaedics identified through an external review, they sought assurance on whether there were other high-risk services that might give rise to similar concerns. The minute recorded that: “Concern was expressed that there may be other high-risk services that could have similar safety and quality risks and also pose reputational risk to the organisation. The medical director, acute services is working at pace to provide a list of operational concerns and ensuring that the risks are documented at a strategic, sector and service level.”

4.194 We wrote to the chief executive of NHS Grampian on 24 July 2026 requesting a copy of the reported list of high-risk services. In response on 5 October 2026, the chief executive advised that no such report had been prepared and that the discussion referred to in the confirmed minute had been limited to two services: vascular surgery and upper gastrointestinal surgery. This response raises significant concerns. It has taken over two months to establish that no report existed, despite the minute clearly indicating that work was underway to identify operational concerns and document risks at strategic, sector and service level. Given the seriousness of the issues that had already come to light, it would have been both prudent and expected for NHS Grampian to undertake a comprehensive review of other potentially high-risk services and to report the findings to the board. The fact that this did not occur, or that no formal report was produced, is itself a matter of concern.

4.195 Board members did participate in some learning and development activities, but the evidence suggested that these were mostly internally focused. There was little evidence of active participation in national learning and development activities run by Public Services Delivery Scotland and other organisations. Some non-executive directors who had participated in Public Services Delivery Scotland national development programmes described feeling uncomfortable when working with peers from other boards who appeared more familiar with the use of data and intelligence. This inhibited further engagement but, in retrospect, may have reflected an organisational development need within NHS Grampian rather than a deficit on the part of individual board members.

Assessment against the Healthcare Improvement Scotland Clinical Governance Standards and the Essentials of Safe Care

4.196 These findings are directly relevant to Healthcare Improvement Scotland's Clinical Governance Standards, published in 2026. The standards apply across clinical services in Scotland and describe seven interdependent areas of clinical governance:

- leadership and staffing
- quality management and continuous improvement
- clinical effectiveness; clinical safety and risk management
- education and training; service user and patient involvement
- data and information.

The concerns identified here relate particularly to Standards 1, 2, 4, 5 and 7 and should therefore be understood as clinical governance issues rather than solely as matters of board administration or information flow.

4.197 Standard 1 – **leadership and staffing**. This requires effective leadership and staffing governance, including clear management structures, defined responsibilities for the escalation and management of clinical risk, and appropriate reporting to clinical leadership.

4.198 Standard 2 - **quality management and continuous improvement**. The findings also relate closely to this standard, which requires robust governance and oversight of quality and safety outcomes and the use of data and intelligence to identify signals of concern and opportunities for learning. Reports that describe activity without demonstrating impact, improvement or reduction in risk do not provide meaningful assurance.

4.199 Standard 4 – **clinical safety and risk management**. This standard requires robust governance and reporting arrangements that provide effective oversight and assurance of clinical safety and risk. In that context, the reported lack of board visibility of important safety concerns, uncertainty about what should reach the board, and reliance on committee processes without sufficient collective scrutiny are significant. Effective delegation to committees does not remove the need for the board to maintain a clear line of sight to material clinical risks and to be able to demonstrate that those risks are being identified, escalated, controlled and reviewed.

4.200 Standard 5 – **education and training**. This addresses education and training as an integral part of safe and effective clinical care. Resident doctors in training (RDITs) account for around 40% of the medical workforce in NHS Scotland. Challenges and risks to clinical and educational supervision means RDITs may be working out with their scope of competence and confidence and is a direct patient safety issue. Intelligence from clinicians in training can provide an important early warning of deteriorating systems, unsafe working environments or weaknesses in clinical supervision. Where such concerns do not progress through expected governance routes or are not visible to those charged with organisational oversight, an important source 'floor to board' patient-safety intelligence is lost.

4.201 Standard 7 – **data and information**. This reinforces the importance of information that is sufficiently reliable, accessible and useful to support clinical governance and decision-making. The concerns expressed by board members about raw data, limited interpretation, lack of trend analysis and weak triangulation therefore have direct relevance to the board's ability to discharge its clinical governance responsibilities.

4.202 These findings also align with Healthcare Improvement Scotland's Essentials of Safe Care Framework, which describe essential drivers including:

- person-centred systems and behaviours
- safe communication within and between teams
- leadership that promotes a culture of safety at all levels
- safe and consistent clinical and care processes.

