Recommendations 1-6 - When the Review of Ayrshire Maternity Unit report was published, it was agreed that NHS Ayrshire & Arran would provide three monthly reports on progress against the recommendations. In September 2017, NHS Ayrshire and Arran provided the first progress report. The submission includes an updated action plan and a detailed narrative of the actions that have been/are being taken forward to address the recommendations in the report. We acknowledge the significant amount of work that has gone in to preparing this update.

Healthcare Improvement Scotland, with input from external colleagues, has reviewed the action plan and supporting evidence of progress. We acknowledge that it is three months post publication. A number of the actions have been concluded, or will be by the end of November 2017. There are longer term actions anticipated to be concluded by March 2018, and the impact of many of these actions will only be fully demonstrable beyond this point. However, progress to date is in line with what we would expect to see at this point in time. 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/

Recommendation 7 - NHS Education for Scotland have convened a short life working group comprising professionals from across Scotland and Scottish Government to provide advice to Government on this recommendation by the end of this year.

Recommendation 8 - Healthcare Improvement Scotland has reviewed the findings, conclusions and recommendations within the report to support further development and implementation of the National Framework for Learning from Adverse Events. HIS has secured external expertise (from existing adverse event programme board) to assist in taking forward the following actions:

- map the report’s conclusions and recommendations with the adverse events framework and the NHS Ayrshire & Arran action plan
- consider wider information, data and intelligence to identify any areas of improvement required to support either improvements to the National Framework or support for its implementation
- use findings to inform an adverse event quality assurance model as part of the Quality of Care Approach
- work with the adverse event community of practice to improve the national framework, also taking into account the Duty of Candour legislation and procedure.

Future updates and evidence of progress from NHS Ayrshire and Arran will be followed up at three monthly intervals, and will fall in line with the board’s internal governance reporting schedule. Updates on all recommendations will be posted on our website at these three monthly intervals.