Healthcare Governance Committee
Tuesday 12 May 2026 at 9.30am
Room 5 Turnberry, Ailsa Hospital, Ayr / MS Teams

Present:

Non-Executives:
Ms Sharon Morrow (Vice Chair)
Cllr Marie Burns
Mr Neil McAleese

Board Advisor/Ex-Officio:
Ms Geraldine Jordan, Director of Clinical and Care Governance
Dr Crawford McGuffie, Medical Director
Ms Jennifer Wilson, Nurse Director

In Attendance:
Ms Caroline Clark, Divisional General Manager
Ms Julie Barrett, Associate Nurse Director and Lead Nurse, NA HSCP
Ms Jacqui Donald, Deputy Director of Acute Services
Ms Jincy Jerry, Director of Infection Prevention and Control
Mr Alistair Reid, Director for Allied Health Professions
Ms Attica Wheeler, Site/Midwifery Director, Associate Nurse Director
Kay Carmichael, Business Manager Nurse Directorate (Minutes)

1. Welcome, Apologies and Introductory Remarks

1.1 The Committee Vice Chair, Ms Sharon Morrow welcomed those present to the May meeting of the Healthcare Governance Committee, particularly Caroline Clark deputising for Vicki Campbell.

Apologies were noted from Ms Lesley Bowie, Ms Vicki Cambell, Mr Liam Gallacher, Mr Tom Hopkins, Prof Gordon James, Ms Lynne McNiven and Ms Linda Semple.

NOTED

2. Declaration of Interests

2.1 There were no declarations noted.

NOTED

3. Minute of Previous Meeting

3.1 The Committee considered the minute of the meeting held on 2 March 2026 and were content to approve the minutes as a full and accurate record of the meeting

APPROVED

4. Matters Arising

4.1 The Committee considered the items detailed on the Rolling Action List (RAL) presented for approval.

The Committee noted that there was one item proposed for closure with updates provided in the RAL.

The Committee were content to approve the Rolling Action List subject to the change noted above.

APPROVED

4.2 AAA Screening

Ms Caroline Clark provided an update to Committee on progress with Vascular Workforce, the main points of note were:

Challenges remain around recruitment with 6 Consultants in posts with the recruitment of locums taking to 8 Consultants. The service requires 10 Consultants to be in post to deliver the services.

The Consultant within Ayrshire and Arran are working closely with Harimyres. Currently there are 369 patients on waiting lists, however, these are due to be seen throughout May and June.

The Committee were content to note the update.

NOTED

4.3 Clinical Governance Standards

Ms Geraldine Jordan, Director of Clinical and Care Governance provided an update to Committee following the publication of the clinical governance standards at the end of February 2026 by Healthcare Improvement Scotland (HIS). It was noted there are 7 broad standards with 66 criteria.

Standard 1: Leadership and staffing
Clinical services have effective leadership and oversight including staffing levels.
Standard 2: Quality management and continuous improvement
Clinical services implement a whole-system approach to plan, improve, maintain and assure safety and quality.
Standard 3: Clinical effectiveness
People receive timely, effective, personalised and evidence-based clinical care.
Standard 4: Clinical safety and risk management
Clinical services effectively manage healthcare-related risks, safety concerns, adverse events and near misses.
Standard 5: Education and training
Staff delivering clinical services have the skills, competencies, training and support to provide safe, effective and person-centred care.
Standard 6: Service user and patient involvement

People and communities are meaningfully engaged in the design, delivery and governance of clinical services, in line with statutory duties and national guidance.

Standard 7: Data and information

Clinical services store and share personal data appropriately and use safe, secure systems and tools.

Ms Jordan stated they do not cover the scheme of delegation or sub-committees of the Board as this is aligned to the Blueprint for Good Governance.

Currently the Clinical and Care Governance Unit are supporting the impact assessment of the standards refining the self-assessment tool to allow for a more in-depth report.

Ms Morrow questioned if there is a timescale for completing the review set out by Healthcare Improvement Scotland. Ms Jordan confirmed there was no timeline, however, would expect it to form part of future inspection process. She anticipates the team will have completed the impact assessment by December 2026 and will provide an update back to Committee. **GJ**

The Committee were content to note the update.

NOTED

4.4 Committee Workplan 2026/27

The Committee considered the Healthcare Governance Committee Workplan for 2026/27 presented for approval. The Committee were content to approve the paper noting the workplan would be a live document to ensure items are presented to Committee for assurance.