For a board, these principles require more than receipt of information. They require:

- leadership behaviours that encourage curiosity, openness and challenge
- communication systems that allow important safety intelligence to move reliably from the point of care to senior decision-makers
- governance processes capable of demonstrating that identified risks result in learning and measurable improvement.

4.203 Taken together, our findings suggest a gap between formal governance structures and effective clinical governance in practice. The central issue is not whether committees meet, reports are produced or actions are recorded, but whether the board can demonstrate a sufficiently accurate and evidence-based understanding of the quality and safety of care across NHS Grampian. The Healthcare Improvement Scotland Clinical Governance Standards and the Essentials of Safe Care Framework place particular emphasis on leadership, reliable information, risk management, learning and a culture in which concerns are heard and acted upon. On the evidence available to us, these are areas in which NHS Grampian's board arrangements require significant strengthening.

4.204 Similarly, the NHS Scotland Blueprint for Good Governance describes the core attributes of well-functioning system of board level governance and in which there is "a need to be able to demonstrate that their governance arrangements respect and pursue the rights and interests of all their stakeholders, and enable board members to hold their executive leadership teams to account for improving population health and addressing health inequalities, while delivering safe, effective and high quality healthcare services".

Summary of Findings: NHS Grampian's board scrutiny and oversight of clinical governance are inadequate.

4.205 The board did not consistently receive the information, analysis or intelligence required to develop a clear understanding of the quality and safety of care across NHS Grampian.

4.206 Non-executive directors described difficulties obtaining meaningful assurance, with reports often focusing on activity and process rather than demonstrable improvement, risk reduction or patient outcomes. They had not taken action to correct this but accepted the situation.

4.207 A divergence of opinion appeared to exist concerning the nature and extent of information that should be provided for consideration by non-executive directors. Some executives questioned whether the level of detail presented was proportionate to the board's governance role, whereas others emphasised the importance of comprehensive information to enable robust challenge, assurance and oversight.

4.208 Concerns relating to educational governance, workforce issues and patient safety did not always reach board level, limiting visibility of important warning signals. Although formal governance structures were in place, we found evidence of a gap between governance processes and effective clinical governance in practice, with insufficient challenge, limited use of data and intelligence, and an over-reliance on executive reassurance rather than evidence-based assurance. Collectively, these findings suggest that the board's arrangements require significant strengthening to provide robust oversight of quality, safety and clinical risk.

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

Challenges facing the medical workforce

4.209 One of the challenges facing Dr Gray's Hospital is the fragility of its medical workforce. Some of these challenges arise from structural factors specific to Dr Gray's Hospital, including its geographical location, the size of the institution and the availability of alternative employment opportunities in the north-east of Scotland. We are also aware of challenges relating to individual doctors which have required considerable support and input from hospital and system managers and leaders. The unusually high number of such cases within a small body does raise concerns about culture, governance and possibly suitability.

4.210 Concerns regarding service sustainability, governance, workforce fragility and patient safety were formally escalated to the chair and chief executive in September 2024 by the area medical committee [24]. The area medical committee identified concerns regarding

- fragile services
- extensive locum dependence
- inadequate bed capacity
- inequitable access to services
- insufficient progress against Dr Gray's Hospital strategy
- concerns about the gap between executive assurances and frontline experience.

4.211 In December 2024, the area medical committee highlighted widespread concerns regarding organisational performance, patient harm, transparency and culture, and reported limited evidence of operational improvement despite executive engagement.

4.212 In 2025 the area medical committee re-escalated these concerns and lack of progress in improvement activities to the chief executive, executive medical director and executive nurse director.
In April 2026 the area medical committee restated the ongoing, "live" nature of these concerns and raised further concerns about the lack of any meaningful improvement.

[24] The area medical committee is the standing advisory committee of medical professionals in NHS boards.

4.213 We have seen insufficient evidence of NHS Grampian seeking to create a workforce model in which Dr Gray's Hospital is not required to stand entirely on its own in relation to its medical establishment. We recognise that there were some attempts to create joint appointments between Dr Gray's Hospital and Aberdeen Royal Infirmary. This was tried in emergency medicine but did not sustain. We do not underestimate the inherent difficulty of providing a stable, well-motivated medical workforce at Dr Gray's Hospital, but it is essential if safe and sustainable services are to be provided. There have been repeated and unsuccessful attempts to fill stand-alone posts[25].

