NHS Ayrshire & Arran

Meeting: **Ayrshire and Arran NHS Board**

Meeting date: **Tuesday 7 April 2026**

Title: **Quality and Safety – Acute Services**

Responsible Director: **Vicki Campbell, Director of Acute Services**
Jennifer Wilson, Executive Nurse Director

Report Authors: **Ruth McMurdo, Deputy Nurse Director**
Stephanie Frearson, QI Lead Acute
Nina McGinley, Board Excellence in Care Clinical Lead and Lead for Practice Development
Gillian Biggans, Resuscitation Service Lead
Linda Robertson, QI Lead FFN
Laura Harvey, QI Lead Patient Experience
Debbie McCard, Risk Manager

1. Purpose

This is presented to the Committee for:
- Awareness

This paper relates to:
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambitions:
- Safe
- Effective
- Person Centred

This supports the following Corporate Objectives:
- **Better Care** – Ensuring our services provide safe care for our patients

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 and Arran Acute Services.

2.2 Background

NHSAA is participating in The Scottish Patient Safety Programme (SPSP), a national quality improvement programme which aims to improve the safety and reliability of

care. The programme has entered a new phase with the introduction of the Adults in Hospital Programme, 2025–2027. For the first time, this programme extends to community hospitals and builds on learning from previous SPSP collaboratives. The national safety priorities for 2025–2027 are:

- Deteriorating patient
- Falls
- Pressure ulcers
- Medicines in hospital (diabetes medicines management at transitions of care).

NHSAA continues to implement the national assurance programme and framework, Excellence in Care (EiC) and reports monthly quality of care data to Public Health Scotland via the Care Assurance and Improvement Resource (CAIR) dashboard.

2.3 Assessment

A range of site and ward level data continues to be collected and reviewed to monitor progress and inform focus of quality improvement work, complaints and adverse events.

Falls: Falls rates for both acute sites demonstrates sustained reduction with no further signals of improvement. The median rates for both sites is below the current Scottish national median rate of 7 (per 1,000 OBDs).
Pressure Ulcers: Despite improvement efforts, the incidence of Grade 2–4 PUs has continued to increase across both acute sites.
Cardiac Arrest: Cardiac arrest rate across acute sites demonstrates normal variation at 2.1. This is above the national median rate of 1.2.
Survival to discharge rates on both acute sites are below the national benchmark.
Nutrition and Hydration: Malnutrition Universal Screening Tool **(**MUST) compliance across both UHA and UHC remains high.
Complaints: Concerns and Stage 1 complaints remains stable with an average of 54 per month, Stage 2 complaints averaged 35 per month and showed an increase between September and November. Performance against target response times for both stages has remained below national targets, with significant improvement work underway to address delays in investigations and response drafting.
Significant Adverse Events: 120 Local Management Team Reviews (LMTRs) and 278 action plans are overdue. 44 Significant Adverse Event Review (SAER) reports and 56 action plans are overdue. Work continues to address overdue LMTR/SAER reports, and an improvement plan is in progress to address overdue action plans.
Excellence in Care: Both acute sites have demonstrated positive practice learning environment (QMPLE) scores, reflecting a strong learning environment. However, student feedback submission rates remain low. Quality assurance boards and documentation improvements are progressing well.

Full details of progress of Quality Improvement (QI) work, assurance programmes, complaints and adverse events within Acute Services are detailed in Appendix 1.

2.3.1 Quality/patient care

SPSP provides an opportunity for NHSAA to participate in a national improvement programme aimed at reducing harm and enhancing the experience and outcomes for people in acute care. This is complimented by the EiC assurance programme.

2.3.2 Workforce

Participation in local and national improvement and assurance programmes, management of complaints and learning from adverse events is essential to enhance patient experience and support delivery of high-quality, person-centred care.

2.3.3 Financial

Failure to maintain engagement and performance against SPSP and EiC measures may have financial implications. In particular, higher rates of falls with harm or PUs are associated with extended lengths of stay, demand on clinical resources, and additional costs.