Ms Geraldine Jordan emphasised the items being brought to Committee are strong in terms of the key areas that the Committee will be interested in.

The Committee were content to note the update.

NOTED

5. Report of Executive Director

5.1 Ms Jennifer Wilson took time to acknowledge International Nurses Day of 12 May along with International Midwife Day which took place on 5 May 2026, highlighting several communications had gone out across the organisation.

It was noted over the last 3-4 weeks had seen full capacity come down, however, challenges remain over the weekend periods and during April there was a bank holiday weekend.

In terms of cancer performance which will be reported through Performance Governance Committee real improvement has been made which are now showing 100%.

Following a walkround with members of the Assurance Board from Scottish Governance to the UHC site Flow Navigation, CAU, Orthopaedic and Ward 5D they are keen to work with the NHS Board and HSCPS to ensure patients were enabled to be in the right setting.

The second meeting of the Flow Board took place with a focus on AWI and SAFER programme working on hospital occupancy with HSCP colleagues over the next 2 years to allow us to have a flow through hospitals into community.

Dr McGuffie highlighted the delays in the system are in two categories: those beyond 14 days, and those ready to be discharged to homely setting. There are currently 144 delays in the system at the moment. This work is feeding into the work of the Ayrshire Transformation Board with the Chief Executives of the council and health board to set a trajectory with the ambition we won't go into full capacity after the summer.

Members queried confidence in this work given that Summer is approaching. Dr McGuffie stated the model is similar to that within NHS Forth Valley and the SAFER programme work will try to reduce the non-delays over 14 days which has currently taken 1.5 days off length of stay.

The Committee were content to note the update.

NOTED

6. Inspection Reports

6.1 Ailsa Hospital – mental health safe delivery of care inspection report: December 2025

Ms Julie Barrett provided an update to Committee following the HIS Inspection on 29 July 2025.

The Inspection Report was published on 9 December 2025 and resulted in six areas of good practice and 7 requirements, with the following points noted:

- Inspectors observed compassionate interactions between patients and staff. Staff told inspectors they felt there was a supportive culture with visible leadership and a good relationship between staff and managers. All staff we spoke with said they enjoyed working in Ailsa Hospital.
- The majority of care documentation reviewed was completed to a high standard with detailed information on patient care needs and goals.
- Mealtimes were well coordinated, and patient centred.

- Patients in both wards have access to a garden which was in good condition and well maintained.
- However, low compliance rates of mandatory training, including basic life support and violence and aggression practical training were identified.
- They also identified gaps in senior management oversight of mandatory training and the use of staff personal alarms.
- Other areas for improvement include ensuring the hospital environment is maintained to enable effective cleaning and ensuring falls improvement work is maintained.

The 18-week post inspection improvement action plan was returned on 13 April 2026

Ms Jenifer Wilson expressed her thanks to Ms Barrett who is new to the Lead Nurse/Associate Nurse Director role in terms of her leadership in supporting teams on the ground and the improvement work being undertaken.

Ms Sharon Morrow queried whether there is expectation of a follow up to the inspection, it was noted we are not actively expecting as the recent return of the improvement action plan was positive, however, Ms Geraldine Jordan highlighted there is learning to be taken from the recent mental health and maternity inspections.

Ms Wilson highlighted to Committee a narrative around the Health and Care Staffing Act which all Boards are seeing within inspection reports, however, this will be raised nationally to ensure working collaboratively with HIS.

The Committee noted the inspection report and were assured of the progress made to the improvement action plan.

***NOTED**.*

6.1 South West Scotland Breast Screening Centre – IR(ME)R inspection report: November 2025

Ms Jacqui Donald presented the Inspection Report following an announced IR(ME)R inspection of the Southwest Scotland Breast Screening Centre in August 2025 by Healthcare Improvement Scotland (HIS). The inspection identified two Requirements and three Recommendations.

It was noted the action plan was agreed and formally signed off by the Director of Acute Services in October 2025 and is being delivered through established Imaging and Radiation Governance arrangements.

The Committee welcomed the update on the recent inspection and work to progress the Improvement Action Plan, however, members requested a refinement to dates of completion for the actions and the completed action plan be brought back to a future meeting. **VC/JD**

NOTED.