4.214 The Dr Gray's Hospital leadership triumvirate escalated concerns about the risks to safety of dependence on locum staffing and asked for a review, neither the acute medical director nor the executive medical director took effective action.

4.215 Nevertheless, as with other challenges facing Dr Gray's Hospital, these inherent difficulties are amplified by systemic weaknesses. Improvement at Dr Gray's Hospital must therefore address both local and system-wide factors. These should be brought together within a coherent medical workforce plan, which NHS Grampian currently lacks.

Job planning is inadequate

4.216 Consultant job planning in the NHS is the formal annual process that agrees how a consultant's working time will be allocated to deliver clinical services, teaching, management, research, and professional activities. It is a contractual requirement for both doctors and employers but more importantly is how NHS Grampian can align its medical workforce to its priorities. Job planning is a core duty for an executive medical director and other medical managers. NHS Grampian's own policy correctly makes clear that it must be completed between January and March to align with service plans.

4.217 Consultant job-planning arrangements are inadequate and not compliant with NHS Grampian's own policy. The latest data was that 45% of job plans were signed off for NHS Grampian and 27% for Dr Gray's Hospital.

4.218 The executive and acute medical directors acknowledged this, and problems with the content of those that were signed off. They acknowledged the need for improvement but had no plan to address this. Job planning was already highlighted as an area for action in the KPMG report. This is not simply an administrative or audit issue. Medical consultants are a high-value and high-cost component of the clinical workforce and undertake some of the most complex and highest-risk clinical work. Despite this, they were not included in the single improvement plan which we found surprising.

[25]3 Minute Brief – Medical Workforce DGH; Proposal: Acute & General Medicine Service Model and Workforce Redesign at Dr Gray's Hospital, DGH Medicine Service and Workforce redesign; Acute Sector Governance Meetings – DGH, Thursday 26 February 2026 14.00-16.15

4.219 A clear understanding of the actual capacity available to deliver consultant-led care is fundamental to workforce planning and to the safe and effective delivery of both elective and unscheduled care. Incomplete job planning limits the organisation's ability to understand clinical capacity, align consultant activity with service need and provide reliable assurance about the deployment of its senior medical workforce.

Medical appraisal

4.220 The General Medical Council requires that all doctors have an annual appraisal in a prescribed format to demonstrate continuing fitness to practice and contribute to the revalidation process. The responsible officer (the board executive medical director) must ensure all doctors do this. In 2023/24 there were 174 deferrals in secondary care, of which 150 of these were classed as 5A and attributed to lack of appraisal capacity. In the subsequent years NHS Grampian funded primary care appraisers to support appraisal and by 2025/2026 there was an increase in actual secondary care appraisers.

Medical staff appointments

4.221 Given the significance and longevity of consultant appointments, decisions to create or replace posts should be informed by careful assessment of service need, workforce configuration and the role required within the future clinical model.

4.222 Decisions are routinely made at divisional level without appropriate involvement of the executive medical director or the acute medical director.

4.223 We saw evidence of consultant posts being advertised without account of significant changes to the relevant service model that was under way. In some cases, those changes might reasonably have prompted consideration of a different clinical role or workforce configuration. This creates a risk that recruitment decisions respond to immediate vacancies rather than forming part of a coherent, sustainable medical workforce strategy. The review could find no evidence that such a medical workforce strategy existed.

Weaknesses in managing consultant performance and conduct

4.224 We found evidence of prolonged consultant conduct, capability and employment issues that had not been resolved and were having a direct impact on service delivery. We recognise that NHS Grampian cannot control every aspect or timescale of these processes.

4.225 We heard that there was a culture of avoiding difficult conversations with consultants about performance and professional behaviours. Medical staff engagement with organisational change and improvement was inconsistent and, where consultant engagement was limited, change was more difficult to achieve. For example, unscheduled care where improvement has been documented as a priority and requires medical leadership to deliver it. Workforce governance, professional management and medical engagement were also identified by the NHS Grampian chief executive as significant challenges to effective workforce engagement and organisational control.

4.226 We have raised in the single improvement plan, which was presented at the NHS Grampian 13 August 2026 Board meeting, the reference under action CLG 13:

"Potential behaviours of senior clinicians to engage with transformation activities: Concerns were raised about the impact and behaviours of some senior clinicians in certain areas obstructing attempts to address concerns and improve services".

This item was stated as being deferred until March 2027.