2.3.4 Risk assessment/management

Failure to engage with national improvement programmes, complaints and adverse events management may increase the risk of patient harm, generate complaints and result in adverse publicity for the organisation.

2.3.5 Equality and diversity, including health inequalities

An impact assessment has not been completed.

2.3.6 Best value

This paper supports Best Value by strengthening:

- Vision and Leadership through clear priorities for improving quality and safety across Acute Services. It promotes
- Effective Partnerships by aligning with national programmes such as SPSP and Excellence in Care and by working collaboratively with clinical teams and wider stakeholders.

Governance and Accountability are enhanced through robust oversight structures, regular data scrutiny, and clear reporting on risks, performance, and assurance. The paper demonstrates good Use of Resources by targeting improvement activity where harm, cost, and operational impact are greatest, supporting more efficient and sustainable service delivery. Strong Performance Management is evidenced through continuous monitoring of safety measures, complaints, and adverse events, enabling focused action and improvement.

2.3.7 Other impacts

The improvement and assurance work described in this paper positively contributes to wider local outcomes improvement plans by supporting safer, more reliable care and improving patient experience across Acute Services.

Strengthened governance, learning systems, and quality processes also align with community planning priorities, particularly around wellbeing, prevention of harm, and delivering high-quality public services.

2.3.8 Communication, involvement, engagement and consultation

All programmes of work require sustained communication, engagement, and collaboration with key stakeholders to support successful implementation and delivery of impact. Stakeholder involvement includes:

- Regular updates to clinical governance and improvement groups
- Participation in local and national learning activity

- Access to local and site-level data to inform decision-making/ improvement activity.

2.3.9 Route to the meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.
Healthcare Governance Committee, 2 March 2026.

2.4. Recommendation

For awareness. The Board is asked to note the quality and safety activity within NHS Ayrshire and Arran Acute Services.

3. List of appendices

The following appendix is included with this report:

- Appendix 1: Acute Services Quality and Safety Update

Appendix 1 - Acute Services Quality and Safety Update

NHS Ayrshire & Arran

1. Introduction

This paper outlines quality of care and progress with national and local quality improvement (QI) and assurance programmes of work. It describes current progress and plans going forward in relation to patient safety measures including:

- Falls
- Falls with harm
- Pressure Ulcers
- Cardiac Arrest
- Food Fluid and Nutrition
- Excellence in Care
- Complaints/feedback
- Adverse Event Activity

2. Scottish Patient Safety Programme (SPSP)

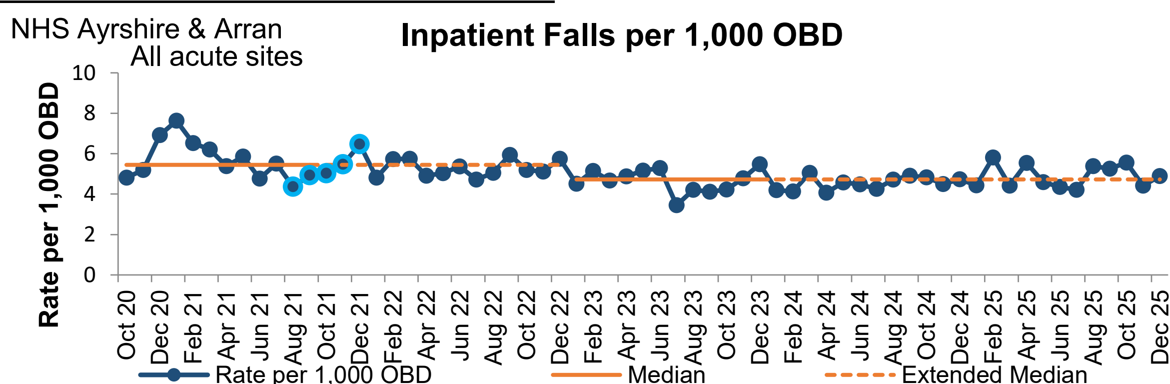
NHS Ayrshire Arran (NHSAA) is participating in The Scottish Patient Safety Programme (SPSP), a national quality improvement programme which aims to improve the safety and reliability of care. The programme has entered a new phase with the introduction of the Adults in Hospital Programme (2025–2027). For the first time, this programme extends to community hospitals and builds on learning from previous SPSP collaboratives. The national safety priorities for 2025–2027 are:

- Deteriorating patient
- Falls
- Pressure ulcers
- Medicines in hospital (diabetes medicines management at transitions of care)

2.1 Falls/Falls with Harm

The current median rate for falls across both acute sites is 4.7 per 1,000 occupied bed days (OBDs) (Chart 1). This has been sustained since January 2023 and remains stable demonstrating normal variation and no new signals of improvement.

Chart 1: All Falls rate for All Acute Sites



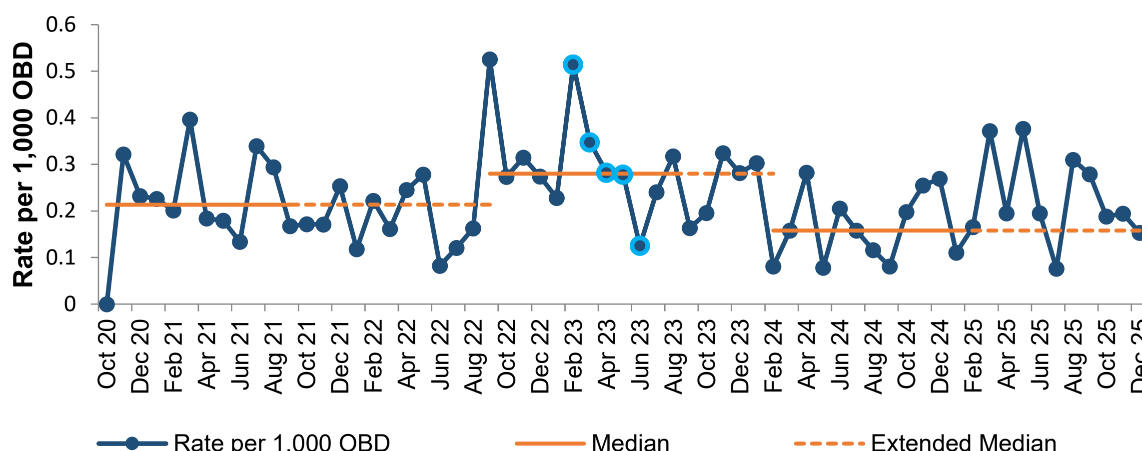
The incidence of falls with harm (FWH) has decreased on both acute sites, the median rate is 0.15 per 1,000 OBDs (Chart 4). This has been sustained since February 2024 and demonstrates normal variation with no new signals of improvement.

Chart 2: Falls with harm rate All Acute Sites

NHS Ayrshire & Arran

All acute sites

Inpatient Falls with Harm per 1,000 OBD



QI works to support the sustained reduction in falls continues across both acute sites.

2.2 Falls Co-ordinators

Falls Coordinators provide leadership and operational support to clinical teams to improve patient safety and reduce harm. Key activities include:

- **Data Monitoring:** Sharing monthly falls data and producing hotspot SBARs for wards with ≥7 falls to guide targeted action.
- **Targeted Support:** Focused support currently provided to two hotspot areas with high fall rates.
- **Incident Review:** All level 4/5 harm falls are reviewed to extract and share learning.
- **Guidelines & Decision Support:**
  - Essential Care after an Inpatient Fall
  - Management of Falls in Hospital and Safe Use of Bedrails
  - Higher Level Supervision guideline and risk assessment
  - Bedrail and falls risk assessment
- **Education:** Falls Champion sessions planned for 2026, LearnPro modules in development, and monthly awareness training delivered.
- **Standards:** Supporting tests of the HIS definitions of a “fall” and “fall with harm.”