7. Patient Experience

7.1 Patient Experience Performance Report

Ms Geraldine Jordan presented the Patient Experience: Feedback and Complaints Performance Report cover the period January to March 2026 (Q2 2025/26), highlighting the following key points:

- Stage 1 performance remains stable, with an average of 309 cases per quarter, reflecting normal variation.
- In contrast, Stage 2 has seen a sustained increase, rising from 186 cases last quarter to 222 this quarter. This increase is accompanied by greater complexity, with the median response time rising from 96 to 126 days (a 30% increase) and an overall 76% rise in complaints.
- The increase is impacting performance and is primarily driven by Surgical Services rather than unplanned care pathways, with contributing factors likely including waiting times, access to care, and aspects of clinical treatment.
- While complaints relating to attitude and behaviour remain stable, concerns around appointment scheduling and communication persist.
- Key areas affected include Women and Children's Services and Mental Health, while front door and unplanned pathways remain stable.
- Performance against targets shows Stage 1 at 82% (against a target of 85%) and Stage 2 at 18% (against a target of 75%).
- Improvement work with Acute colleagues has been ongoing, however, Quality Improvement work has now been paused to allow reallocation of QI and Practice Development support to undertake a Complaints Sprint.
- Currently, 60 cases are in the improvement process and 130 are under investigation, which is identified as a key pressure point requiring additional support.
- Increasing referrals to the Ombudsman are adding pressure, driven in part by dissatisfaction with response times.
- Currently three decision notices have been published and two cases closed.
- Feedback remains mixed, with Care Opinion showing 82% positive feedback, but complainant satisfaction has declined in some areas.

Councillor Marie Burns highlighted complainant satisfaction is an important aera and was disappointed to see this dipping in areas, however, was supportive of the improvement work being taken forward. Ms Jordan stated additional support has been brought in to assist with complainant satisfaction.

Ms Jennifer Wilson, stated patient experience performance is a priority area, with a review of process currently being undertaken with a QI lens to look for improvement in collaboration with services to

support 2 way communication, acknowledging the incredibly complex complaints being managed and the need to remember there is a patient/family members at the centre to ensure key learning that can make the system work better.

Ms Caroline Clark highlighted within the acute services the additional supported is welcomed to review the current process and how it is being managed particularly with the rise within surgical and access to treatment/appointments and if there is something different, we can do differently.

Ms Sharon Morrow noted her disappointment with the performance due to the work that has been undertaken over the last year, and questioned what support is required from the Committee to support. Ms Jordan emphasised the improvement focus work which will be undertaken around the process and how we communicate, with further work around de-escalation and supporting difficult conversations.

The Committee welcomed the discussion and were assured with the actions which were being taken to address performance, noting this will remain challenging.

NOTED.

7.2 Spiritual and Staff Care Strategy

Mr Alistair Reid provided an update to Committee following the launch of the Spiritual and Staff Care Strategy in 2025 and the agreed delivery and measurement plan, with the first milestone review undertook in April 2026 assessed progress against these commitments.

It was noted overall, good progress has been made, with 13 out of 18 milestones achieved. The programme is therefore being positioned as a positive news story, reflecting the collective effort across teams. Some gaps were identified, particularly in relation to bereavement support, where progress has not aligned with the original level of ambition. This has largely been influenced by wider organisational pressures, including Level 4 status and the efficiency expectations associated with Reduced Working Week (RWW). These factors have impacted the pace of delivery in this area.

In March 2026, the national service specification for spiritual care was published. While the current framework is expected to align with this, a benchmarking exercise is now underway to confirm alignment and identify any areas for improvement. The work of the spiritual care and staff care teams remains key, particularly in the context of wider service pressures, with a continued focus on strengthening activity and impact data.

Mr Reid, extended his thanks to the Spiritual, Staff and Person-Centred Care teams for their contributions.

Ms Sharon Morrow welcomed the report and expressed her thanks to the teams who inputted to the report, recognising the importance of supporting staff wellbeing and the direct link this has to the quality of patient care

The Committee noted the report.

NOTED.

8. Patient Safety

8.1 Food Fluid Nutrition

Mr Alistair Reidt provided an update to the Committee on the FFN HSE Action Plan noting that overall assurance remains limited, although improvements are being made. The key points of note were:

- Workforce capability continues to present challenges, with capacity constraints affecting delivery.
- The associated Corporate Risk remains rated as high, reflecting ongoing incidents and patient safety concerns that require continued intervention and close oversight.
- A critical gap has been identified in relation to education, and it was agreed that this must remain a priority. While a local education framework has been developed and aligned, progress has been impacted by the pause in champion roles, meaning that workforce competency cannot yet be fully assured.
- A self-assessment of the mealtime coordinator role has been undertaken; however, human factors and wider system pressures are affecting reliability.
- Notwithstanding these challenges, strong leadership has been noted from the Consultant Speech and Language Therapist.
- A training update was provided, recognising the need to balance delivery with current system pressures.
- In addition, a short communication campaign is being developed to ensure key messages reach not only staff but also patients and families.
- Further work will include revisiting adverse events to identify themes and additional improvement actions, alongside the anticipated Health and Safety audit, which will inform a comprehensive action plan.