Impact of these weaknesses

4.227 The combined effect of these weaknesses is to exacerbate the inherent difficulties Dr Gray's Hospital faces in medical recruitment, performance, retention and workforce stability, education and supervision. Doctors whom NHS Grampian would wish to recruit to Dr Gray's Hospital may be less likely to seek or remain in these posts if the service is perceived within the medical profession as professionally isolated, unstable or insufficiently supported. We have heard views from staff, the KPMG report and the Area Medical Committee that a major cultural change is required.

4.228 We believe these weaknesses have contributed to dependence on locum consultants rather than substantive, long-term employees. The heavy reliance on locums within acute medicine is of particular concern because of its potential impact on continuity of care, clinical leadership and the development of stable teams in a high-volume and important service for the people of Moray.

4.229 Similarly, dependence on very small consultant teams operating relatively independently, rather than as part of resilient and genuinely integrated pan-NHS Grampian services, creates challenges for rota stability, out-of-hours cover, succession planning and wider service resilience. The perceived lack of visibility, presence and support from senior medical leadership, described elsewhere in this report, further compounds these problems.

Relationship to Healthcare Improvement Scotland Clinical Governance Standards and the Essentials of Safe Care Framework

4.230 Standard 1 – **leadership and staffing**. This requires effective leadership and oversight of clinical services, including staffing levels, clear management structures and responsibilities, sustainable workforce planning, appropriate skill mix and processes to identify and mitigate staffing risks.

4.231 Against that framework, the absence of a coherent medical workforce plan, incomplete consultant job planning, inconsistent senior medical oversight of recruitment and dependence on locum or very small consultant teams are not simply workforce or operational issues. They have clinical governance implications because they affect the organisation's ability to demonstrate that staffing is planned, deployed and governed in a way that supports safe, sustainable and high-quality care. The same is true of prolonged performance and conduct issues where these have a direct effect on service delivery and where timely organisational action and mitigation are not evident.

4.232 There is also an important relationship with the Healthcare Improvement Scotland Essentials of Safe Care Framework. These describe four essential drivers of safe care:

- person-centred systems and behaviours
- safe communication within and between teams
- leadership that promotes a culture of safety at all levels
- safe, consistent clinical and care processes across health and care settings.

Medical workforce arrangements are fundamental to each of these. Stable and appropriately supported teams provide continuity, shared understanding, effective communication and consistent clinical practice. Conversely, excessive reliance on temporary staffing, fragmented teams, weak medical engagement and limited senior leadership support can make these conditions more difficult to sustain.

4.233 The findings concerning avoidance of difficult conversations, inconsistent medical engagement and unresolved conduct or capability issues are particularly relevant to leadership and safety culture. A safe culture requires leaders to support staff while also addressing concerns about performance and behaviour fairly, consistently and in a timely way. Similarly, effective professional and clinical leadership should create conditions in which consultants are engaged in service improvement, understand their responsibilities within the wider system and are supported to work across organisational and geographical boundaries rather than within isolated professional or service structures.

4.234 The significance of these standards is that the workforce difficulties facing Dr Gray's Hospital cannot be regarded solely as unavoidable consequences of geography or scale. Those factors are real and substantial, but they increase rather than diminish the need for strong clinical governance. A small and geographically isolated hospital requires particularly clear workforce planning, senior clinical oversight, succession and resilience arrangements, effective professional management and integration with larger services elsewhere in NHS Grampian. The governance response should therefore be proportionate to the vulnerability of the service and capable of demonstrating how identified workforce risks are being actively managed and reduced.

Summary of findings: NHS Grampian's leadership and management of the medical workforce are weak

4.235 Dr Gray's Hospital faces genuine structural challenges in recruiting and sustaining its medical workforce. Its geography, size and the small scale of some specialties make recruitment, retention, rota resilience and continuity inherently difficult. NHS Grampian has made efforts over several years to reduce the professional and organisational isolation of the hospital, and these challenges should not be underestimated.

4.236 However, our review indicates that these inherent difficulties are being amplified by weaknesses in the leadership and management of the medical workforce. There is no sufficiently coherent medical workforce plan; consultant job planning remains incomplete; recruitment decisions are not consistently subject to strategic senior medical oversight; and prolonged performance, conduct and employment issues have affected service delivery. Medical engagement in organisational change and improvement also remains underdeveloped.

