Approved by Committee on 4 August 2025

Healthcare Governance Committee
Monday 9 June 2025 at 9.30am
Hybrid – Meeting Room 1, Eglinton House and MS Teams meeting

Present:

Non-Executives:
Ms Linda Semple (Chair)
Cllr Marie Burns
Dr Tom Hopkins
Mrs Sharon Morrow
Mr Neil McAleese

Board Advisor/Ex-Officio:
Mrs Vicki Campbell, Director of Acute Services
Mrs Geraldine Jordan, Director of Clinical Care Governance
Ms Jennifer Wilson, Nurse Director

In attendance:
Ms Thelma Bowers, Head of Service, Mental Health item 6.2
Dr Debbie Browne, Deputy Medical Director, Mental Health item 6.2
Mr Martin Egan, Senior Manager, Justice Services item 5.3
Ms Sandra Ferrol, Litigation Manager item 6.5
Ms Alexa Foster, Head of Midwifery item 6.3
Mr Darren Fullarton, Associate Nurse Director, Lead Nurse NA HSCP item 6.2
Ms Helen Gemmell, Assistant Director, Estates and Support Services item 9.1
Ms Jincy Jerry, Director of Infection Prevention and Control item 6.1
Ms Carly Wylie, Public Inquiries Coordinator item 6.4
Ms Dee Richmond, Complaints Manager (observer)
Mrs Angela O'Mahony, Committee Secretary (minutes)

Welcome

The Chair welcomed everyone to the meeting and noted that Dee Richmond, Complaints Manager, was joining as an observer.

1. Apologies for absence

1.1 Apologies were noted from Mrs Lesley Bowie, Ms Claire Burden, Dr Crawford McGuffie, Mrs Lynne McNiven, Ms Ruth McMurdo and Mr Alistair Reid.

2. Declaration of any Conflicts of Interest

2.1 There were no conflicts of interest declared.

3. Draft Minute of the Meeting held on 28 April 2025

3.1 The Minute of the meeting held on 28 April 2025 was approved as an accurate record of the discussion.

4. Matters arising

4.1 The action log had previously been circulated to members. All items were either on the agenda, a date had been scheduled for the discussion or the action was complete. The following update was provided:

- **Item 5.1 (13/01/2025), Patient Experience themed report- waiting times and appointments, Digital communication with patients** – this report had been deferred to the meeting on 8 September 2025. The Director of Acute Services, Vicki Campbell, advised that this was a significant piece of work which she had discussed with her team. She assured members that this will be a priority area of focus going forward. The Chair requested that a detailed assurance report on progress with the Digital strategy be provided at a future committee meeting given the linkages with the quality, safety and patient care agenda. **NG**

4.2 The Committee noted the draft work plan for 2025/26. The Nurse Director, Jennifer Wilson, highlighted that submission of the Integrated Health and Care Governance Framework had been deferred to the meeting on 29 July 2025. This work was progressing well and HSCPs were agreeing organisational governance structures.

5. Patient Experience

5.1 Patient Experience Quarter 4 report

The Director of Clinical and Care Governance, Geraldine Jordan, presented the Patient Experience quarter 4 report and compliance with the complaint handling process.

There had been a slight reduction in the number of stage 1 complaints and the position had been relatively stable over the last few quarters. Stage 2 complaints had been increasing since 2023 but had been stable since quarter 1 of 2024. There had been a slight deterioration in responding to stage 1 complaints in quarter 4 to 80% against the target of 85%. A number of actions were in place to try to improve current performance, including focused complaint handling work with the Director of Acute Services and team. Overall performance in responding to stage 2 complaints had improved slightly, at 74% against the 75% target.

The Director advised that priority was being given to responding to out of time complaints over 100 days which had reduced from 65 to 30 in Quarter 4, with most related to Acute services which received the highest volume of complaints. The Nurse Director, Jennifer Wilson, commended the progress made in responding to out of time complaints while managing in-time complaints.

Members received a detailed update on complaint outcomes, with 25% of stage 1 and 17% of stage 2 complaints fully upheld. There were 13 referrals to the Scottish Public Services Ombudsman (SPSO) in quarter 4. For the 16 reported in the previous quarter, two had

progressed to investigation. The report detailed complaint themes and sub themes which were similar to previous reports.

