Approved by Committee on 3 November 2025

Healthcare Governance Committee
Friday 5 September 2025 at 9.30am
Hybrid Meeting Room 1, Eglinton House and MS Teams meeting

Present:

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

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

In attendance:
Ms Sally Amor, Public Health Consultant, Inclusive Health item 10.2
Ms Bobbie Coughtrie, Screening Improvement and Development Manager item 10.3 + item 10.4
Ms Jincy Jerry, Director of Infection Prevention and Control item 6.1
Ms Lynsay Lawless, Associate Director of Pharmacy item 10.7
Ms Rosalyn Morrin, Public Health Lead, Sexual Health item 10.5
Ms Jennifer Reid, Senior Programme Manager, Mass Vaccinations item 10.8
Ms Marie Richmond, Assistant Director, Digital Services item 7.2
Ms Diane Smith, Improvement and Development Manager for Screening, item 10.6
Ms Karen Smith, Transfusion Practitioner item 10.9
Ms Attica Wheeler, Midwifery Director, Associate Nurse Director, Women & Children's Services item 6.2
Mrs Angela O'Mahony, Committee Secretary (Minutes)

1. Welcome / Apologies for absence

1.1 The Committee Chair, Linda Semple, welcomed everyone to the meeting. The agenda was re-ordered slightly to allow colleagues joining to present their papers.

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

1.2 **Appointment of Committee Vice Chair** – Committee members unanimously supported Sharon Morrow's nomination as Committee Vice Chair with immediate effect.

2. Declaration of any Conflicts of Interest

2.1 There were no conflicts of interest declared.

3. Draft Minute of the Meeting held on 4 August 2025

3.1 The Minute of the meeting held on 4 August 2025 was approved as an accurate record of the discussion, subject to the following changes being made:

Item 4.1, the update should have read:

- **Item 9.1 (09/06/2025), Strategic Risk Register** - Director of Clinical and Care Governance, Ms Geraldine Jordan, updated the Committee that the Prison and Police Custody Clinical Governance Group reports into the East HSCP Clinical Governance Group. The risk from prison are included in papers for East HSCP Risk Management Group. There are 4 risks currently identified, the risk management advisor has met with the Clinical Service Manager to review and update the risks. Further risks have been identified by the service and they are currently being supported to develop these.

Item 5.4, last paragraph should have read:
Ms Geraldine Jordan advised in relation to the HSMR national model obstetrics and psychiatry are excluded from reporting numbers.

4. Matters arising

4.1 The action log had previously been circulated to members and all progress against actions was noted. The following updates were provided:

- Item 9.1 (09/06/2025), Strategic Risk Register – members noted the update on Prison governance risk reporting arrangements at strategic and operational level.
- Item 5.1 (04/11/2024), Patient experience themed report, clinical treatment, update on CAMHS performance – Work ongoing with the Head of Corporate Governance to schedule a report for a future Committee meeting and onward reporting to the NHS Board. Submission date to be confirmed.

4.2 The Committee noted the draft work plan for 2025/26.

The Nurse Director, Jennifer Wilson, advised that as part of the ongoing governance review, it was likely that a number of the reports currently provided to this Committee, including Public Health screening reports, would in future be submitted to the proposed new Board Population Health Committee. This would enable Healthcare Governance Committee to have greater focus and deeper discussion in relation to clinical care, safety and quality. Committee members would be kept updated of progress.

5. Patient Experience

5.1 Patient Experience themed report - Communication

The Director of Clinical and Care Governance, Geraldine Jordan, presented the first in a series of themed reports exploring complaint themes and sub-themes.

The report reviewed complaints received between August 2024 and July 2025. During this period, communication or staff attitudes and behaviours were identified as a theme in 703 complaints, compared to 504 in the previous series, with 44% of the total number of complaints related to this theme.

Members received an update on common areas for complaints on this theme, for example, keeping patients and families updated on their care and treatment, discharge and shared decision-making. The Quality Improvement Lead was linking with colleagues across the system to try to promote understanding of the wider impact.