Ms Jennifer Wilson highlighted the strength of the mealtime coordinator role but noted the challenges of releasing staff for ad hoc training. She has requested a proposal to deliver planned full-day training sessions, supported by bank staff to enable attendance. She acknowledged given the vulnerable patient cohorts, some inherent risk particularly choking will remain, however, the focus should be on effective mitigation.

Ms Wilson will confirm the status of the Health and Safety audit and associated action plan. **JW**

The Committee noted the update.

NOTED.

8.2 Aging and Frailty Standards

Mr Alistair Reid provided an update to the Committee of the benchmarking review into the HIS Aging and Frailty Standards, noting the key points:

- A Strategic Steering Group had been established to oversee this work and has conducted a multi-directorate baseline review, resulting in the development of local action plans.
- Engagement has been undertaken with key stakeholders including Pharmacy, Palliative Care, and Hospice services.
- Of the 121 standards assessed:
    - 11 standards are fully or partially met
    - 100 standards are partially achieved
- There remains some hesitancy in confirming full compliance, primarily due to concerns regarding consistency of delivery across services.
- The standards themselves are broad and aspirational in nature.
- Improvement plans are progressing through local governance structures
- Ownership of standards should now sit locally
- The Strategic Steering Group has now fulfilled its purpose, with ongoing work to be embedded within existing governance arrangements.
- No standards identified as unmet
- No immediate risks identified

Mr Reid expressed his appreciation for the collective team effect with thanks to the Clinical and Care Governance Unit for supporting with the baseline assessment process.

Ms Jennifer Wilson will write to clinical leads in Acute and HSCP to ask for update to be provided to Healthcare Governance Committee as part of the Annual Reporting to the Committee. **JW**

The Committee supported the closure of the Strategic Steering Group with updates being provided from Acute and HSCPs into their Annual Reports to Healthcare Governance Committee.

NOTED.

8.3 HAI Report

Ms Jincy Jerry (JJ) presented the updated HAI report, highlighting that the new annual standard for *Clostridioides difficile* infection (CDI) is no more than 70 cases. In Quarter 3 there were 19 cases, representing a reduction from the previous quarter and contributing to an overall improving trend. Of these, 12 cases were hospital-acquired (greater than day 3 of admission). Community CDI remains subject to no national target; however, 4 cases were reported in Quarter 3 (rate 4.3), which is below the Scottish rate for the period.

Ms Jerry advised that community *E. coli* bacteraemia (ECB) continues to be a significant outlier position. While there is no national target, the Board has been consistently flagged across multiple quarters, reflecting the highest rates of community ECB and the complexity of this as a whole-system issue. Work has been undertaken with Scottish Government and Public Health partners, and improvement activity continues, particularly focused on community ECB during this quarter. At the same time, there are signs of improvement within hospital settings, although this has not yet translated into reductions in community cases.

In discussion, members acknowledged the complexity of the position. noting the challenging nature of community ECB but recognised the improvement work underway and areas where progress is being demonstrated.

Ms Wilson highlighted strengthened alignment across teams in relation to improvement actions, particularly for SAB and *E. coli*, and noted the ongoing environmental challenges

Ms Morrow raised a question in relation to catheter-related ECB and potential learning from other Boards; Ms Jerry confirmed other Boards are, in fact, looking to NHS Ayrshire & Arran for shared learning.

In response to a query from Ms Morrow regarding Aspergillus cases, Ms Jerry confirmed that while there are no new patient placements, the associated risk remains and continues to be managed.

The Committee noted the current performance against the national HAI Standards and the update on outbreaks reported during Quarter 3.

NOTED.

8.4 Infection Prevention and Control Teamwork Programme

Ms Jincy Jerry provided an update on progress with the IPCT Work Programme 2025/26, which aligns with the National IPC Standards, as set out in Healthcare Improvement Scotland (HIS) documentation issued in 2022.

It was noted the programme remains a live document to allow for adaptation as required to meet areas of focus, the work programme is monitored and reviewed through the Prevention and Control of Infection Committee.

The Committee was assured by the content of the report.

NOTED.