Care Opinion remained the main source of feedback. 149 stories had been shared in Quarter 4, with 74% of these completely positive and they had been read more than 13,000 times.

For complainant satisfaction, following feedback from members, the run charts provided at Appendix 3 had been updated. Areas of focus for the team from this feedback included keeping people up-to-date during the handling of their complaint and people agreeing with the outcome of their complaint.

The Director of Acute Services, Vicki Campbell, reiterated that the Director of Clinical and Care Governance, Geraldine Jordan, had done significant work with the team and there had been six complaint focused business led meetings to discuss. It had been agreed that a test of change would take place in one service area which would be given ownership of the complaint handling process to completion, recognising that an increasing number of complaints related to waiting times.

Committee members commended the complaint handling improvement work being done, in particular the improved performance in relation to stage 2 complaint handling performance since the end of 2024. Ms Jordan advised in reply to questions from members that there were various options for keeping complainants updated on the progress of their complaint and any delays, including via e-mail and telephone contact. She and the Nurse Director had oversight of all stage 2 complaint responses to ensure they adopted a person-centred approach. Ms Jordan would discuss patient communication and how to manage patient expectations in relation to waiting times with the Director of Acute Services and Head of Access and an update would be circulated to members. **GJ/VC**

In reply to a question from a member, Ms Jordan explained that should a complaint be converted to a significant adverse event review (SAER), there may be elements of the complaint which still had to be managed through the complaint process and both processes could run in parallel which could impact complaint numbers. The team had improved the process for converting a complaint to an SAER, with the complainant being advised and given a single point of contact, which would help overall complaint handling performance.

Members requested that in future reports the data chart on the number of out of time complaints should state the number of weeks they are overdue if over 40 days, as well as the percentage of complaints resolved within the timeframes provided in the chart.

Outcome: Committee members noted organisational activity in relation to patient, carer and family feedback and complaints in Quarter 4, noted compliance with the complaint handling process and controls and

mitigations in place to improve the current position.

5.2 **Scottish Public Services Ombudsman (SPSO)**

The Director of Clinical and Care Governance, Geraldine Jordan, presented a summary of SPSO cases part or fully upheld that met SPSO criteria for closure between April 2024 and May 2025.

Since April 2024, there had been one case closed by the Ombudsman. This case related to care provided by emergency and medical services at University Hospital Ayr and involved incomplete assessment for injury, discharge process and re-admission. There were no issues identified related to the complaint handling process. Three actions had been identified and the action plan had been completed.

The Director advised in reply to a query from a member that she would include detail of the number of cases referred to SPSO and those to be taken forward to investigation in future reports.

In reply to a question from a member the Nurse Director, Jennifer Wilson, advised that responsibility for progressing clinical actions should follow a triumvirate approach rather than sitting with an individual and she would take this forward offline. **JW**

Outcome: Committee members noted the summary of SPSO cases part or fully upheld that were closed between April 2024 and May 2025.

5.3 **Patient Experience – HMP Kilmarnock**

Martin Egan, Senior Manager, Justice Services, provided an update on patient experience and quality of care following transfer to Scottish Prison Service (SPS) on 17 March 2024.

Mr Egan provided a detailed update on areas of challenge since the transfer to SPS related to the level of engagement and communication with local managers in progressing issues related to healthcare services; increased prison population and impact on delivery of healthcare; challenges due to the daily timing of the prison regime and changes to prison staff and impact on delivery of healthcare services; and challenges related to the physical facilities for delivering healthcare services. Discussion was ongoing with SPS and the Prison Governor who had submitted a range of priorities for spending in the prison. There was a need to agree where healthcare would sit in these priorities.

Members were advised of positive improvement work that had taken place since the transfer. To address challenges due to changes to the daily timing of prison regime and ensure patients got their medication at the appropriate time, a successful project had been implemented from December 2024 which had significantly reduced workload in delivering medicines, with positive benefits for those in

the care of the prison taking responsibility for managing their medication and healthcare with support. There had been no adverse events in relation to the change and nationally other prison establishments were looking at options to introduce similar schemes.