The Director highlighted some of the areas for improvement and learning being taken forward as outlined in the report. For example, development of a focused improvement programme to support further implementation of Treatment Escalation Plans across Acute Services. A new training calendar is under development, including sessions on managing difficult conversations, including end of life conversations. Staff continue to be reminded and kept up-to-date on other opportunities to resolve complaints at an early stage.

The Director advised that while there had been an increase in complaint numbers, themes remained consistent. She recognised that 70% of the feedback received via Care Opinion was positive. However, there was a need to continue to focus on improvement efforts and learn from things that had not gone well.

The Nurse Director, Jennifer Wilson, agreed in reply to comments from members that organisational culture started at Board level and it was important to live these values and behaviours. She advised that this linked to the People Strategy and the work being done currently on workplace culture. She and the Medical Director had recently had a walkround of the Staff Wellbeing Suite to see the excellent facilities being provided. She highlighted the work being done by the Staff Care and Wellbeing Team in relation to intelligent kindness. All of this work linked to other strategies being progressed across NHSAA. Members were supportive of the culture work being done and also considered the concept of civility. The Director would consider how these approaches could support staff and teams in progressing patient experience improvement work going forward.

Members acknowledged the whole system improvement work taking place and future plans to triangulate adverse event, quality and safety and feedback and complaints activity in Governance Committee **JW**

reporting. Members requested that an update on this work be provided at a future meeting.

Outcome: Committee members noted the first in a series of themed reports exploring themes and sub-themes, related to communication, staff attitudes and behaviours.

5.2 **Patient Experience Quarter 1 report**

The Director of Clinical and Care Governance, Geraldine Jordan, presented the Patient Experience quarter 1 report and performance in responding to patient, carers and family complaints.

The Director advised that there had been a slight increase in Stage 1 and Stage 2 complaints over this quarter but the position had been relatively stable over the last 12 months. Performance in responding to Stage 1 complaints had decreased to 77% against the 85% target. This was as a result of workload within both the Complaints team and wider services. For Stage 2 complaints, despite relentless focus, performance had reduced significantly to 48% this quarter. Focused work is taking place to develop further improvement approaches.

The Director provided an overview of out of time complaints, the majority of which are in Acute Services. She outlined the targeted improvement work being progressed, working in collaboration with the Director of Acute Services to clear the backlog.

The report detailed Scottish Public Services Ombudsman (SPSO) activity. There were three referrals that had progressed to investigation. Once closed, these would be reported to the Committee for assurance. 79% of Care Opinion feedback received was relatively positive.

The Director advised in reply to a question from a member about the increase in prison complaint numbers that she would work with the Complaints team to understand if any themes had been identified and provide and update in the action log. **GJ**

The Nurse Director, Jennifer Wilson, recognised and thanked Geraldine Jordan, the Director of Acute Services and team for the focused improvement work being done to clear the backlog which should enable staff to better manage complaints at operational level. She underlined the need to maintain a supportive approach given the pressures facing staff across the system.

Committee members thanked the team and supported the focused improvement work taking place.

Outcome: Committee members noted organisational activity in relation to patient, carer and family feedback and complaints in Quarter 1, and noted compliance with the complaint handling process.

6. Patient Safety

6.1 Healthcare Associated Infection (HAI) report

The Director of Infection Prevention and Control (IPC), Jincy Jerry, presented the Board's current position against the national HAI Standards for infection reduction in Clostridioides difficile infection (CDI), Staphylococcus aureus bacteraemia (SAB) and Escherichia coli bacteraemia (ECB). The data remained unchanged from information shared at the previous meeting.

Members also received a summary of outbreaks up to June 2025 and key learning and improvement actions being taken in response to improve patient care.

The Director advised in reply to a question from a member related to a COVID-19 outbreak that staff should use appropriate personal protective equipment (PPE) when caring for COVID-19 patients. For this outbreak, staff were not aware that the patient had received a COVID-19 test. Patients are no longer routinely tested for COVID-19. As soon as the patient was identified as COVID-19 positive the appropriate PPE was worn. The Nurse Director, Jennifer Wilson, assured members that valuable lessons had been learned, including around how to manage future COVID-19 outbreaks. She emphasised the need for Executive level oversight in managing outbreaks.