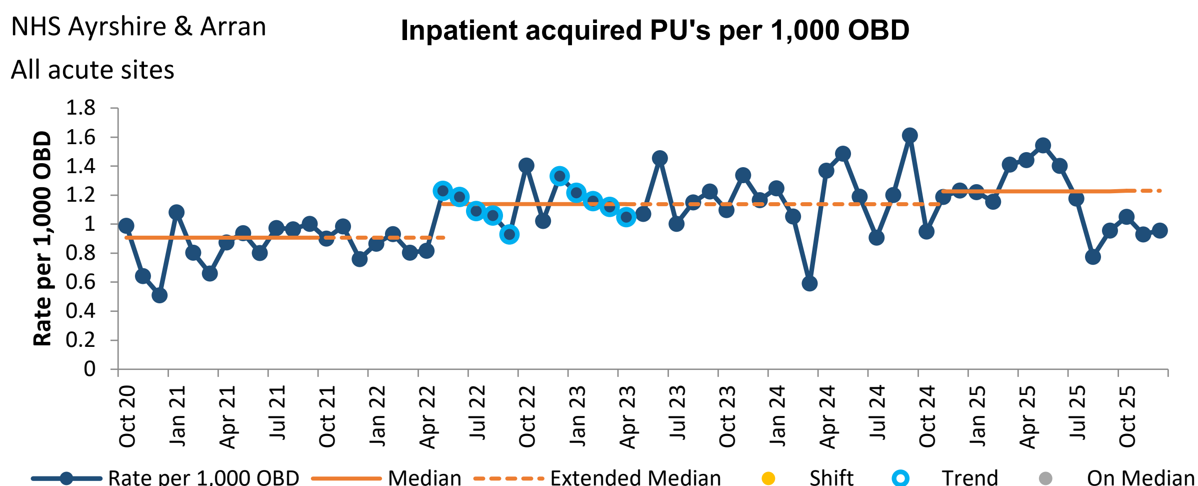
2.3 Acute Falls Group/Targeted Falls Improvement Work

The Acute Falls Group was formed in early 2025, to deliver an 18-month improvement programme across three acute wards at both hospital sites. This is led by the Lead Nurse for Emergency Care and Orthopaedic Trauma, with support from the Falls Coordinators and QI team. An evidence-based workbook approach has been adopted to guide change, complemented by a series of interactive workshops. Topics include continence and delirium, and nutrition.

3. Pressure Ulcers

QI work to support Pressure Ulcer (PU) prevention has involved multiple interventions including the PU Champion Programme, the PU Collaborative, revised Care and Comfort guidance, and PUDRA implementation. Despite these efforts no sustained reduction in PU’s has been demonstrated. The current median rate across both acute sites is 1.23 per OBDs (Chart 3)

Chart 3: Rate of acquired pressure ulcers - All Acute Sites



A PU improvement workstream has been included in the new SPSP Adults in Hospital Programme this will include quarterly submission of NHSAA PU data to HIS.

3.1 Acute Pressure Ulcer Group

The Acute PU Group was established in January 2025 to provide strategic oversight and support delivery of an 18-month improvement programme. Led by the Lead Nurse for Medicine, with support from the PU Improvement Nurse (PUIN) and QI team, the programme uses an evidence based workbook approach to promote consistency and guide change. This is supported by interactive workshops delivered by subject matter experts to reinforce learning and embed best practice, with further sessions planned throughout the programme.