8.5 Quality and Safety Report - Gynaecology and Sexual Health

Ms Attica Wheeler presented the first standalone Quality & Safety Report for Gynaecology and Sexual Health, welcoming it as a helpful step in providing assurance. Key areas included:

- the Women's Health Plan (Phase 2)
- fertility services
- emerging developments such as nurse-led endometriosis pathways and robotics.
- challenges within the termination of pregnancy service, including a current three-week wait and the wider social and capacity factors influencing demand.
- Actions to improve access are underway.
- Positive patient feedback was noted alongside ongoing work to strengthen adverse event processes and staff training.

The Committee was assured by the content of the report.

NOTED.

8.6 Quality and Safety Report – Maternity

Ms Attica Wheeler presented the Quality and Safety Report for Maternity Services, noting it has been presented through governance routes and aligns with SPSP reporting and national measures. They key areas of note were:

- Sustained improvement in stillbirth rates was recognised, with assurance that all cases are reviewed via PMRT and no care provision concerns identified.
- High compliance with MEWS completion and escalation (median 99.5%) with assurance regarding frequency and use, albeit recognising current reliance on paper recording systems.
- Postpartum haemorrhage (>1.5L) rates were acknowledged as an area of focus; while not wholly preventable, work is underway to improve risk assessment and management.
- Triangulation through Excellence in Care (EiC) reporting, including positive QMPLE feedback (92%) and strong documentation audit compliance (98% locally reported
- The recent HIS inspection improvement action plan was noted: 50 actions identified with c.50% complete and the remainder in progress within agreed timescales
- Infection prevention and control compliance was recognised as strong (hand hygiene 90–100%) and considered through an MDT lens.
- Rates of 3rd/4th degree tears remain in line with national benchmarks and are not an outlier
- Publication of 11 national maternity standards with impact assessment underway.
- Complaints remain low but increasingly complex.
- Workforce planning and succession planning were noted as a key strength, with sustained focus required.

The Committee was assured by the content of the report.

NOTED.

9. Quality Improvement

9.1 ReSPECT

Dr Alison Speirs provided an update on progress with the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). The Committee noted that ReSPECT supports future care planning by recording shared decisions about emergency care and treatment, based on an individual's values, priorities and anticipated health trajectory. Key points highlighted were:

- ReSPECT enables discussion about what individuals might expect in relation to future health and ensures that this information is shared, including with the Scottish Ambulance Service in the event of an emergency.
- Digital access issues have largely been resolved, with systems now widely accessible to staff across care settings.
- Training arrangements were noted, including mandatory LearnPro modules embedded within induction and the continued development of communication skills through the CONnECT course.
- Significant focus over the past 12 months has been on communication skills, recognising that ReSPECT is not solely a care planning document but a process that requires high-quality, values-based conversations with patients and families.
- The CONnECT programme was highlighted as supporting staff to develop confidence in these discussions and reinforcing that medicine is not always the preferred or appropriate option.
- In operational terms, approximately 500 ReSPECT plans are in place across Ayrshire and Arran, with around 250 completed in the past year. While this demonstrates progress, uptake remains inconsistent, with around half of eligible staff actively using ReSPECT.
- Implementation is more established within palliative care and Hospital at Home services, and overall progress was described as positive but still fragile.
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Dr McGuffie recognised the cultural shift associated with ReSPECT, moving towards clearer recognition of the limits of medical intervention and a stronger focus on what matters to patients, particularly as they become frailer.

Dr McGuffie highlighted the progress made to date, particularly given limited resources, and commended Dr Speirs and the team for their leadership and delivery, including the CONnECT training programme.

Members discussed the challenge of embedding ReSPECT more widely and considered how the Committee and Board could support further adoption, particularly in alignment with Realistic Medicine and the "Caring for Ayrshire" vision. The need for additional project

management support was noted as a key constraint, reflecting findings within the paper that resource limitations are impacting the pace and consistency of rollout.

The Committee was assured by the content of the report.

NOTED.

9.2 COVID-19 Update

Dr Crawford McCuffie spoke to the paper, which provided an update on the national COVID-19 Inquiries. The paper was presented for awareness, reflecting the legislative requirement for NHS Boards, with delegated oversight through the Healthcare Governance Committee.

It was noted that Modules 3 and 4 have implications for Boards, with Module 3 (including section 2.3) outlining recommendations where Boards may be involved in implementation following national direction. Module 4 recommendations were highlighted as primarily national.