The prison healthcare team was delivering Medication Assisted Treatment (MAT) Standards, including proactively following up and meeting people with substance misuse support needs. Delivery of Mental Health services was one of the most significant healthcare needs and the team had successfully introduced mental health practitioners and self-help workers in prison following a prevention and early intervention approach. A Psychologist was being recruited which would have a significant positive impact to the prison healthcare team.

The prison had been inspected by HM Inspectorate of Prisons for Scotland (HMIPS) in May 2025 and there had been positive verbal feedback on progress made to deliver improvements to patient care in prison. A draft report was expected in July 2025 and the report would be published in September 2025.

Mr Egan advised in reply to a question from a member that HMP Kilmarnock was a national resource and while the majority of the prison population was from Ayrshire, there would be a significant number from other areas, and NHSAA was responsible for covering all healthcare costs. The medicines budget was one of the most significant cost pressures due to the high number of patients on Opiate Substitution Therapy.

The Chair requested that the published HMIPS inspection report be presented to the Committee when available. **CMcA**

Committee members thanked Mr Egan for his strong leadership and commended the whole team for the good work being done and improvements made in difficult circumstances.

Outcome: Committee members noted the update on patient experience and quality of care at HMP Kilmarnock. Members looked forward to receiving a further update on the HMIPS inspection report when available.

6. Patient Safety

6.1 Healthcare Associated Infection (HAI) report

The Director of Infection Prevention and Control, Jincy Jerry, provided an update on Board's performance with the HAI Standards.

For Clostridioides difficult infection (CDI), the verified rolling annual rate for year ending December 2024 was 19.2, an increase from 14.4 compared to the previous year and the Board was above the Scottish rate and local target. There were 13 hospital acquired episodes across nine wards, with one confirmed outbreak involving two cases.

A CDI trigger tool was completed for this and a report provided to committee in January 2025. Nationally, there had been an increase in CDI across all Boards.

The verified annual rolling rate for Staphylococcus aureus bacteraemias (SAB) for year ending December 2024 was 23.8, an increase from 19.3 compared to the previous year. The Board had been an outlier in the previous quarter and a number of measures had been introduced. The quarterly rate had reduced to 27.2 from 33.0 in the previous quarter which was below the 95% confidence interval upper limit and above the Scottish rate. The Director reassured members that everything possible was being done to reduce SAB rates.

For E coli baceraemia (ECB), the verified rolling annual rate for year ending December 2024 was 43.2, a slight increase compared to the previous year. The Board had been an outlier in relation to community acquired ECB for the last three quarters, with some other larger Boards having reported a significant reduction in rates. Locally, the rate had remained reasonably stable over the last three years. Exception reports had been received in quarter 1 and 2 and support had been sought from Antimicrobial Resistance and Healthcare Improvement (ARHAI) Scotland to better understand the epidemiology within NHSAA. A multi-agency short life working group had been set up and collaborative work was ongoing to identify and target improvements within the community to reduce rates.

Outbreaks of COVID-19 continued to occur across Scotland. The Board had dealt with 22 COVID-19 outbreaks in quarter 2. There were two outstanding non-respiratory outbreaks, with an outbreak of ESBL Klebsiella pneumoniae which had recently been closed and an ongoing outbreak of Aspergillus which it was hoped would close soon as there had been no new cases. The report detailed the key learning and actions being taken in response to these outbreaks. Members requested that future reports provide the dates of outbreaks.

The Nurse Director advised in reply to a question from a member that the Board took on board shared learning from other areas where there had been improved performance. However, there were a number of factors that were out with the Board's control and which it was not able to influence, for example, the ageing hospital estate which did not provide ideal bed space, as well as high bed occupancy rates. She highlighted the work being done by the team to provide ventilation in clinical areas and plans for e-surveillance of HAI data which would have a positive impact and enable targeted improvement activity.

Outcome: **Committee members noted the Board's performance with the HAI Standards. Members noted the summary of outbreaks and key learning and actions being taken in response to improve patient care.**

6.2 Quality and Safety report – Learning Disabilities (ward 7A)

The Associate Nurse Director and Lead Nurse for NA HSCP, Darren Fullarton, provided a report on quality and safety issues in Learning Disabilities (LD) Ward 7A at Woodland View Hospital, improvement actions in place to mitigate areas of concern and challenges, and options for closure of Ward 7A at this time.