4.237 The consequences are important for both workforce sustainability and patient care. Dependence on locum consultants and very small clinical teams reduces continuity, makes the development of stable multidisciplinary teams more difficult and increases vulnerability in rota cover, succession planning and service resilience. These are therefore not solely human resources or operational matters; they are clinical and medical educational governance and patient safety issues.

4.238 The findings align closely with Healthcare Improvement Scotland's expectations for effective leadership and staffing governance and with the Essentials of Safe Care Framework, particularly leadership and safety culture, safe communication and safe and consistent clinical processes. Sustainable improvement will require NHS Grampian to address the local vulnerabilities at Dr Gray's Hospital while simultaneously strengthening system level medical leadership, workforce planning, professional management and integration across NHS Grampian. Without both elements, there is a risk that repeated short-term solutions will continue to mitigate immediate pressures without resolving the underlying causes of workforce fragility.

5. Recommendations

5.1 NHS Grampian has been subject to several external and internal reviews and has received numerous recommendations for improvement. The review team does not consider that a further extensive set of recommendations would be helpful. The recommendations below are therefore deliberately limited to six areas where the findings of this review indicate that clear organisational decisions, strengthened accountability and demonstrable change are urgently required.

Recommendation 1: Implement an integrated, respectful and sustainable plan for Dr Gray's Hospital

5.2 NHS Grampian should make and implement clear decisions about the services that can be safely and sustainably provided at Dr Gray's Hospital as part of the wider NHS Grampian and north of Scotland system.

5.3 Previous strategies and planning processes have not resolved the gap between the stated ambitions for Dr Gray's Hospital and the increasing fragility of some services. A further aspirational strategy or programme of review will not address this.

5.4 The board should agree a realistic future clinical model, informed by patient need and access, clinical safety, workforce availability, service interdependencies and the consequences for services elsewhere in NHS Grampian and NHS Highland. This should specifically resolve the future model for those services identified through this review as particularly vulnerable, rather than allowing temporary arrangements and workarounds to become the default service model. The agreed model should also include clear operational and governance arrangements, including defined escalation processes for workforce, capacity and patient-safety risks, to ensure emerging concerns are identified, acted upon and communicated in a timely and consistent manner.

Recommendation 2: Substantially increase organisational capability, oversight and accountability for assuring effective clinical governance

5.5 The NHS Grampian Board should urgently increase and strengthen the organisational systems for assuring clinical governance, patient safety and quality of care. This should include properly empowering and supporting the quality management work being led by the recently appointed deputy medical director with responsibility for clinical governance. This work should have significant visibility and engagement from the board. It also requires a significant shift from activity to outcome-based improvement in NHS Grampian.

5.6 The review found that clinical quality and patient safety have not received sufficiently systematic board-level scrutiny. The board has not consistently been provided with the information required to understand significant clinical risks, but it has also not exercised sufficient curiosity and challenge where assurance was incomplete. Addressing this requires change in both the information provided to the board and the way in which the board uses that information.

5.7 The board should establish routine, integrated oversight of quality and safety, including:

- clinical outcomes
- significant adverse events
- patient experience
- workforce and educational governance
- vulnerable services
- the organisation's principal clinical risks.

Reporting should enable members to understand what has changed, where risks remain and whether actions have resulted in measurable improvement, rather than principally describing activity undertaken.

5.8 The board should also review its own effectiveness in relation to quality and safety, including the respective responsibilities of executive and non-executive members, the quality of challenge and scrutiny, and whether its committee arrangements provide the assurance required by the board.

5.9 Where significant risks remain unresolved, the board should require a named executive lead, a clear course of action and timescale, and evidence of resolution. Where a risk cannot be adequately mitigated, the board should explicitly consider whether it is prepared to accept that risk or whether further intervention is required.

Recommendation 3: Establish effective organisational leadership and management of the medical workforce

5.10 NHS Grampian should establish effective organisation-wide leadership and management over the deployment and management of its senior medical workforce, with particular attention to services where current arrangements are contributing to clinical risk, fragility or unsustainable service models.

5.11 The review identified significant weaknesses in recruitment, job planning, appraisal, deployment and the management of prolonged professional and employment issues. These are not isolated administrative shortcomings. Collectively, they have contributed to service models that do not consistently reflect clinical need and, in some areas, have increased reliance on temporary staffing and local workarounds.

