NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting date:	**Monday 11 August 2025**
Title:	**Quality & Safety Report - Maternity**
Responsible Director:	**Jennifer Wilson, Nurse Director**
Report Author:	**Attica Wheeler, Site Director Women and Children's / Midwifery Director and Associate Nurse Director Women and Children's Services**

1. Purpose

This is presented to the Board for:

- Awareness

This paper relates to:

- Annual Operational Plan

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2. Report summary

2.1 Situation

The aim of this paper is to provide assurance to Healthcare Governance Committee and subsequently the NHS Board on the Maternity service at NHS Ayrshire & Arran by providing information on the current service and future plans for the service.

2.2 Background

The overall purpose of NHS Ayrshire & Arran NHS Board is to ensure the efficient, effective and accountable governance of the organisation and to provide strategic leadership and direction, focused on improving health and care outcomes for women, babies and families of Ayrshire and Arran.

This paper will set out the progress of maternity services aligned to the four quality pillars:

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

2.3 Assessment

2.3.1 Quality Planning

HIS Maternity Inspections

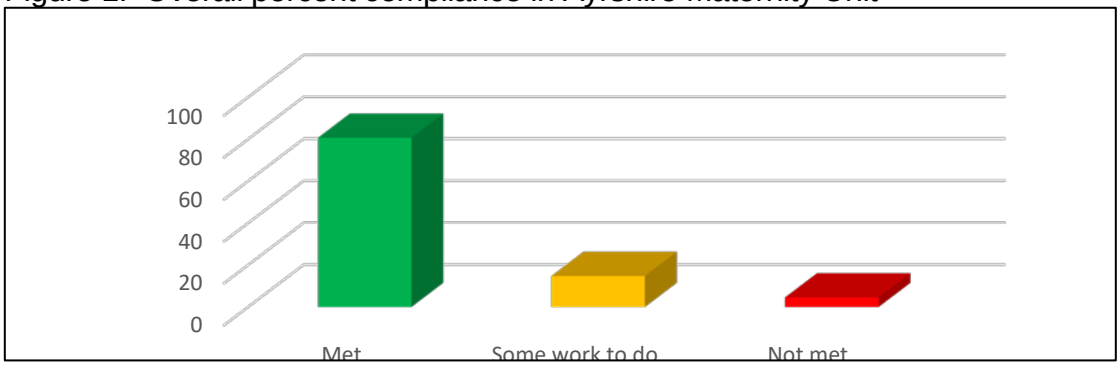
In August 2024 Health Improvement Scotland (HIS) announced that they will be undertaking inspections of all maternity units in Scotland from January 2025. Following this announcement the local maternity service commenced preparations. This has involved delivery of HIS inspection information sessions for senior staff and mock inspections being carried out, based on the anticipated areas for inclusion:

- People's experience of safe accessible care and support that meets their needs and is based on relevant evidence, guidance and current best practice
- Staffing arrangements are sufficient to ensure people receiving care are provided with the care and support that meets their needs
- Leadership and culture

The mock inspections were carried out, during February and March 2025, with the aim of identifying any areas for improvement. Inspections were based on Peer Review and supported and conducted by Women and Children's Quality Improvement team and Clinical Staff. Each department was issued with its own report detailing areas for improvement.

The following results were observed:
Departments in Ayrshire Maternity services, Neonatal unit and Gynaecology (Ayrshire maternity unit building)

Figure 1. Overall percent compliance in Ayrshire Maternity Unit



*Community services were not included in these inspections

The full report has been sent to every member of the Senior Management Team and the Senior Charge Nurses and Senior Charge Midwives in each ward / department. An action plan has been developed and is progressing.

A key theme that required further insight was the feedback around lack of perceived leadership visibility within Maternity Services. Along with Staff side we have devised a staff feedback exercise in order to inform, support and manage expectations of the service going forward.

HIS Maternity Workforce Tool development

NHS Ayrshire and Arran maternity services are proactively supporting and participating in the development of the maternity workforce tool. This is national work being carried out with HIS to align midwifery staffing to the Health and Care (Staffing) (Scotland) Act 2019. Maternity teams have been involved in the testing and sampling during all test cycles and all maternity teams have now participated in testing. The

next cycle is due to commence on the 12th of May 2025 and will run for 2 weeks this testing will be utilising Optima as the reporting template we have 3 teams participating. Preparation for this has seen rapid development of rosters and training of maternity staff on data input into this system as it is not yet utilised within maternity services.

Maternity Delivery Group and Maternity Standards

We have introduced in February 2025 a maternity delivery group called "Maternity Evolution Group (MEG)". The aim of this group is to have oversight of the quality planning and performance including transformational projects within maternity with all relevant stakeholders involved. In particular this forum allows for the triangulation of our clinical risk, practice development and quality improvement within maternity allowing more streamlined learning and improvement from clinical adverse events. This group is contributing to the national development of Maternity Standards that are due to come for local board consultation in August 2025.

2.3.2 Quality Control

Infection Prevention and Control

Women and Children's Services have commenced the submission of the IPC paper on a quarterly basis. Compliance with each of the measures as per the IC rolling programme are provided to the IPC Team quarterly for each ward / department in Women and Children's Services. The 2025/6 IC rolling programme has been circulated and all wards advised to ensure they have been activated for all measures in the QI Portal.

Training and Development

Training figures for the Scottish neonatal resuscitation course (SNRC) led by SMMDP which is mandatory role specific training for midwives and neonatal nurses are showing a steady increase following this training being paused during the COVID 19 response. This training should be renewed every four years. The figures in 2021 of those compliant had dropped to 35%. We have now managed to increase this figure to 51% at the end of training year 2024 -2025. Plans to improve this figure further in this training year has seen work with SMMDP and local training faculty to increase the number of courses delivered locally.

Within Women and Children's services recorded completion of PDP /PDR has always been low. The most recent figures show that this is currently recorded as 34% compliance. We have carried out work to better understand the figures and identify barriers to improving this figure. Through this work it has been identified that there was a training and learning need for reviewers as they were reporting a much higher compliance of PDP /PDR completion with their reviewees. To support this learning need we have delivered training on the use of the platform to reviewers. We have appointed a Women and Children's PDP champion as a point of contact for support. This champion has also developed a flow chart to support reviewers and reviewees in the completion of the PDP /PDR that will show it as completed within the reporting templates.

Lanarkshire Fatal accident inquiry (FAI)

Following the publication in March 2025 of the FAI into the deaths of Leo Lamont, Ellie McCormick and Mira-Belle Bosch within maternity we immediately benchmarked our service against the recommendations and judges observations of this inquiry. Of the 11 recommendations and 2 observations, four were recommendations that required a national approach of the others NHS Ayrshire and Arran only have 1 observation not met. This is the recording and storage of triage calls. We have explored the ability to

record and store triage calls in the past however it was not deemed as cost compliant to do this as maternity records require to be stored for 25 years.

Recommendation 1 advised that NHS Greater Glasgow and Clyde should produce a "trigger list" to identify and assess preterm labour symptoms and share with all health boards. This has now been produced and we are in the process of incorporating this "trigger list" into our preterm labour guidelines to further strengthen local clinical guidelines.

A detailed further paper will be submitted to Heath Care Governance Committee for Assurance and discussion.

2.3.3 Quality Assurance

Complaints and Compliments

Within maternity services we have a weekly assurance meeting to ensure complaints are been handled timeously and to analysis for themes and trends.

	Complaints			**FOI's**			MSP Enquiry		
	Jan	**Feb**	**Mar**	Jan	Feb	Mar	Jan	Feb	Mar
	2	**0**	**0**	2	6	4	0	0	0
Concern	0	0	0						
Stage1	1	0	0						
Stage 2	1	0	0						

Maternity Adverse Events

The clinical risk team within Women and Children's services work with the Directorate Management Team in the delivery of the corporate agenda on Clinical Risk Management and Incident Reporting and have a supporting role in the continuous development of the Directorate Risk Register.

This involves the overall co-ordination of the clinical risk management programme across Maternity, Gynaecology, Neonatal and Paediatric services which includes the robust review of all adverse events. This is in collaboration with the Senior Management Team and multi-professional team to promote a culture of learning from adverse events which is shared with the wider teams promoting a supportive and just culture.

The clinical risk co-ordinators are key members of the perinatal mortality group and use a multi-professional approach to investigating clinical incidents which includes participating in Serious Adverse Event Reviews (SAER). Support is provided to ward level reviewers and lead reviewers as well as the Senior Management Team, Clinical Risk Management Teams, Clinical Midwifery/Nurse Managers to implement the recommendations arising from clinical incidents ensuring the highest standards of clinical care through the promotion of evidence based practice. The reviews contribute to the overall aims of Quality Improvement within the Scottish Patient Safety Programme (SPSP) Perinatal Collaborative and reduce the organisations' exposure to adverse events, complaints and clinical negligence claims by having systems in place that allow for the reporting and analysis of untoward clinical incidents using a multidisciplinary approach.

The table shows the number of adverse events position in Quarter 1 of 2025. This information is shared and discussed at weekly Quality Assurance meetings with trends analysis.

Maternity Adverse Events Q1 2025		Overdue
Total number of Adverse Events submitted	97	
Number Rejected*	14	
Ongoing SAER	5	3
LMTR	0	0
CRMG	1	1
Ward level review including RIDDOR	71	14
Total finally approved in Q1	60	

*rejected due to no adverse event occurring/not meeting criteria for submission

As of 31/03/2025 the total number of adverse events awaiting review are 29 (13 overdue). 5 of these are Mortality cases awaiting review for reasons such as awaiting post mortem results.

2.3.4 Quality Improvement

Scottish Patient Safety Programme (SPSP)

NHSAA have signed up to the SPSP Perinatal Collaborative. The overall aim of the programme is to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies and families across all care settings in Scotland.

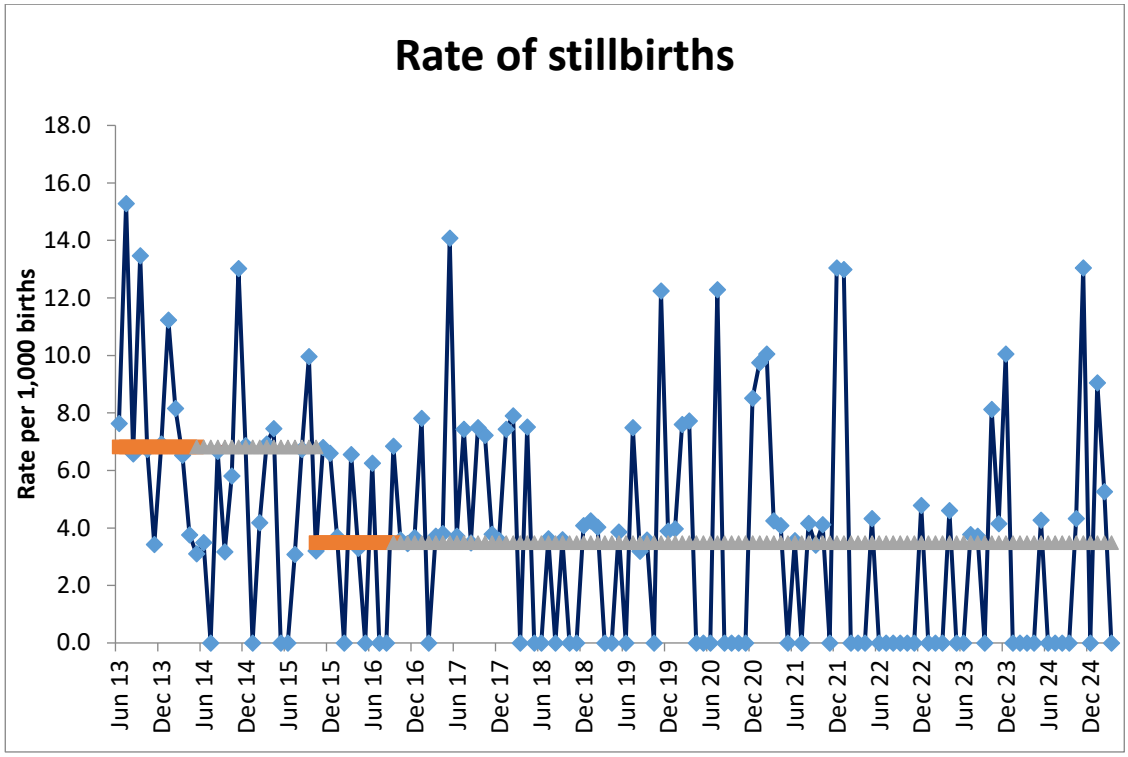
NHS Boards report regularly on SPSP performance measures to Healthcare Improvement Scotland (HIS) in order to enable Boards and the national programme team to understand overall progress in relation to the aims of the SPSP and EiC.

The Maternity work stream reports nationally on agreed measures within the Maternity Care Measurement matrix. Under the terms of the joint partnership Agreement with the SPSP Team, NHS Ayrshire & Arran have agreed to measure the following within maternity services:

- Stillbirth rates
- Maternal deterioration (MEWS)
- Postpartum haemorrhage (PPH) rates >1.5 litres

Rate of Stillbirths

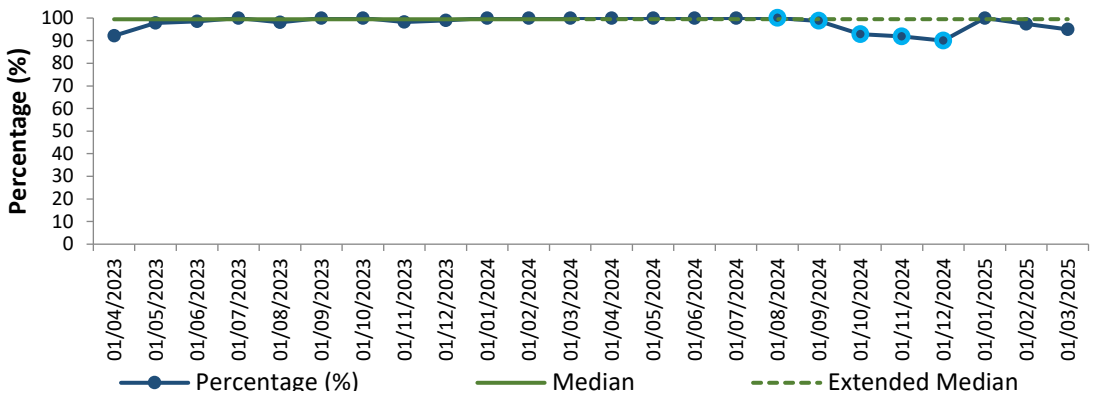
NHS Ayrshire & Arran continue to demonstrate sustained improvement against the national stillbirth rate. However, since October 2024 we have reported seven intra uterine deaths within our Unit. This figure is inclusive of two cases where the pregnancy was terminated due to fetal anomaly. Each case has been reviewed utilising the Perinatal Mortality Review Tool (PMRT) and subject to the Being Open process. None of the cases reviewed were linked to care provision and were found to be unavoidable. Figure 1 below demonstrates the rate of still births per 1,000 births from June 2013 through to March 2025.



Maternity Early Warning Score (MEWS)

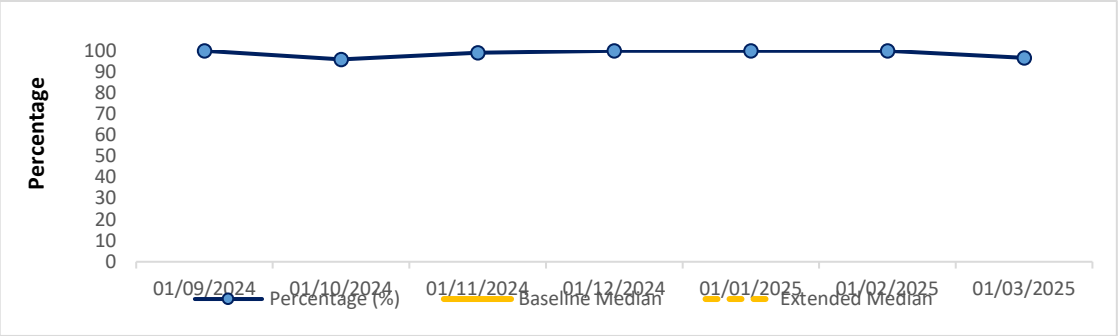
The Maternity Early Warning Score tool was launched within Maternity Services at AMU on 24 December 2018. Compliance with the Maternity Early Warning System (MEWS) is measured as part of the SPSP Perinatal Programme and EIC.

Percentage of Maternity Early Warning Score (MEWS) charts completed, and frequency met



The graph demonstrates a 99.5% compliance with MEWS frequency of observation.

Percentage compliance with MEWS chart escalation pathway

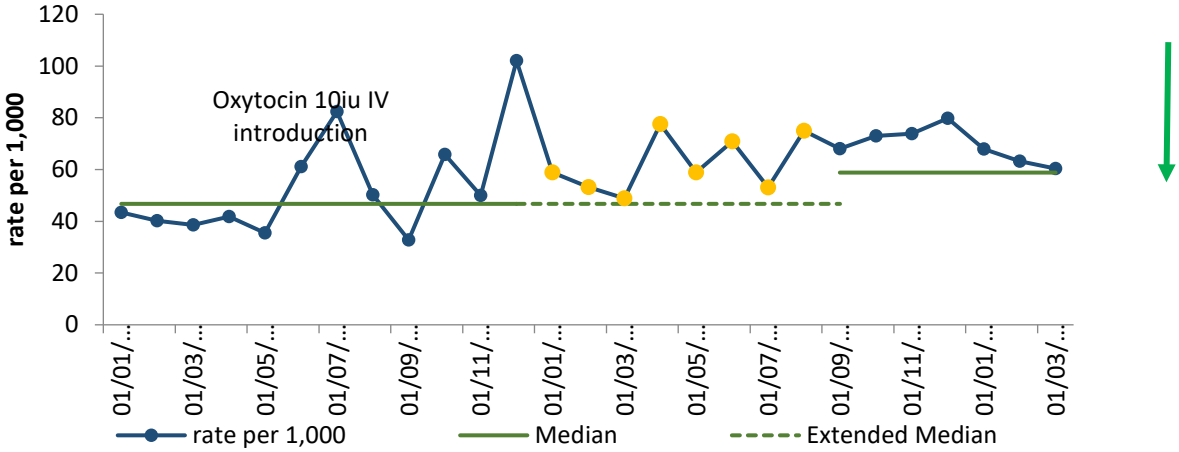


The chart above demonstrates compliance with MEWS escalation. The data presented from September 2024 is in concordance with national changes to measure definition. Local scrutiny highlights 99% compliance with all elements of the measure.

<u>Rate of Post-Partum Haemorrhage (PPH)</u>

Historically we collected outcome data on severe PPHs (≥2.5 litres) along with three process measures; Use of Tranexamic Acid to control blood loss, use of a post event checklist and the measurement of cumulative blood loss. When the revised measures were released, it was agreed we would measure the rate of PPHs >1.5 litres.

Rates of PPHs ≥1500mls



We are currently sitting on a median of 58.8 /1000 births with a PPH ≥1500 mls. Having looked at the National data, we are not sitting as an outlier with this measure, however, we are taking steps to improve this rate.

We have completed the testing of a risk assessment tool for stratifying PPH prophylaxis medication, which has recently gone through Clinical Effectiveness and subsequently Clinical Governance for approval.

We have also looked at the number PPHs >1500mls for vaginal births. The rate of vaginal births with a PPH >1500mls is 15.9/1000, concurring that Caesarean birth presents an increased occurrence of PPH.

Excellence in Care (EiC)

Local Implementation of the national assurance programme and framework, Excellence in Care (EiC), commissioned by the Scottish Government in response to the Vale of Leven Inquiry recommendations, equips clinical teams with quality and safety oversight to provide assurance of quality of care. The elements of the EiC Framework are interlinked with the ethos that to ensure 'excellence in care' all elements are of equal importance.

NHSAA report quality of care measures monthly to Public Health Scotland via the Care Assurance and Improvement Resource (CAIR) dashboard. This is inclusive of workforce, quality of care and pre-registration nursing feedback data and provides clinical teams with data intelligence to support triangulation of data. This data can be further utilised to evidence the quality-of-care element of the Health and Care (Staffing) (Scotland) Act 2019, Common Staffing Method.

Furthermore, NHSAA submit an EiC report to Scottish Government bi-annually with overview and status of local implementation of EiC key deliverables.

2.3.5 Quality/patient care

The overall aim of the service is to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies and families across all care settings in Scotland.

2.3.6 Workforce

NHS Ayrshire and Arran Maternity Services remains compliant with the Health care staffing Bill and continues to report to the board on performance.

Staffing whole time equivalents within maternity are being impacted by the agenda for change pay agreements which are providing a reduced working week from 37.5 hours per week to 36 hours per week and the introduction of protected learning time. The loss in whole time equivalent (WTE) to these changes are:

- Reduced working week 7.79 WTE
- Protected learning time 5.62

In addition to the above within maternity we have identified that the age profile of midwives has the potential to impact on our workforce as we have a significant proportion of trained midwives over the age of 55.

- Age greater than 60 years – 14.9 WTE
- Age 55 years to 59 years – 36.51

NHS Ayrshire and Arran has actively recruited student midwives by proactive succession planning. We are currently over establishment however this provides development of those student to newly qualified midwives to ensure the continued safe delivery of care linked to the age profile of qualified midwives.

We continue to identify and support effective recruitment which ensures no vacancies unfilled within the service.

2.3.7 Financial

There may be financial implications identified as national recommendations are identified and require implementation. This along with current work costing is

monitored, scrutinised and planned as part of our Senior Management team meetings for Women and Children's Services.

2.3.8 Risk assessment/management

Delivery of the programme is aimed at reducing harm within Women & Children's services. Non delivery of the programme could impact on the provision of a safe service and reputation of the organisation if timely effective implementation does not happen.

2.3.9 Equality and diversity, including health inequalities

By working towards compliance with each of the measures as agreed with the SPSP Partnership, we aim to protect and improve the health and wellbeing of the population and reduce inequalities, including through advocacy, prevention and anticipatory care.

2.3.10 Other impacts

We aim to provide compassionate partnerships between patients, their families and those delivering health and care services which respect individual needs and values; and result in the people using our services having a positive experience of care to get the outcome they expect.

We will protect and improve the health and wellbeing of the population and reduce inequalities, including through advocacy, prevention and anticipatory care

2.3.11 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

- A partnership agreement between SPSP collaborative and NHS Ayrshire & Arran in relation to the way forward with new measurements were signed off and sent to all relevant parties on 29 January 24.
- Regular reporting through approved governance routes for Maternity service operational and performance outputs.
- This work is discussed at the bi-monthly Perinatal QI Group meeting. Any issues arising are taken forward at the Maternity Clinical Governance Group.

2.3.12 Route to the meeting

The report was discussed in detail at the Healthcare Governance Committee meeting on 9 June 2025.

2.4 Recommendation

For awareness. The Board are asked to note the quality activity within Maternity Services including the contribution to the Scottish Patient Safety (SPSP) Perinatal programme and Excellence in Care.