Mr Fullarton advised that Ward 7A provided pan-Ayrshire services for adults with learning disabilities. Unfortunately, the assessment and treatment model that had been developed had not been provided in ward 7a for a number of years and the ward was currently operating as a continuing care unit for learning disabilities due to a number of factors which were outlined in the report.

Despite the efforts of leadership and the multi-disciplinary team, there had been a sustained high level of violence and aggression incidents. Following a significant incident of violence and aggression in November 2024, weekly risk meetings had been taking place to focus on emerging areas of risk. As the level of risk had not reduced, the leadership team had made a decision in May 2025 to close the ward and transfer patients over the coming weeks.

In reply to questions from members, Mr Fullarton advised that all incidents of violence and aggression were recorded on the datix incident recording system, with data provided in the report. He confirmed that for patients transferred to other mental health wards, incidents of violence and aggression would be documented and reviewed weekly and advice offered on other measures required to mitigate risk. He highlighted the workforce recruitment and retention challenges faced and advised that nationally there was a shortage of LD nurses. The service was able to access staff from the wider mental health workforce as well as the nurse bank and agency to support the workforce as required. LD nurses would follow the patients to mental health wards to which patients are boarded to provide clinical expertise in the ward. Whilst this was not the preferred option for these patients, it was not possible to manage the current level of risk in ward 7A.

Mr Fullarton confirmed that all incidents of restraint were recorded, however, due to the way this was currently recorded it was difficult to specify the length of time. A new policy “From Observation to Intervention” had recently been implemented within Mental Health services involving clinical pause, with use of restraint only if absolutely necessary. He advised that managers would continue to monitor sickness absence rates, including staff impacted by the changes being made, working collaboratively with staff side colleagues and the staff group to address any concerns raised. A communication plan had been developed and would be issued shortly.

The Head of Mental Health services, Thelma Bowers, advised that monthly meetings continued with Scottish Government and Ward 7A had been discussed regularly in terms of areas of risk and

challenges. Transformation work had been ongoing over the last 18 months looking at a future service model. She assured members that LD acute assessment continued at Woodland View, with a number of people in acute adult mental health wards receiving care and treatment who should have been in ward 7A, although this did reduce capacity across the whole acute site for mental health and LD. As part of the process to close Ward 7A, a detailed equality impact assessment (EQIA) was being developed involving advocacy and an engagement plan would be worked through with key stakeholders.

The Director of Acute Services, Vicki Campbell, reiterated the impact on inpatient capacity as a result of patients awaiting a complex care package before they could be discharged, and an increase in the number of patients requiring one to one care. Teams were working to support discharge and escalate any issues as required. The position would be monitored through the EQIA process in terms of the impact across all sites.

The Nurse Director, Jennifer Wilson, advised that the patients currently in Ward 7A should be living in their own homes and enjoying life outside of the hospital environment. It was important to put their requirements first, including ensuring out of area patients are transferred back to their own area. She supported the decision taken to close ward 7A and plans to progress EQIA and keep Scottish Government and MWC updated. She emphasised that staff were doing their best, with positive feedback from MWC on their last visit to ward 7A.

Committee members recognised that this was an evolving situation and requested that a further assurance report on progress be provided at the next Committee meeting. **CC/DF**

Outcome: Committee members noted the assurance report on improvement actions in place to mitigate concerns and challenges and noted options for closure of Ward 7A at this time. Members looked forward to receiving a further assurance report on progress at the next Committee meeting.

6.3 **Quality and Safety report – Maternity services**

The Head of Midwifery, Alexa Foster, provided an assurance report on quality and safety work in Maternity services against the four quality pillars:

- Quality Planning
  - Healthcare Improvement Scotland would be inspecting all Maternity services during 2025 and the Board was proactive in readiness and mock inspections had taken place.
  - NHSAA was playing an active role in development of a national workforce tool and workforce standards.