5.12 The chief executive and board should require a time-limited programme of action to establish effective medical workforce governance. This should include:

- clear organisational oversight of consultant recruitment and establishment decisions, aligned to agreed service models
- completion and quality assurance of consultant job planning
- sustainable arrangements for medical appraisal
- active senior oversight of prolonged professional, conduct, capability or employment processes where these affect service delivery
- regular assessment of the cumulative impact of medical workforce decisions on patient safety, service resilience, and cost.

5.13 Progress should be reported directly to the board and should include objective measures of improvement rather than assurance based solely on completion of actions.

Recommendation 4: Simplify governance and demonstrate that it works before introducing further structures

5.14 NHS Grampian should rationalise its current governance arrangements and avoid creating additional committees, groups or reporting structures unless there is clear evidence that an identified governance function cannot be delivered through existing arrangements.

5.15 The review found extensive governance activity and repeated redesign, but considerably less evidence that this resulted in reliable escalation, decision-making, accountability and resolution. Further structural change risks adding complexity without addressing the underlying weakness.

5.16 NHS Grampian should therefore demonstrate the effectiveness of its governance system by tracing a sample of significant clinical risks and adverse events from identification through escalation, decision and action to evidence of reduced risk or improved care.

5.17 This should be used to identify and address specific weaknesses in accountability, information flow and decision-making. The emphasis should be on making governance work, rather than designing more governance.

Recommendation 5: Establish outcome-based external oversight of improvement

5.18 NHS Grampian, Scottish Government and relevant external organisations should agree a proportionate mechanism for independently assessing progress following this review.

5.19 Given the recurrence of concerns identified through previous reviews and improvement activity, assurance should not depend principally upon NHS Grampian reporting completion of recommendations or actions. Follow-ups should test whether the underlying conditions identified by this review have materially changed.

5.20 A small number of measurable outcomes should therefore be agreed, reflecting the principal findings of the review, with defined points at which progress is independently assessed. These should include evidence that:

- longstanding risks are being resolved
- governance processes result in action
- medical workforce arrangements are becoming more sustainable
- agreed service decisions for Dr Gray's Hospital are being implemented.

Recommendation 6: Strengthen board governance, decision making and collective accountability

5.21 NHS Grampian should establish and maintain a shared understanding among executive and non-executive members of the board's statutory responsibilities, governance role and decision-making authority, consistent with the NHS Scotland board governance framework.

5.22 The review identified markedly different perceptions among executive team and board members regarding how decisions are made, the extent of board scrutiny and challenge, and the respective responsibilities of executive and non-executive members. Effective governance depends upon a common understanding of accountability, assurance, scrutiny, and decision-making responsibilities.

5.23 The chair and chief executive should lead a structured programme to strengthen governance arrangements and board effectiveness. For example:

- Formal reaffirmation of the board's role in decision-making, assurance and scrutiny, and the respective responsibilities of executive and non-executive members.
- Review of board and committee processes to ensure that members are routinely provided with sufficient information, including alternative options, risks, benefits, and implications where significant decisions are required.
- Development of a common understanding of the distinction between strategic oversight and operational management, while recognising the board's responsibility to seek assurance regarding matters that may affect patient safety, quality, effectiveness and organisational performance.
- Facilitated development sessions for board members and executive team members focused on governance responsibilities, collective accountability, and effective challenges.

- Regular assessment of board effectiveness, including the quality of discussion, scrutiny, decision-making, and assurance.
- Mechanisms to ensure that substantial decisions presented to the board demonstrate how options have been considered, challenged and evaluated before approval is sought.

5.24 The board should receive regular reports on progress and be able to demonstrate, through observable changes in behaviour, documentation and decision-making processes, that governance arrangements are operating consistently with the NHS Scotland governance framework and support effective collective accountability.

Appendix 1: Terms of Reference for the diagnostic review

1. Purpose

The purpose of this Terms of Reference (ToR) is to set out the remit, governance arrangements, membership and ways of working for the **NHS Grampian Responsive Diagnostic Support Programme** requested from Healthcare Improvement Scotland (HIS).

This diagnostic will provide:

- a clear, evidence-based diagnostic assessment of risks, strengths and improvement priorities in relation to safety, quality, governance and organisational culture
- the primary focus on services at Dr Gray's Hospital, recognising these are delivered as part of the wider NHS Grampian system, and will therefore consider relevant system interactions and dependencies where these materially impact on care delivery
- the output will be a stand-alone diagnostic report - with clear priorities and proposed next steps - that makes recommendations for NHS Grampian. There will also be consideration of needs for ongoing support from HIS and other bodies.