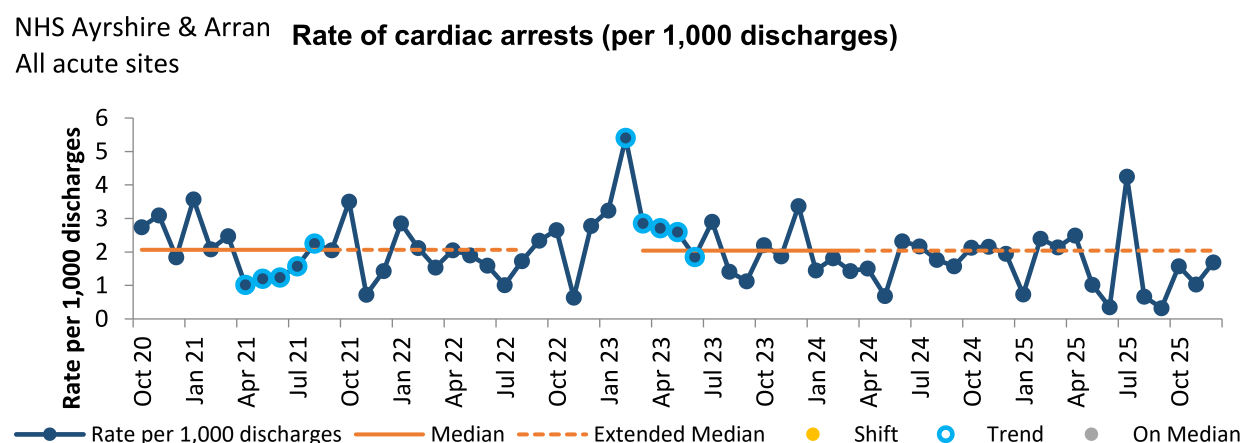
The incidence of Grade 2–4 PUs has continued to increase. As a result, a PU Assurance Oversight Group has been convened to strengthen governance, provide strategic direction, and offer assurance in support of PU prevention and reduction across both acute hospital sites.

4. Deteriorating Patient

4.1 Cardiac Arrest

Acute Sites Cardiac arrest rate data continues to demonstrate normal variation (Chart 4), with the median currently 2.1 per 1,000 deaths and discharges. NHSAA rate is above the national median of 1.2

Chart 4: Acute Sites Cardiac Arrest Rate per 1,000 Deaths and Discharges



4.2 National Cardiac Arrest Audit (NCCA)

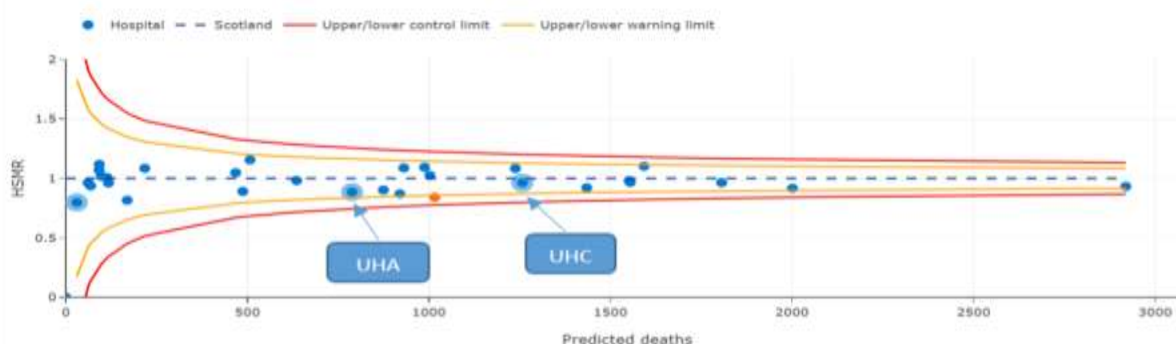
National Cardiac Arrest Audit (NCAA) quarterly data for UHA demonstrates a 7.1% survival to discharge rate which has decreased from the last report period, where survival to discharge was 22.2%.

UHC data demonstrates a survival to discharge rate of 9.1%, which has decreased from the last reporting period survival to discharge of 12.8%. Both sites are below the national average.

4.3 Hospital Standardised Mortality Ratio

The latest Hospital Standardised Mortality Ratio (HSMR) data published by Public Health Scotland on 11th November, shows UHA and UHC to be within the control limits as shown in Chart 5. UHA HSMR rate is 0.89 and UHC 0.96.

