Recommendations 1-6 – On 30 July 2018 we received NHS Ayrshire and Arran’s fourth update on progress against the recommendations. This submission included the final, completed action plan along with a detailed narrative on progress. The Board continues to report regularly on progress to their Healthcare Governance Committee.

Healthcare Improvement Scotland has reviewed the action plan and supporting evidence. We acknowledge the progress that has been made since the previous update, with all actions now concluded (with the exception of the work ongoing in relation to the Being Open pilot and testing of the national Maternity Services Adverse Events Framework which will be reported to the Chief Medical Officer and Chief Nursing Officer).

We note the governance arrangements in place, and the reporting and monitoring requirements for the management of adverse events. In addition, we also note the commitment that NHS Ayrshire & Arran will undertake ongoing assurance work in relation to the adverse event management process and report annually into the Risk Management and Healthcare Governance Committees.

We welcome the commitment to publishing a learning summary following every SAER and that the effectiveness and impact of the learning process will be measured through the governance routes, with an audit process to assess the quality of learning notes. Demonstrating implementation of change and the impact on service delivery as a result of this will be important going forward. It will also be vital to continue to build a culture of openness and leadership to ensure staff feel encouraged and supported to report adverse events in order to manage and learn from these events.

From the information and evidence provided to date, we are satisfied that governance and assurance processes are in place within the board to support the management of adverse events. We therefore will not be requesting ongoing quarterly updates. The upcoming NHS Ayrshire and Arran Board level review will provide an opportunity for the board to share their ongoing improvement journey with this work. However, should NHS Ayrshire and Arran identify areas where further support would be helpful in the future, Healthcare Improvement Scotland will be notified.

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/

In addition to the HIS recommendations and requirements detailed in our report, NHS Ayrshire and Arran has undertaken a further piece of assurance work regarding the management of adverse events across the organisation. NHS Ayrshire and Arran has shared the outputs of this work with HIS and a meeting was held on 10 August 2018 to discuss the findings. The Board described the work undertaken to review the categorisation and appropriateness of adverse event reviews between December 2013 and June 2017. The board also described the revisions been made to the board-wide policy and supporting guidance and clarified the process for categorising adverse events, the level of review to be applied, and the monitoring arrangements in place to ensure this is robust. The discussions were very helpful in assisting HIS to comprehend the processes surrounding adverse events and it was noted that there is no further need for follow up at this time. However, there will be an opportunity to further test this assurance through the upcoming Board level review and future adverse event quality assurance work.
**Recommendation 7** – Scottish Government is currently working with NHS Education for Scotland and work has been completed on outlining a programme of core mandatory update training for midwives and obstetricians in Scotland. Scottish Government, NHS Education Scotland and NHS Boards are working on a plan for implementing and monitoring the uptake of this programme of update training from 2019.

No further follow-up on this recommendation will be undertaken by HIS.

**Recommendation 8** – An update of the National Framework ‘*Learning from adverse events through reporting and review: A national framework for NHSScotland*’ incorporating duty of candour requirements was published in July 2018. Work continues on a more comprehensive revision which will take account of the learning from implementing the duty of candour legislation as well as wider information and other relevant data and intelligence. Healthcare Improvement Scotland will continue to review and assess, in collaboration with NHS boards, to take this work forward. Further information will be provided on the scrutiny/governance/assurance section of the HIS website.

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. The framework is being updated and will be published in September 2018. Through this work, we will continue to develop how we support NHS boards to improve their adverse event management assurance mechanisms. 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)