In reply to a question, the Nurse Director advised that as Ward 4A at University Hospital Crosshouse was not currently available, alternative plans were being considered for decant of Ward 3A to enable remedial works to take place.

The Director IPC advised that winter preparedness plans were underway and training had begun. Following recruitment to the Infection Prevention and Control Team, it should be better able to support clinical teams. It was noted that the Flu vaccination programme had also begun.

Outcome: Committee members noted current performance against the national HAI Standards, as well as the update on incidents and outbreaks that occurred during quarter 1.

6.2 Quality and safety report – Paediatric Services

The Director of Midwifery and Associate Nurse Director, Women and Children's Services, Attica Wheeler, presented the quality and safety report for the Paediatric work stream aligned to the four quality pillars:

- Quality Planning
- Quality Control
- Quality Assurance
- Quality Improvement

The Nurse Director, Jennifer Wilson, highlighted Child Protection concerns about the increase in traumatic head injuries being reported nationally and that ICON training is to be rolled out across Scotland. The Director advised that specific human factors work was taking place in Paediatrics focusing on medication errors, with the aim to link data to improvement work. Attica Wheeler advised that while these incidents were reported via Paediatrics, they may not have occurred within the service. She highlighted the root cause work taking place and other work planned in the next few months related to training, systems and processes. Members supported the targeted work being done to improve the position and requested an update in a future report. She confirmed that details of the positive feedback received in Paediatric services will be included in future reports. **JW/AW**

The Nurse Director advised that the Board was carrying out work to support staff in readiness for the Healthcare Improvement Scotland inspection of Maternity services which was likely to include Paediatrics.

Outcome: Committee members noted the update on quality and safety activity within Paediatric services. Members requested an update on targeted improvement work being progressed at a future meeting.

6.3 **Quality and Safety report – Acute Services**

The Nurse Director, Jennifer Wilson, presented the quality and safety report for Acute Services. The report set out progress with quality improvement activity, complaints and adverse events and described the current status and plans going forward in relation to:

- Falls and falls with harm
- Pressure Ulcers (PU)
- Cardiac Arrest
- National Early Warning Score (NEWS)
- Food Fluid and Nutrition (FFN)
- Excellence in Care (EIC)
- Complaints Performance
- Adverse Event Activity

The Director described the improvement work done by the Director of Clinical and Care Governance and team in collaboration with the Director of Acute Services looking at governance from floor to Board. Structures had been set up in triumvirates from clinical teams to Healthcare Governance Committee and Board. This positive improvement work underlined the scrutiny and grip in these areas, many of which now had quality improvement boards to monitor progress, following the successful approach adopted in Maternity Services.

The Committee Chair, Linda Semple, advised that she had discussed the increase in Pressure Ulcer (PU) rates across both Acute sites with

the Nurse Director. It was recognised that PU was one of the sentinel measures of care and the position would continue to be monitored closely. An in-depth PU report will be provided at a future meeting. **JW/RMcM**

Committee members discussed the relatively low number of nutrition and hydration champions at both University Hospital Crosshouse and University Hospital Ayr. The Nurse Director recognised the considerable activity taking place across the organisation and system pressures in different areas. She advised that there may be a need to re-focus efforts around the role of champions in some clinical areas if required.

The Director of Clinical and Care Governance, Geraldine Jordan, advised in reply to a question from a member about Cardiac Arrest review data that she would provide more detailed information on this within the action log. She emphasised that it was important to get recognition and response right and for shared decision-making, including in relation to do not attempt cardiopulmonary resuscitation (DNACPR), to ensure Cardiac Arrest is treated appropriately. **GJ**

Outcome: Committee members noted the report and acknowledged areas of improvement and ongoing challenges. Members supported continued implementation of local improvement programmes and management of complaints within Acute Services.