- Quality Control

- Infection prevention and control (IPC) - Women and Children's Services had commenced the submission of the IPC report on a quarterly basis. There had been no major outbreaks over the last 12 months.
- Training figures for the Scottish neonatal resuscitation course (SNRC), mandatory role specific training for midwives and neonatal nurses, showed a steady increase in uptake and there were plans to increase further.
- Work was taking place to improve performance in the completion of staff personal development plans and personal development reviews.
- Lanarkshire fatal accident inquiry – there had been local benchmarking against recommendations and a report would be provided in due course.

- Quality Assurance
  - Complaint handling – discussed weekly with trend analysis.
  - Maternity adverse events – discussed weekly with trend analysis

- Quality Improvement
  - Scottish Patient Safety Programme Perinatal Collaborative and Excellence in Care data provided in the report. In terms of maternity early warning score and post-partum haemorrhage recording, both measures showed positive data.

The Nurse Director, Jennifer Wilson, thanked the Midwifery Director and Head of Midwifery for the work being done with the team in preparation for the HIS inspection.

Members commended Maternity services for the proactive improvement approach being taken more widely, taking on board learning from issues identified in other areas. Members requested that compliance data on areas for improvement in the Ayrshire Maternity Unit be presented as a table rather than 3d chart in future reports.

Ms Foster advised in reply to a question from a member that around a third of midwives were aged over 55 years. Workforce planning was ongoing, with appointment of newly qualified midwives on two-year fixed term contracts to develop them into the role. Ms Wilson underlined the importance of the succession planning approach being adopted locally, including over-recruitment to some roles, to mitigate expected workforce challenges in the next two to three years. Members noted that similar workforce challenges were facing a number of professions and there was a need for a coordinated national approach to workforce planning.

Outcome: Committee members noted the assurance report on quality and safety work in Maternity services.

6.4 **COVID-19 Inquiries update**

Ms Carly Wylie, Public Inquiries Coordinator, provided an update on the status of the UK and Scottish COVID-19 Inquiries.

The UK Inquiry was almost halfway through the 10 modules, with modules one to five and seven now concluded. Since publication of the module one report in July 2024 there had been no further reports published by the Inquiry and there was no agreed timeline for other reports to be published. There had been indications that module three, impact of the COVID-19 pandemic on Healthcare Systems, could be expected in 2026 and the report's recommendations may directly impact Scottish territorial boards. Module six, impact on the Care Sector, would be taken next, with evidential hearing beginning on 30 June 2025. Modules eight and nine would take place later this year and module 10 next year. That would conclude the evidential hearing process of the Inquiry.

The Scottish COVID-19 Inquiry was taking a different approach, with a focus on impact hearings, with evidence from patients, families, charities and representative groups, covering Health and Social Care; Education and Young People; Finance, Business and Welfare; Justice Services; Worship and Life Events. Equalities and Human Rights impact hearings would run from 10-20 June 2025. Once all impact hearings had concluded there would be an announcement on next steps, particularly the approach next year.

Members received assurance that the Board had met all deadlines for information. Ms Wylie thanked all directorates and services that had provided information. She advised that quarterly reports on the Inquiries continued to be provided to the Corporate Management Team, with exception reporting as required.

Outcome: Committee members noted the report and received assurance that the Board had the required systems in place to comply with the requirements of the UK and Scottish COVID-19 Inquiries.

6.5 **Operation Koper**

Ms Sandra Ferrol, Litigation Manager, provided an update on ongoing investigations of COVID-19 related deaths in care settings and assurance that required systems are in place to respond to and comply with Operation Koper.

Ms Ferrol highlighted that Central Legal Office costs for Operation Koper and the COVID-19 UK and Scottish Inquiries were split between the Boards in the cohort, with NHSAA's proportion of the cost amounting to £54,987 as at 31 March 2025. Members recognised that there were further costs to the Board which had not been quantified related to the significant time and effort required by staff in responding to Operation Koper and both Inquiries.

Ms Ferrol advised in reply to a question from a member on the impact on individual staff that investigations were being taken forward and information provided on a team basis. A small number of clinicians had been asked to provide a formal statement based on an individual patient and these staff had been supported to do this. The Nurse Director, Jennifer Wilson, advised that as this work moved forward, should there be an impact on Care Home staff, the Care Home Professional Support Team had pastoral support available. She emphasised that staff had made decisions based on information available at the time, with this often changing rapidly. This was an area that had already been picked up by the Inquiries in terms of learning for a future pandemic. The Director of Acute Services, Vicki Campbell, advised that the Board had robust governance in place during the pandemic and clearly documented decision-making logs which were being used to respond to requests for information so there was less reliance on individual feedback.

Outcome: Committee members received a report for assurance that the Board had the required systems in place to respond to and comply with Operation Koper.

7. Quality Improvement

7.1 Quality and Safety Walkrounds

The Director of Clinical and Care Governance, Geraldine Jordan, provided an update on quality and safety walkrounds within NHSAA from March 2025.

The Director outlined the quality improvement approach adopted to inform redesign and refresh of quality and safety walkrounds which were relaunched within NHSAA in May 2025, with the aim for 80% of all planned walkrounds to take place by December 2025. Directors had advised of all areas to be visited and there was a good balance between clinical and non-clinical walkrounds. Four walkrounds had been scheduled between May and the current date and all had gone ahead with no cancellations. A flexible approach was being adopted to provide cover for colleagues unable to join walkrounds. The Director thanked Non-Executive Board Members who had taken on additional work to provide cover.

Members commented that the quality and safety walkrounds workshops held in April 2025 had been worthwhile and informative and the new arrangements appeared to be working well. Members commended the commitment of staff and teams in taking forward this improvement work. The Director of Acute Services, Vicki Campbell, advised that staff were keen to be involved in these walkrounds and there was good support from senior leadership. Both she and the Nurse Director highlighted the positive impact of recent walkrounds for teams working in the area and thanked colleagues for their support.

Outcome: Committee members noted progress with quality and safety walkrounds following the relaunch in May 2025.

8. Corporate Governance

8.1 Minutes

8.1.1 **Acute Services Clinical Governance Group** – Members noted the draft minutes of the meeting held on 3 April 2025.

8.1.2 **Area Drug and Therapeutics Committee** – Members noted the approved minutes of the meetings held on 13 January and 10 March 2025.

8.1.3 **Paediatric Clinical Governance Group** – There were no minutes to report.

8.1.4 **Prevention and Control of Infection Committee** – There were no minutes to report.

8.1.5 **Primary and Urgent Care Clinical Governance Group** – Members requested that more detailed minutes of the meeting held on 29 April 2025 be provided for assurance. **JW**

8.1.6 **Research, Development and Innovation Committee** –There were no minutes to report.

9. Risk

9.1 Healthcare Governance Committee Strategic Risk Register

The Director of Clinical and Care Governance, Ms Geraldine Jordan, presented the latest version of the Healthcare Governance risk register. The report had been discussed in detail at the Risk and Resilience Scrutiny and Assurance Group (RARSAG) meeting on 25 April 2025.

There were four risks assigned to the committee. All four risks had been reviewed and there was no change to risk scores. Additional narrative was provided for updates undertaken in other areas, as detailed in the report. There were no risks for termination. Two new risks had been developed and agreed at RARSAG. Members requested that the high level summary chart be updated to reflect the current very high risk rating for risk ID 767.

There was a new risk related to Ventilation within the oncology ward at University Hospital Crosshouse. The Assistant Director, Estates and Support Services, Helen Gemmell, outlined the background and range of control measures in place to mitigate the risk. Control measures had been updated since the report was written and these updates would be included as part of the next review. Members were assured that everything possible was being done to manage the risk to immunocompromised patients, particularly given the potentially

high levels of Aspergillus present in the environment surrounding the hospital site.

Risk ID 884 – Provision of effective surveillance of infections – this had been proposed as an escalated strategic risk having previously been on the Nurse Directorate's operational risk register. The Nurse Director, Jennifer Wilson, advised that as a business case had now been approved, once e-surveillance is in place the risk should be able to be removed from the strategic risk register.

Ms Jordan advised in reply to questions from members that the risk related to Learning Disability Ward 7A was currently on the operational risk register which was appropriate at this time given the risk was being treated. She would meet with the Head of Mental Health Services and Lead Nurse for NA HSCP to discuss how the risk should be managed in the future. Members requested that the further assurance report on Learning Disability Ward 7A to be provided at the next meeting should also include the operational risk register for Ward 7A given the challenges and the need for the ward to return to its intended purpose as an acute assessment area for people with Learning Disability. **CC/TB/DF**

In reply to a question from a member, Ms Jordan advised that the team would review governance and risk management arrangements in relation to prison healthcare and report back at a future meeting. **GJ**

Outcome: Committee members noted the risk register report and took assurance from the work being done to manage strategic risks which fall under the Committee's remit.