Chart 5: HSMR for Deaths within 30 days of admission to hospital July 2024 - June 2025



4.4 Cardiac Arrest Reviews and Treatment Escalation Planning Improvement Work

Resuscitation Services have reviewed 100% of true cardiac arrests for both acute sites between January and December 2025 and collated themes for learning and improvement. A key area identified is improving Treatment Escalation Planning (TEP).

Treatment Escalation Plans (TEPs) are designed to support the decision-making process and ensure continuity of care. Phase 1 of focused TEP improvement work is underway within targeted areas at both acute sites with learning and improvements shared at a workshop held in February 2026. Further TEP improvement work is planned throughout 2026 in Acute Services.

Learning identified from cardiac arrest reviews continues to be shared with Senior Charge Nurses (SCNs) from the area where the cardiac arrest occurred and wider with key groups.

A process for cardiac arrest review teams to escalate cases for further review to the Adverse Event Review Group (AERG) is established with 26% of all cardiac arrests at UHA and 25% at UHC escalated to AERG for review since January 2026.

5. Food Fluid and Nutrition

FFN standards data is collected monthly from 32 inpatient wards across both acute sites. Staff can use the Food, Fluid and Nutrition Measurement Tool as a tool to understand, measure, monitor and improve the quality of nutritional care in their clinical setting and to make and implement improvements in their process, and subsequent the care that is delivered.

The results from EiC MUST measurement continue to be reported monthly with reports shared with teams and senior nurses for review and action. Information is discussed at the Acute Quality and Safety Oversight Group meeting bi-monthly. The Mealtime Coordinator audit is also collated and shared with the suite of EiC measurements.

MUST Score Compliance across UHA and UHC remains high with compliance from March 2025 shown in Chart 6 and 7

Chart 6: MUST Compliance - UHA

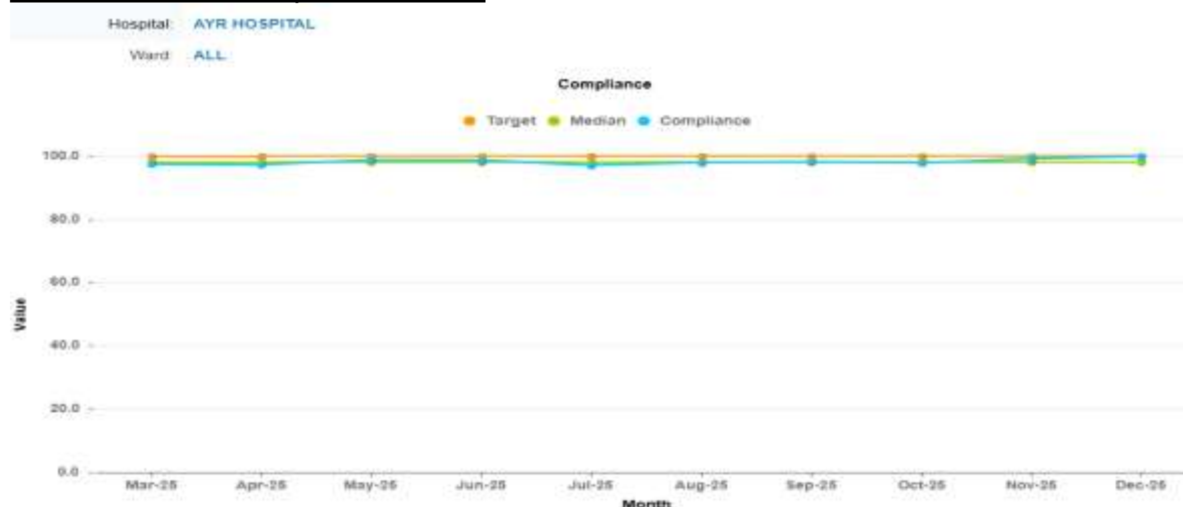
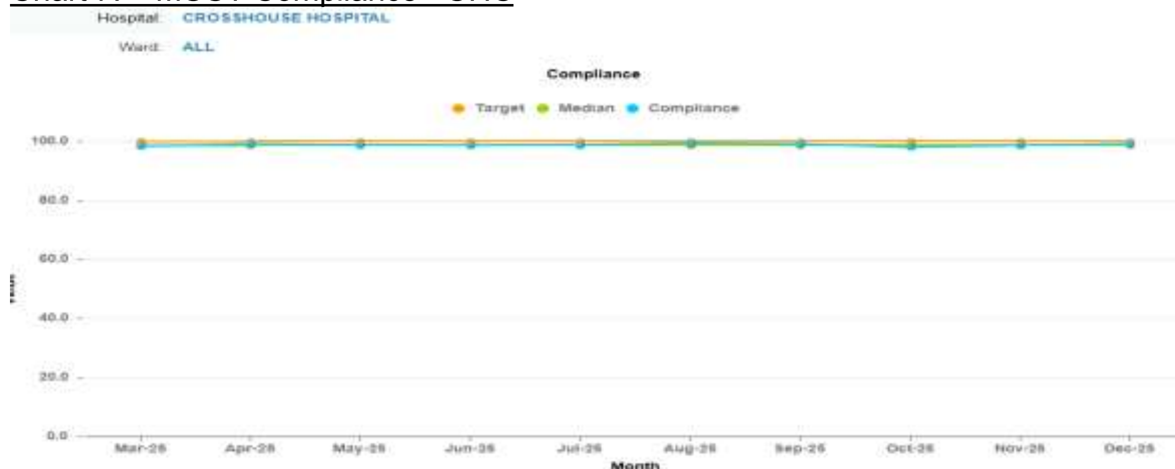