7. Quality Improvement

7.1 Quality Strategy evaluation

The Nurse Director, Jennifer Wilson, introduced and invited the Director of Clinical and Care Governance, Geraldine Jordan, to provide an evaluation of the current Quality Strategy and plans to provide a new strategy by March 2026.

The Director outlined the background to development of the strategy and considerable progress made since implementation in 2019, with 90% of the strategy's deliverables currently being delivered or having been delivered in support of the Board's strategic objectives. The Board had agreed an 18-month extension to the strategy and this was now coming to an end. The Director highlighted the focused work done to understand and evaluate the impact of the strategy and plans for development of a future Strategy, building on progress made and any learning identified.

Committee members recognised that despite the pressures facing the organisation, the Board continued to progress improvement work, for example, around governance and management of significant adverse event review systems and processes. Members supported the co-design approach being taken in developing the new strategy, working with people with lived experience, which should give positive results.

Outcome: Committee members noted the evaluation of the current Quality Strategy and plans for development of a future strategy.

7.2 **Digital Strategy update**

The Assistant Director, Digital Services, Marie Richmond, provided a presentation on local progress with the Digital Strategy, in the context of improving healthcare quality and safety.

Members were advised that the Integrated Care Record programme was being re-baselined to ensure all areas were included, with digital patient communication a central objective. Work was taking place with the national team related to digital front door which will be implemented in NHS Lanarkshire from December 2025. NHSAA was keen to be the next Board to implement digital front door. Alternatively, it was proposed to use Netcall. Marie Richmond outlined the benefits of digital patient communication in terms of improved patient experience and access, as well as financial and operational benefits.

In reply to questions from members, Marie Richmond explained that patients would require to sign up to access digital front door. For Netcall, patients would follow a link to access information.

The Chief Executive, Gordon James, highlighted national work ongoing across the public sector, working with Council colleagues, looking at use of patient CHI numbers as a primary key, working across multiple public sector systems, with plans for people to be the custodian of their own records in the future. The Chief Executive assured members that use of digital patient communication was a key area of focus for the Board. He had met with the Chief Operating Officer at NHS Scotland to discuss NHSAA's wish to be the second Board to implement digital front door and he would continue to promote this aim. He emphasised the need for a collaborative approach, working with colleagues at national level, taking on board and sharing learning where appropriate with regional Boards in progressing digital patient communication. He recognised that there would continue to be a need to meet specific requests from patients who still require a letter or additional support to make appointments.

Members agreed that a report be provided to Committee at a later date on the Digital work programme specifically related to clinical safety. **MR**

Outcome: Committee members noted the update on the Digital Strategy, including progress of digital communication with patients.

8. Corporate Governance

8.1 **Minutes** – Committee members noted the minutes of the following meetings:

8.1.1 Acute Services Clinical Governance Group approved minutes of meeting on 3 June 2025

8.1.2 Area Drug and Therapeutics Committee – There were no minutes to report.

8.1.3 Paediatric Clinical Governance Group approved minutes of meeting on 25 April 2025.

8.1.4 Prevention and Control of Infection Committee approved minutes of meeting on 9 April 2025.

8.1.5 Primary and Urgent Care Clinical Governance Group draft minutes of meeting on 29 May 2025.

8.1.6 Research, Development and Innovation Committee draft minutes of meeting on 23 April 2025.

9. Risk

9.1 Healthcare Governance Committee Strategic Risk Register report

The Director of Clinical and Care Governance, Geraldine Jordan, presented the Healthcare Governance strategic risk register. There were two risks reviewed during the reporting cycle, with no changes to risk grading. There were no risks proposed for escalation or termination and no emerging risks to report.