The Committee noted the supporting arrangements, including a small team established to manage Inquiry requirements, together with updates provided through the Area Partnership Forum (APF) and Area Clinical Forum (ACF). Operational considerations such as the retention (non-deletion) of mailboxes were also highlighted as part of risk management arrangements.

The Committee was assured by the content of the report.

NOTED.

9.3 SIGN Guidelines and HIS Standards

Dr McGuffie provided an update on SIGN Guidelines and HIS Standards highlighting this is a Board-level governance matter with the current status as:

- 26 HIS standards are in total, with 25 under review and 1 superseded/withdrawn, alongside ongoing SIGN guideline reviews.
- It was confirmed that all guidelines and standards have undergone impact assessment, with action plans in place for local delivery and monitored through governance processes.
- Four SIGN guidelines and six HIS standards were presented for closure approval, supported by completed assessments and action plans.
- Where recommendations are not fully implemented, a clear, well-governed rationale must be documented, including associated risks

Ms Morrow welcomed the report and took assurance from the progress described.

The Committee approved closure of 4 SIGN guidelines, and 6 HIS standards

NOTED.

10. Risk / Audit

10.1 Strategic Risk Register

The Committee reviewed the Strategic Risk Register and those risk aligned to the Healthcare Governance Committee which included eSurvellience, GP Practices, Ventilation.

Ms Sharon Morrow queried if there was a risk in relation to PDR compliance. Ms Geraldine Jordan confirmed this is reported through Staff Governance Committee.

The Committee noted the report.

NOTED.

10.2 Scottish National Audit Programme (SNAP)

Ms Jordan presented a follow-up on the Scottish National Audit Programme (SNAP), previously tabled at Committee, outlining current position and progress against the 2025 national audit data and ongoing governance process. The key points were noted:

- It was highlighted that 11 key issues were identified through the 2025 process, with progress made in several areas. Six of these have now been addressed, with further work ongoing across the remaining areas
- Hip fracture performance, while still below the Scottish average in some measures, has shown significant improvement from previous positions, supported by strengthened orthogeriatric input.
- the importance of clinical teams viewing SNAP findings as an improvement opportunity, with good engagement evident across services.

The Committee noted the progress made to date and ongoing improvement work, recognising both areas of good performance and those requiring continued attention.

NOTED.

10.3 Significant Adverse Event Review Progress Report

Ms Jordan provided an update on the SAER improvement plan agreed in January 2025 identified 93 overdue reports, of which 80 have now been closed, with the remaining 13 incorporated into Phase 2 of the improvement plan. It was noted the current position, including 64% of open reports are overdue (65 of 101 reports), with 28 reports within the governance approval process, and a significant level of rework across submissions.

It was acknowledged learning from Phase 1 particularly that a sole focus on clearing backlog risks displacing current workload and creating further backlog. In response, a refocus of the Risk Management Team role is being progressed to ensure a more balanced and sustainable approach to both backlog reduction and current performance.

Improvement plan agreed January 2025, identified 93, closed 80. Remaining 13 included in Phase 2. We have learned from Phase 1 that if focus on backlog, then todays work becomes the backlog. Refocus Risk Team role.

It was further noted that governance arrangements remain in place, including the AERG Review Groups and Leadership Oversight Group, chaired by Nurse and Medical Directors. The Risk and Resilience Scrutiny and Assurance Group (RARSAG), continues to oversee progress, with a requirement for each Director to present a clear trajectory for improvement

The Committee noted the report for assurance.

NOTED.

11. Corporate Governance

11.1 **Acute Services Clinical Governance Steering Group**
Members noted approved minutes of meeting held on 2 February 2026

11.2 **Area Drug and Therapeutics Committee**
Members noted approved minutes of meeting held on 12 January 2026

11.3 **Prevention and Control of Infection Committee**
Members noted approved minutes of meeting held 9 February 2026

11.4 **Primary and Urgent Care Clinical Governance Group**
Members noted approved minutes of meeting held on 10 February 2026

12. Points to feed back to NHS Board

Members agreed the following key items to be reported to the NHS Board on 8 June 2026:

- Patient Experience Performance Report Q4 -complaints backlog and plan in place, challenging area for complaints team at moment.
- Aging and Frailty Standards -with improvement actions plan going through local governance routes.
- FFN –improvement actions
- Significant Adverse Events Review – progress with improvement actions

13. Any Other Competent Business

There was no other business.

14. Date and Time of Next Meeting

Tuesday 14 July 2026 at 9.30am, Meeting Room 5, Turnberry and MS Teams

Signed by the Chair, Linda Semple Date: 14 July 2026