2. Strategic Context

In 2025, the chief executives of Healthcare Improvement Scotland and NHS Education for Scotland raised serious concerns with NHS Grampian regarding patient safety, clinical quality, organisational culture and the education and training environment. Following this, NHS Grampian has been escalated within the Scottish Government performance management framework and significant leadership changes have taken place.

In response to a request from NHS Grampian for support and assistance, Healthcare Improvement Scotland has agreed to provide some ongoing support to the organisation, commencing with a structured diagnostic to draw together existing intelligence, undertake targeted engagement, and provide a clear, evidence-based assessment to support prioritisation of improvement. Any further support from Healthcare Improvement Scotland beyond this diagnostic is to be determined following completion of the diagnostic programme.

3. Remit

The responsive diagnostic support programme will:

- consolidate and review existing intelligence relating to safety, quality, governance and culture
- test and deepen understanding through targeted engagement with clinical and operational services
- identify strengths, risks and underlying causes
- provide clear, evidence-based findings
- make prioritised, actionable recommendations to support improvement planning and with this offer reflections on the resource required to deliver (internal and external)

The diagnostic will be framed with reference to:

- Healthcare Improvement Scotland Clinical Governance Standards
- Essentials of Safe Care Framework
- key lines of enquiry.

The diagnostic will pursue key lines of enquiry:

- Clinical and educational governance - including quality and safety, education and training, clinical processes, adherence to clinical standards and guidelines and collaborative quality improvement and learning
- Service models and patient pathways (including interaction with the wider system)
- Workforce and staffing (including capacity considerations and sustainability)
- Operational delivery and management oversight
- Workplace culture, teamworking and organisational learning
- Leadership and accountability.

4. Scope and Exclusions

Scope:

- Primary focus on services at Dr Gray's Hospital.
- Consideration of wider NHS Grampian system interactions where these materially impact care delivery, including patient pathways through Dr Gray's Hospital.
- Use of existing data, intelligence and prior reviews supplemented by targeted engagement.

Exclusions

The diagnostic will not:

- replace NHS Grampian's statutory management or governance responsibilities
- act as a formal inspection or regulatory process
- develop or implement detailed improvement plans
- duplicate ongoing assurance activity or internal improvement already underway at NHS Grampian unless necessary to test key risks in agreement with the board.

5. Leadership, accountabilities and delivery

Sponsorship and strategic oversight

Programme executive sponsor: Chief executive, NHS Grampian
Overall strategic lead for this work as the chief executive officer who has requested support from Healthcare Improvement Scotland acts as the primary point of engagement with:

1.1. HIS chief executive
1.2. Scottish-government chaired assurance board
1.3. NHS Grampian Board

Strategic Lead Provider:

Robbie Pearson, Chief Executive, Healthcare Improvement Scotland

1.4. provides overall strategic leadership and assurance
1.5. acts as the primary point of engagement with NHS Grampian chief executive and Scottish Government
1.6. supports high-level relationship management and system alignment.

Executive Lead Provider:

Simon Watson, Medical Director and Director of Safety, Healthcare Improvement Scotland

- provides executive oversight of delivery
- supports the core review team
- oversees quality of analysis, findings and recommendations
- acts as escalation point for programme risks and delivery issues.

Core review team (CRT)

In response to the request for support, Healthcare Improvement Scotland will commission, lead and support a core review team comprising senior, experienced healthcare leaders. The team will undertake the diagnostic work and exercise collective professional judgement on findings and recommendations.

Programme management

Programme manager (Healthcare Improvement Scotland): Responsible for coordination, planning, risk management, evidence collation, stakeholder liaison and reporting.

A single point of contact for liaison with the programme manager from Healthcare Improvement Scotland has been identified to ensure a seamless flow of information and weekly agreed programme of work.

Decision-making and escalation

The CRT will agree findings and recommendations by consensus. This work is being undertaken as a diagnostic support programme in response to the request for assistance from NHS Grampian.

Any immediate patient and staff safety and wellbeing concerns identified by the CRT will be immediately escalated to the NHS Grampian chief executive and/or the medical/nurse directors.

6. Membership – core review team

Proposed CRT membership includes:

Kay Fawcett OBE - Former NHS Nurse Director and senior nurse leader, with extensive experience in clinical governance, workforce, culture and organisational improvement. Dr Fawcett was previously Executive Chief Nurse at Derby Hospitals NHS Foundation Trust, and University Hospitals Birmingham NHS Foundation Trust.