Committee members discussed and scrutinised the risk register. Members requested that an update on Risk ID 921 related to the refurbishment of Ward 3A, University Hospital Crosshouse, be in included in the action log for the next Committee meeting on 3 November 2025. **GJ**

The Nurse Director would discuss mitigations in place related to Risk ID 674, GP sustainability, with the Director of Clinical and Care Governance and provide an update at a future meeting. **JW/GJ**

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

9.2 Significant Adverse Event Review (SAER) Quarter 1 report

The Director of Clinical and Care Governance, Geraldine Jordan, presented a report with progress on all active Significant Adverse Event Reviews (SAERs) and completed action plans for SAERs.

The Director advised that a SAER improvement plan was agreed in January 2025. There had been a total of 50 reports progressed through the initial approval stage. Members received a detailed update on progress with the eight recommendations. Although progress had been made there were ongoing challenges with the process and timescales for some actions had not been fully achieved, with a number of reviews still to complete. It was proposed that the timescale for recommendation 7 be extended to 30 September and recommendation 9 to 31 December 2025 to enable work to take place.

The Director advised that eight SAERs were being presented to members to support closure, with a summary and learning provided in the report's appendices.

The Director updated that there were currently 71 SAERs overdue, 44% of which were at final draft stage. The Director of Acute Services was committed to getting these reviews completed and it would require a shift in priorities for the team to deliver this work.

The report outlined performance data in relation to eight SAER key performance indicators (KPIs) agreed to support monitoring and improvement, with some early signs of improvement.

Committee members acknowledged that while some progress had been made, there were ongoing challenges and concerns related to the backlog of historical SAERs. Members supported plans for a comprehensive review of the SAER process, recognising that behind every case there is a patient or family requiring closure.

The Nurse Director, Jennifer Wilson, underlined the need for organisational grip and focus to complete historic SAERs. Directors were taking a pragmatic and supportive approach in reviewing action plans. Some actions remained open due to factors out with the individual or team's control, for example, the need for investment or a requirement for organisational change. The Director advised that an assurance report detailing progress with SAER and local management team review (LMTR) improvement work will be presented in six months' time. **JW/GJ**

Outcome: **Committee members noted the update and received 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.**
Members looked forward to receiving a further assurance report on progress of SAERs/LMTRs at a future meeting.

9.3 **Adverse Event Review Group annual report**

The Director of Clinical and Care Governance, Geraldine Jordan, presented the annual update on Adverse Event Review Groups' (AERG) activity, improvement arising from this activity and the ongoing development of the Groups.

The Director advised that detailed assurance reports were provided by each Directorate AERG. The reports highlighted a number of themes and areas of good practice covering areas such as governance and structure, communication and transparency, use of technology, review process and learning, monitoring and improvement and representation and collaboration. Themes related to opportunities for improvement included capacity and workload constraints, review quality and consistency, process delays and impact, governance and stakeholder engagement and administrative and coordination challenges. Collaborative work would continue with the Risk Management Team to refine the AERG process.

Outcome: Committee members noted the AERG annual assurance report for 2024/25.

9.4 **Scottish National Audit Programme (SNAP) update**

The Director of Clinical and Care Governance, Geraldine Jordan, provided a summary position of NHSAA's compliance in relation to the 2025 SNAP annual governance process. NHSAA had participated fully in the nine audits within the SNAP programme.

The Director outlined areas where the Board was doing exemplar work, as well as some negative outliers with deviations from the mean on which the Board had to respond to SNAP as part of the national governance process. Areas for improvement identified had been considered through clinician and managerial review. A process was being developed to monitor progress with delivery of SNAP improvement actions and to understand areas of challenge, with Acute Services being the initial area of focus.

Outcome: Members noted the summary position on the SNAP audit and requested an assurance report with progress against actions in six months' time. **GJ**

9.5 **Risk issues to report to the Risk and Resilience Scrutiny and Assurance Group (RARSAG)**

There were no issues to report to RARSAG.

10. Annual Reports

10.1 **Acute Services Clinical Governance Annual Report**

The Director of Acute Services, Vicki Campbell, presented the annual report and highlighted the following areas:

There had been a comprehensive review of Acute Services Clinical and Operational Governance arrangements, with additional control measures in place to ensure enhanced oversight since November 2024 (Acute Services Operational Board)

The Acute Services Clinical Governance Review involved a complete review of remit, membership, meeting format, reporting, terms of reference and annual work plan.

The report set out successful work on Falls reduction at both Acute sites, compliance with Stage 1 complaints and a range of improvements across Planned and Unscheduled Care, such as expansion of robot assisted surgery, improved ambulance handover times and progress to reduce length of patient stay.

Areas of challenge related to worsening PU position, with an increase at both Acute sites, the significant backlog in Stage 2 complaints, LMTRs and SAERs, high occupancy rates and ongoing risk at both front doors and ward areas due to challenges with delayed discharges.

Next steps would include priority work to reduce patient harm and improve outcomes, address the SAER/LMTR backlog, improve complaint handling response times, delivery of the 2025/26 Unscheduled Care Improvement Plan and a range of improvements to be delivered across Planned Care.

10.2 **Gender Based Violence Annual Report**

Sally Amor, Public Health Consultant, Inclusive Health, presented the GBV annual report 2024/25.

She highlighted the profound and enduring impact of GBV on the physical, sexual and mental health of women while shaping the way children grow and develop within family and community life. The GBV action plan 2021/26 focused on strengthening and increasing capacity across the Board area to respond and support those experiencing GBV. The report detailed successful areas of work, areas of challenge and next steps.

Committee members sought clarity in relation to integration of the Navigator service provided in ED with the GBV group, as well as data related to uptake of the Smile On service in North West Kilmarnock area. An update will be provided in the Committee's action log. **JW/SA**

10.3 **Abdominal Aortic Aneurysm (AAA) Annual Report**

Bobbie Coughtrie, Screening Improvement and Development Manager, presented the AAA screening annual report. All men aged over 64 years were invited to participate in the screening programme. There was high screening uptake and performance in NHSAA, with 99.9% of eligible men invited for screening. There had been a marked improvement in quality assurance, attributed to the

introduction of advanced ultrasound equipment and enhanced QA leadership.

There were challenges related to the persistent health inequalities faced. Despite overall higher uptake, men from the most deprived areas were less likely to attend screening but more likely to be diagnosed with an aneurysm. There had been targeted campaigns and digital outreach to address this, with nine self-referrals made since March 2025, and this work would continue. There were challenges in timely treatment and workforce pressures, including limited vascular consultant capacity, which were reflected across Boards. Work would continue to improve the position and to support national workforce planning.

Members sought clarity in relation to the RAG status of KPI data on eligible screening population provided in Appendix 3. The Chief Executive emphasised the need for a regional approach to address Vascular workforce issues. Members sought an update on progress in six months' time. **LMcN/BC**

10.4 **Bowel Screening Annual Report**

Bobbie Coughtrie, Screening Improvement and Development Manager, presented the Bowel Screening annual report. She reported strong uptake and performance, with 65.3% of eligible residents participating in screening, which exceeded the national standard and was close to the Scottish average of 65.7%. There had been 143,457 invitations sent, with 2,859 positive results and 132 confirmed colorectal cancers detected. 66.4% of screen-detected cancers were found at early stages, supporting better prognosis and treatment outcomes.

There were equity challenges, with uptake remaining lower in deprived areas among men, despite improvements and targeted campaigns and digital outreach were being used to address disparities.

10.5 **Cervical Screening Annual Report**

Rosalyn Morrin, Public Health Lead, Sexual Health, presented the Cervical Screening annual report. Coverage for cervical screening continued to be higher than the national average in 2023/24 at 66.8% compared to 63.3% Scotland wide. Coverage was highest in the least deprived areas. There had been a reduction in colonoscopy routine waiting times from 20 weeks to two to four weeks which was within HIS recommendations.

10.6 **Diabetic Eye Screening (DES) Annual Report**

Diane Smith, Improvement and Development Manager for Screening, presented the DES annual report. She advised that diabetes presented a serious health challenge for NHSAA. The number of people with a diagnosis of diabetes locally in 2023 was 28,032, a net increase of 1,110 since 2022. Uptake of successful screening rose

from 65.1% in 2024 to 71% in 2025. The programme continued to pursue additional Health Board provision to address inequalities and increase resilience, with DES provision in Dalmellington and Girvan and further outreach in advanced planning for Millport.

10.7 **Antimicrobial Prescribing and Stewardship annual update**

Lynsay Lawless, Associate Director of Pharmacy, Primary and Community Care Pharmacy, presented the Antimicrobial Prescribing and Stewardship annual report. The report set out the Antimicrobial Prescribing Group's (AMG) progress against plans to reduce total antibiotic use by 5% from 2019 baseline and 70% of total use of antibiotics from the Access category across the human healthcare system by 2029.

2024/25 Acute care prescribing of antimicrobial groups in the report was in line with national trends. Trends in total and 4C antimicrobial use in Primary Care in 2024/25 had improved but further work was required to align with the Scottish average. Project work was taking place in outlier practices in Primary Care to target areas of high 4C antimicrobial prescribing and all these practices had demonstrated improvement. NHSAA's use of ultra-broad spectrum agents remained lower than neighbouring Boards. A supervised learning event was hosted by AMG in November 2024 to raise awareness of new antimicrobial prescribing indicators.

10.8 **Immunisation Programmes**

Jennifer Reid, Senior Programme Manager, Mass Vaccinations, Public Health, presented the Immunisation Programmes annual report.

Members received assurance that there was strong governance in place for immunisation programmes locally and all involved strived to maximise timely update. Uptake of adult pneumococcal and routine shingles vaccination had improved and targeted catch up work was being done to reach those who had not yet been vaccinated. 91.3% of pregnant women had been vaccinated against pertussis, the highest uptake in Scotland.

There were challenges due to the gradual decline in childhood immunisation uptake across Scotland and work was taking place to try to reverse the decline. Next steps included strengthening the role of quality improvement in local planning and implementation of vaccination programmes. There were forthcoming changes to vaccination programmes and while Scottish Government would fund vaccinations there was no funding for delivery of service costs. The service would need to seek funding or work differently to deliver new programmes being implemented.

Members underlined the need for strong communication on the importance of vaccination programmes given the low uptake in some areas.

10.9 **Scottish National Blood Transfusion Service (SNBTS) Blood Transfusion Annual Report**

Karen Smith, Transfusion Practitioner, provided the SNBTS annual report. The report outlined successful work carried out related to transfusion education, infected blood inquiry recommendations and patient blood management. There were areas of challenge related to availability of KPI training data, delays to update transfusion policies and local IT affecting the stability of the SNBTS clinical dashboard. Members sought an update on progress in these areas at a future meeting. **CMcG/KS**

A high level summary of next steps was provided. Karen Smith highlighted that business continuity would be delivered through maintaining compliance with the UK Blood Safety and Quality Regulations, national KPI targets and participation in all national audits as directed by the Scottish National Blood Transfusion Committee.

Outcome: Committee members noted the suite of annual reports, successful work done over the year, areas of challenge and next steps.

11. East Ayrshire, North Ayrshire and South Ayrshire Health and Social Care Partnership Clinical and Care Governance Annual Reports

11.1 The above reports were deferred to the next Committee meeting on 3 November 2025 to allow sufficient time for discussion. **Committee Secretary**

12. Points to feed back to NHS Board

12.1 The Committee agreed that the following key items be raised at the NHS Board meeting on 6 October 2025:

- Suite of annual reports received, including Public Health Screening annual reports
- Detailed discussion and scrutiny of Healthcare Governance Strategic Risk Register
- Verbal update on Digital patient communication in the context of improving healthcare quality and safety.
- To acknowledge the ongoing whole system improvement work and future plans to triangulate adverse event, quality and safety and feedback and complaints activity in Committee reporting.

13. Any Other Competent Business

13.1 There was no other business.

14. Monday 3 November 2025 at 9.30am, Hybrid Meeting Room 1, Eglinton House and MS Teams