Recommendations 1-6 – NHS Ayrshire and Arran provided the second update on progress against the recommendations on 30 January 2018. This submission includes an updated action plan and a detailed narrative of the progress that has been made since the first update. The Board continues to report regularly on progress to their Healthcare Governance Committee.

Healthcare Improvement Scotland has reviewed the updated action plan and supporting evidence. We acknowledge the progress that has been made, with a number of actions concluded since the previous update. We are supportive of the Board becoming a pilot site for the Being Open work which supports effective communication with parents, families and staff with regard to adverse events in maternity units (more information below). For further information please visit the NHS Ayrshire and Arran website – [http://www.nhsaaa.net/about-us/how-we-perform/review-of-the-management-of-adverse-events-at-ayrshire-maternity-unit/](http://www.nhsaaa.net/about-us/how-we-perform/review-of-the-management-of-adverse-events-at-ayrshire-maternity-unit/)

Over and above the HIS recommendations and requirements; NHS Ayrshire and Arran is undertaking an additional assurance piece of work regarding the management of adverse events. NHS Ayrshire and Arran will share the outputs of this work with HIS as part of the next quarterly submission.

Recommendation 7 – NHS Education for Scotland convened a working group to make recommendations for a programme of core mandatory update training for midwives and obstetricians in Scotland. The group submitted its report to Government in late January. Scottish Government are considering the proposals within the report, assessing the implications for Boards and the maternity workforce, and identifying actions that would be required to implement the recommendations and a timetable for that action. It is expected that this work will conclude shortly.

Recommendation 8 – HIS is continuing to revise the National Framework ‘Learning from adverse events through reporting and review: A national framework for NHSScotland’. This further development work has been based on the findings from the Review of Ayrshire Maternity Unit, University Hospital Crosshouse, NHS Ayrshire & Arran (Adverse Events) as well as wider information such as duty of candour legislation and other relevant data and intelligence. The draft revisions will be shared with stakeholder across NHSScotland for comment by end March 2018 prior to publishing the updated version in Spring 2018.

As part of the implementation of the national framework we funded a ‘Being Open’ pilot in the maternity department at Edinburgh Royal Infirmary. Feedback from NHS Lothian is that the experience of this approach has transformed the quality of communication between health care professionals and families leading to greater staff and patient confidence to share difficult discussions and decision making through a review process. NHS Ayrshire & Arran approached Scottish Government, HIS and NHS Lothian seeking support for them to be a further pilot site for the work and a formal proposal will be prepared by the end of March 2018. Further discussions will be held to consider a third pilot and the potential for roll out across all NHS boards as part of a breakthrough collaborative.

The HIS Quality of Care Framework, a guide to services and those externally quality assuring them, on what good quality care looks like and how this can be evaluated and demonstrated, was published as a working edition in December 2017. We are developing an adverse event quality assurance model as part of the Quality of Care Approach. More information on the approach can be found here - [http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx)