NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting date:	**Monday 6 October 2025**
Title:	**Quality and Safety Paediatric Work stream**
Responsible Director:	**Jennifer Wilson, Executive Nurse Director**
Report Author:	**Attica Wheeler Director of Midwifery 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

This paper is for information to the NHS Board following detailed discussion at Healthcare Governance Committee. The paper provides an overview of quality and safety activity within NHS Ayrshire & Arran Paediatric services.

2.2 Background

NHS Ayrshire & Arran's purpose is working together to achieve the healthiest life possible for everyone in Ayrshire and Arran.

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

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

2.3 Assessment

a. Quality Planning

Local Management Team and Significant Adverse Event Reviews commissioned following adverse events remain on target with the triumvirate appointing lead reviewers as directed by AERG on their commission.

An assessment on the number of lead reviewers within the multi-disciplinary team in paediatric services is underway with new lead reviewers being supported to undertake this role. The data indicates a sustained drop in adverse events linked to child deaths within Ayrshire and medicine errors compared to 2024. We continue to review trends on a weekly basis as part of our Quality Assurance meetings.

b. 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 IPC rolling programme are provided to the IPC Team quarterly for each ward / department in Women and Children's Services. The 2025/26 IPC rolling programme has been distributed and all wards advised to ensure they have been activated for all measures in the QI Portal. There were no outbreaks or concerns linked to IPC measures to report for this period.

Training and Development
Recent vacancies within the neonatal qualified in speciality (QIS) staff group have identified a 2% reduction in the required 70% BAPM (British Association of Perinatal Medicine) level of registered staff with this qualification. Robust succession planning has been initiated to ensure that this is rectified. Currently 2.93 WTE registered staff are undertaking this accredited training with a further 1.9 WTE to commence in September 2025. On completion of this training the percentage of staff qualified in neonatal speciality will achieve 78%.

Within Women and Children's services recorded completion of PDP /PDR has historically been low. Focused work has been undertaken to understand the position and identify barriers to improve. Training on the use of the TURAS platform has been delivered to reviewers, and the appointment of a Women and Children's PDP Champion as a point of contact for support. The Champion has developed resources to support reviewers and reviewees in the completion of the PDP /PDR. The compliance with completion of PDP/PDR within children's services has improved to 61%.

Mandatory and Statutory Training (MAST) compliance is 95%.

c. Quality Assurance

An overview of paediatric complaints is detailed below

Paediatric Complaints 01/04/2024 – 31/03/2025

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	TOTAL
Stage 1	1	1	2	2	0	1	1	3	0	0	1	0	**12**
Stage 2	1	0	0	0	0	1	0	0	1	1	1	0	**5**

Primary Theme	Stage 1	Stage 2
Treatment / Clinical	5	1
Staff Attitude	1	1
Procedural	1	1
Waiting Times	2	0
Communication	2	1
Delays	1	1
Complex	0	1

With regards the complaint themes linked to communication factors, local training on managing parents' expectations and communication has been incorporated into staff training. There were no complaints out-with the handling time frames for Paediatrics for this period.

Paediatric Compliments 01/04/2024 – 31/03/2025
No compliments or feedback for Paediatrics within this timeframe.

Paediatric Adverse Events 01/04/2024 – 31/03/2025
The below list provides details of the adverse events within paediatrics:

Detail	Number
Appointment/admission/transfer/discharge	1
Blood Transfusion	1
Caldicott/Confidentiality & Data Protection	3
Contact with/exposure to Hazards	2
Equipment (including Electro medical)	2
Fire, Fire alarms & Fire Risk (incl. Smoking)	3
Infrastructure & Service related	4
Investigation Requests/Reports/Specimens (incl. Diagnostics, Imaging & Lab tests)	8
Technology; IT Systems, IT Security or Telecoms	3
Medicine related	37
Mortality	3
Needle stick / Clinical Sharps/ Blood	6
Patient information related (electronic/case record, charts and documents)	1
Treatment/Care	11
Violence/Abuse/Harassment	1

The incidents have been reviewed as part of the multidisciplinary Paediatric Clinical Risk Management meetings. No trends were noted in submissions for this period.

d. Quality Improvement

NHSAA are participating in the Scottish Patient Safety Programme (SPSP) Paediatric Programme. The overall aim of the programme is to improve outcomes for children, young people and families across Scotland.

The Paediatric Programme reports nationally on agreed measures within the Paediatric Care Measurement matrix. Under the terms of the Partnership Agreement with the SPSP Team, NHS Ayrshire & Arran have agreed to measure the following within paediatric services.

Compliance with the national PEWS Bundle

- Use of correct age-related PEWS chart
- Reliable use of PEWS observations
- Reliable scoring of PEWS
- A reliable response to children and young people who trigger PEWS

The national Paediatric Early Warning Score (PEWS) has been rolled out across Scotland. This allows consistency of reporting and understanding of information across Paediatric services in Scotland and is of particular assistance locally when in discussion with colleagues regarding an individual's progress or deterioration. The national toolkits were launched in January 2024, however, the SPSP requested we backdated data from January 2023 from the historical data we had stored. The charts below demonstrate NHS Ayrshire and Arran's compliance with the national PEWS Bundle.

Use of correct age-related PEWS chart

NHS Ayrshire and Arran demonstrate excellent compliance with the use of correct age-related PEWS charts, with 100% being observed on the majority of occasions. We observed three months where data was not recorded, and we were unable to obtain the data retrospectively.

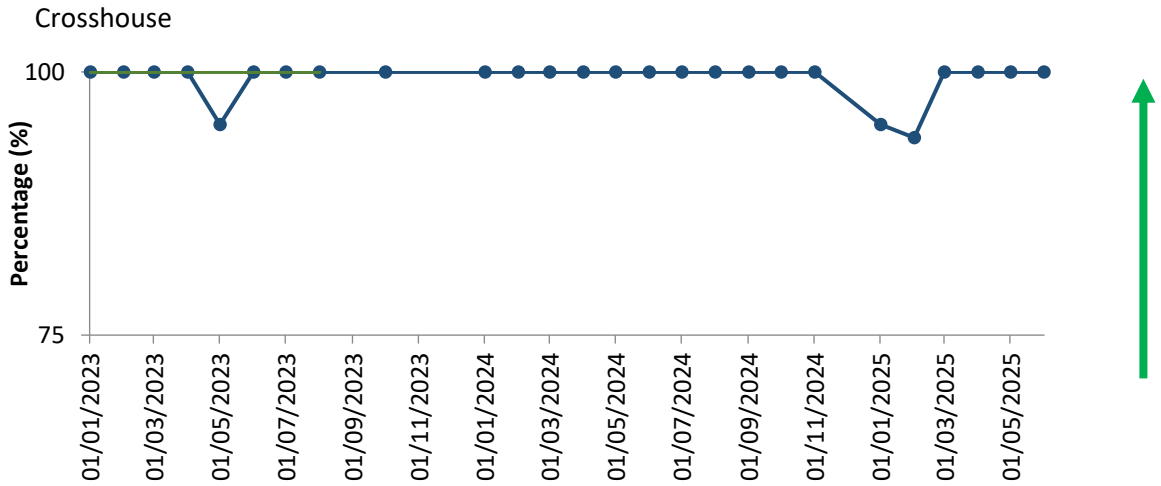

Figure 1. Percentage of children and young people with correct age-related chart

Reliable use of PEWS observations

The measurement of the reliable use of PEWS observations commenced in January 2024. The chart below outlines a median of 94% compliance with this measure.

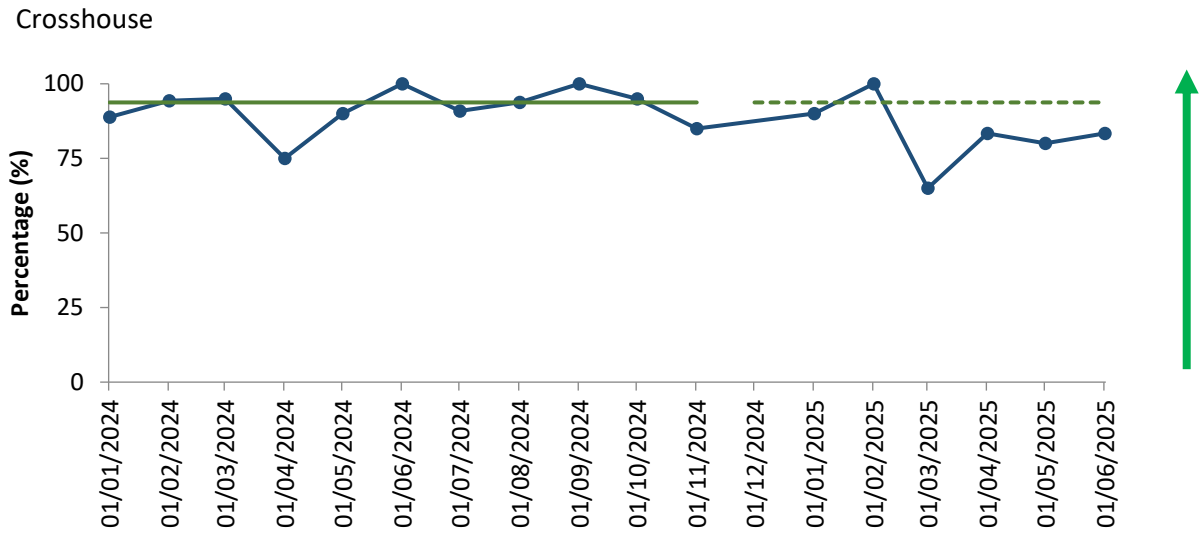

Figure 2. Percentage of PEWS charts with fully correct observations taken at correct frequency

Reliable scoring of PEWS

The reliable scoring of PEWS demonstrates a median of 88%.

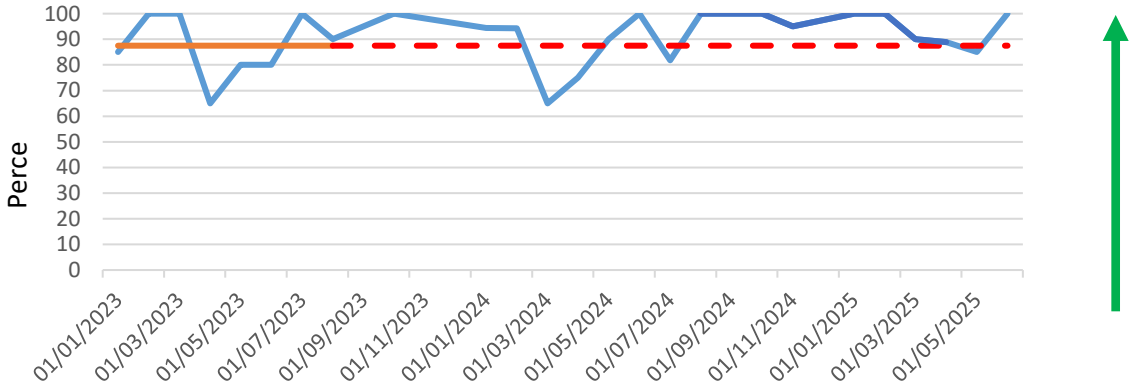

Figure 3. Percentage of PEWS charts with fully correct scores

A reliable response to children and young people who trigger PEWS

Improvement work has been undertaken to improve the reliable response to those children whose care requires to be escalated. A local escalation sticker has been tested in conjunction with the PEWS chart to make the process clearer and demonstrate escalation of care has taken place. We are currently sitting on a median of 93%.

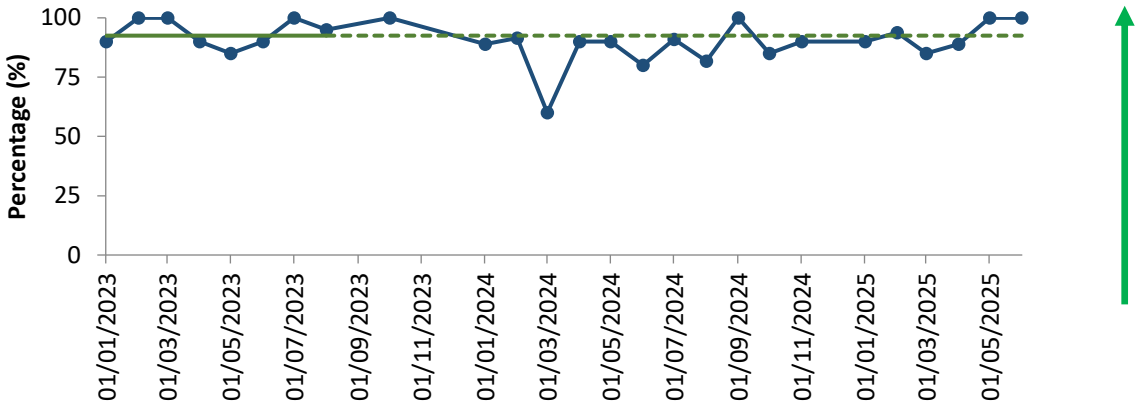

Figure 4. Percentage of children and young people where "at risk" observations are acted on and appropriate interventions are carried out

Additional improvement work undertaken includes

- Developed and tested new documentation to ensure we are capturing the right information.
- Providing ongoing teaching session to nursing and medical staff.
- Teaching at the junior doctors at their induction to ensure they are completely familiar with the processes within the paediatric department in Ayrshire and Arran, and why improvement is at the heart of all we do.
- We have also been very well received by the national SPSP team at HIS at our most recent face to face visit. We also presented the work carried out at the national conference in October 2024.

Governance surrounding PEWS.
A training package has been devised and delivered to all members of the nursing team from Band 3-7. The training package contains detail about the importance of the national PEWS bundle, linking the teaching to an actual case study.

An electronic record of the training is being created on Learn Pro, which evidences that the staff member has attended training and there is also a competency document being designed which will demonstrate that staff have been deemed competent in undertaking observations, calculating PEWS scores and escalating care appropriately.

A PEWS guideline has also been developed and has been ratified through the Women and Children's Clinical Governance Group. The aim of the guideline is to assist staff with the process of recording observations, calculating PEWS and escalating concerns appropriately.

SPSP Programme – future input
HIS SPSP Paediatric Team are in the process of setting up a Paediatric Early Warning Score (PEWS) Scotland Expert Work Group (EWG). Intelligence from teams, and a recent survey, has confirmed a need to revisit PEWS in Scotland.

Alongside this expert working group, HIS is also engaging with paediatric strategic partners in this work in order to guide the review and determine the next steps for the PEWS in Scotland.
The first meeting will:

- Share learning from NHS Scotland boards and emerging learning from NHS England and Wales
- Consider options for the next steps for PEWS in Scotland

As the group will have an advisory remit reliant on experience of Scottish PEWS, members will reflect the views of their organisation, peer group and / or network / group that they are representing and provide advice or opinion in their area of expertise. Members from NHS Ayrshire and Arran have been contacted and the first meeting will be held in August 2025

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.

2.3.1 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.

2.3.2 Workforce

NHS Ayrshire and Arran Paediatric Service remains compliant with the Health and Care (Staffing) (Scotland) Act 2019 and continues to report to the board on performance.

Staffing whole time equivalents within paediatrics in keeping with the organisation are adjusting to 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.

In addition to the above within paediatrics we have identified that the age profile of registered nursing staff is significantly higher in the age range of 40 years and below. This increases the potential for increased maternity leave. Timeous escalation for FTC to cover this are encouraged.

Currently a review of overall occupancy and acuity within the Acute Paediatric Services, which encompasses paediatric in-patient services and paediatric assessment unit is underway to ensure appropriate staffing establishments are achieved.

2.3.3 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.

2.3.4 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.

2.3.5 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.

2.3.6 Other impacts

- Best value
  - Vision and Leadership
  - Governance and accountability

2.3.7 Communication, involvement, engagement and consultation

All programmes of work require sustained communication, engagement, and collaboration with key stakeholders to ensure successful implementation and impact. To date, stakeholder involvement has included:

- Regular updates to relevant governance and improvement groups
- Participation in local and national SPSP/EiC learning
- Provision of access to local and site-level data to inform decision-making and improvement activity.

2.3.8 Route to the meeting

This paper was discussed at Healthcare Governance Committee on the 5 September 2025.

2.4 Recommendation

For awareness. The Board is asked to note the quality and safety activity in Paediatric Services.