9.2 **Significant Adverse Event Review (SAER) Quarter 4 report**

The Director of Clinical and Care Governance, Geraldine Jordan, provided an update in relation to the position and performance of the management of SAERs and action plans within NHSAA.

A detailed update on improvement plans was provided at Appendix 1. Since the last report, 36 SAERs had progressed through the initial approval stage which demonstrated significant progress. The report detailed progress with 52 overdue SAERs and improvement plan recommendations. Appendix 4 provided a summary of completed SAER reports/action plans.

The Director provided a presentation to update on progress against the eight key performance indicators that had been developed to enable the Committee to monitor progress in the completion of SAERs.

The Nurse Director, Jennifer Wilson, welcomed the report and information provided. She recognised that staff were working hard to complete SAERs and it was encouraging to see some signs of recovery. Ms Jordan advised in reply to questions from members that discussion had taken place at national level on the newly revised

national framework and while the Board had raised KPI targets the timescales had not been changed. National work was ongoing to standardise the SAER process across NHS Scotland. She highlighted the system pressures facing clinical staff and the focused improvement approach being taken working with teams, particularly those facing system pressures, to ensure timely completion of SAERs. A workshop was planned later in June 2025 with triumvirates and managers to enable focused discussion and consider how to work together to improve SAER performance.

The Nurse Director, Jennifer Wilson, clarified that for some SAERs there could be nuances, for example, related to Procurator Fiscal investigations which meant that the SAER could not be completed in parallel to the investigation. Members suggested that future reports provide narrative for the reasons behind such delays. Ms Wilson clarified in reply to a question from a member that the decision to undertake a local management team review or SAER was undertaken by the Adverse Event Review Group following clear criteria set out in the HIS adverse event framework and both she and the Medical Director reviewed the decision.

Outcome: Committee members noted the SAER Quarter 4 report and accepted assurance that appropriate governance is in place for these reviews, and that action plans have been scrutinised by local Directorate governance groups with multidisciplinary attendees.

9.3 **Healthcare Improvement Scotland Adverse Event National Framework Summary report**

The Director of Clinical and Care Governance, Geraldine Jordan, provided an overview of the revised HIS National Framework for Reviewing and Learning from Adverse Events in Scotland. The revised framework was published in February 2025.

The report outlined significant changes made to the framework. Locally, an action plan would be developed with timescales and identified owners for the actions required to incorporate the updates in the framework to NHSAA policy and processes.

The Director highlighted that HIS planned to publicly report on Boards' significant adverse event performance and to establish a national approach for consistent identification of significant adverse events by 2026. In the meantime, NHSAA would continue work to improve performance in responding to SAERs.

The Director advised in reply to a question from a member related to the addition of a patient/family involvement chapter that NHSAA already had good systems in place for staff to engage with the patient/family during the review, and a key contact was given to the patient/family and contact maintained during the review. The Director confirmed that future reports will provide timescales for actions required.

Outcome: **Committee members acknowledged the revised framework and supported the actions identified to incorporate the updates to local policies and procedures**

9.4 **Risk issues to report to the Risk and Resilience Scrutiny and Assurance Group**

Members noted and accepted the two new Healthcare Governance risks assigned to the Committee. Members wished to highlight the discussion on Learning Disability Ward 7A and it was expected that RARSAG would discuss the current challenges, areas of risk and mitigations.

10. Points to feed back to NHS Board

10.1 As approved minutes from this meeting will be available for the Board meeting on 11 August 2025, a Chair's report will not be required.

11. Any Other Competent Business

11.1 There was no other business.

12. Date and Time of Next Meeting

The next meeting was scheduled to take place on Tuesday 29 July 2025. The Committee Chair requested that due to several members being on annual leave the meeting be moved to Monday 4 August 2025 at 9.30am, in Room 1, Eglinton House, Ailsa

Signed by the Chair, Linda Semple Date: 4 August 2025