Simon Mackenzie – Former NHS Chief Executive and Executive Medical Director in the NHS, with extensive experience in leading system-wide improvement and organisational recovery. Formerly Executive Medical Director and Chief Executive at St George's NHS Foundation Trust and Acute Medical Director in NHS Lothian.

Kerri Neylon OBE – Senior GP and clinical leader, bringing expertise in primary care, system interfaces and patient pathways across organisational boundaries. Currently, Associate Medical Director at NHS 24 and formerly Deputy Medical Director at NHS Greater Glasgow and Clyde.

Lindsay Donaldson – Deputy Medical Director, Public Services Delivery Scotland, with national leadership experience in clinical governance and medical safety. Prior to joining NHS Education for Scotland, Lindsay was the Director for Medical Education in NHS Greater Glasgow and Clyde and a consultant in Intensive Care Medicine at Glasgow Royal Infirmary.

Mhairi Hastings – Associate Nurse Director, Healthcare Improvement Scotland, with experience in nursing leadership, quality and safety in territorial health boards and in Scottish Government.

Philip Korsah – Deputy Medical Director, Healthcare Improvement Scotland with expertise in acute care, clinical governance and improvement. He was formerly Associate National Clinical Director at the Centre for Sustainable Delivery and Associate Medical Director at NHS Ayrshire and Arran.

7. Structure and phases of work

The diagnostic will be delivered over an indicative eight-week period, structured as follows:

Phase 1: Intelligence consolidation and scoping

- Review and synthesis of existing intelligence
- Identification of key lines of enquiry

Phase 2: Targeted engagement and site visits

- Focused engagement with services, staff and leaders
- Testing and triangulation of evidence

Phase 3: Synthesis, reporting and recommendations

- Ongoing development of report structure and outputs throughout the diagnostic
- Triangulation of evidence to identify themes, risks and areas of strength
- Development of a written report. Clear articulation of findings and prioritised recommendations and options for ongoing support from Healthcare Improvement Scotland/external bodies to implement

8. Outputs

The primary outputs will be:

A written diagnostic report setting out:

- Context and methodology
- Key findings mapped to lines of enquiry
- Strengths, risks and underlying causes
- Prioritised recommendations
- Ongoing resource options from Healthcare Improvement Scotland/external bodies to ensure ongoing support to implement recommendations.

The report will be developed iteratively throughout the diagnostic period, with emerging findings refined through ongoing engagement with the core review team.

Presentation of the report to the NHS Grampian Chief Executive for consideration and subsequent timely presentation to the NHS Grampian Public Board.

Any decision relating to next steps upon receipt of the report is a matter for NHS Grampian, as the owner of the report to determine and lead on.

9. Risk management

An open risk profile will be adopted. Key risks relating to both the delivery of the diagnostic and the wider organisational context will be identified, recorded and actively managed.

NHS Grampian will retain responsibility for risks relating to the delivery of the outputs of the diagnostic and priorities recommended, along with the organisational and operational risks, including those relating to patient safety and service delivery, with escalation through its established governance arrangements.

10. Governance and communications

- Healthcare Improvement Scotland will manage the delivery of the work through its normal management and governance processes.
- The outputs of the work will be managed by NHS Grampian.
- Healthcare Improvement Scotland and NHS Grampian will work collaboratively to support each other's governance in line with the NHS Scotland Blueprint for Good Governance.
- Healthcare Improvement Scotland will provide a weekly progress update to the NHS Grampian CEO and respond quickly to all other communications.
- Engagement with the Scottish Government in relation to the outputs of the review will go principally via NHS Grampian to the Scottish Government Assurance Board, recognising the context of escalation and recovery.

- Healthcare Improvement Scotland will fulfil its statutory accountabilities and reporting responsibilities set out in legislation and our Operating Framework with Scottish Government.
- Media communications from either organisation will be handled through normal bilateral arrangements and best practice.

11. Review and amendment

This terms of reference may be reviewed and amended by agreement between Healthcare Improvement Scotland and NHS Grampian to reflect emerging needs or changes in context.

12. Duration

- These terms of reference apply for the duration of the responsive diagnostic support programme and conclude on delivery of the final report, unless otherwise agreed.
- The CRT will operate for an initial period of 8 weeks.
- Timelines will be kept under review to ensure delivery of pace.

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