Chart 7: – MUST Compliance - UHC



5.1 Food, Fluid and Nutrition Education

Education is part of the Ensuring Safe Care, nursing induction and student nurse forum sessions, delivered by members of the multi-disciplinary teams and a Nutrition and Hydration Champions' education programme provides regular online education network and in person local sessions.

6. Quality and Safety Oversight Group

The introduction of a monthly Quality and Safety Oversight Group in 2023 provides a robust approach to the monitoring and scrutiny of quality and assurance processes, outcome data and service improvement activity. Group membership is inclusive of Senior Nursing Leadership, Site Directors, Clinical and Care Governance, Excellence in Care and Health and Safety, with bi-monthly outcome data reporting by Resuscitation Services, Infection, Prevention and Control and Food Fluid and Nutrition Leads. Data scrutiny has supported the identification of areas of excellence and areas for

improvement. Most recently a focus on monthly compliance of quality process measures and audit data submission has seen an increase in activity and process compliance percentage.

7. Excellence in Care

The Excellence in Care (EiC) programme is the national assurance framework for Nursing and Midwifery, recently expanded to incorporate Allied Health Professionals. This expansion strengthens consistency and visibility of care assurance by aligning scrutiny of fundamental care standards with workforce considerations and the quality measures set out within the Common Staffing Method (CSM) of the Health and Care (Staffing) (Scotland) Act 2019. EiC reporting encompasses a comprehensive set of indicators, including:

- National Early Warning Score (NEWS) accuracy and frequency,
- Food, Fluid and Nutrition (FFN) assessment and management,
- Multi-Drug-Resistant Organism (MDRO) screening,
- Pressure Ulcer and Falls rates,
- Quality Management of the Practice Learning Environment (QMPLE) and,
- Predictable Absence, Supplementary Staffing usage, and Establishment Variance.

Consistent compliance with NEWS accuracy of calculation is demonstrated, however, variance in correct frequency of observation is noted cross-site with a median of 83% in correct frequency in UHA and 85% in UHC. (Chart 8 and Chart 9). There have been several factors that may have attributed to improvement, these include introduction of Deteriorating Patient Champions and implementation of a monthly quality of care highlight report to enhance data scrutiny and assurance.

Chart 8: NEWS Frequency Compliance UHA

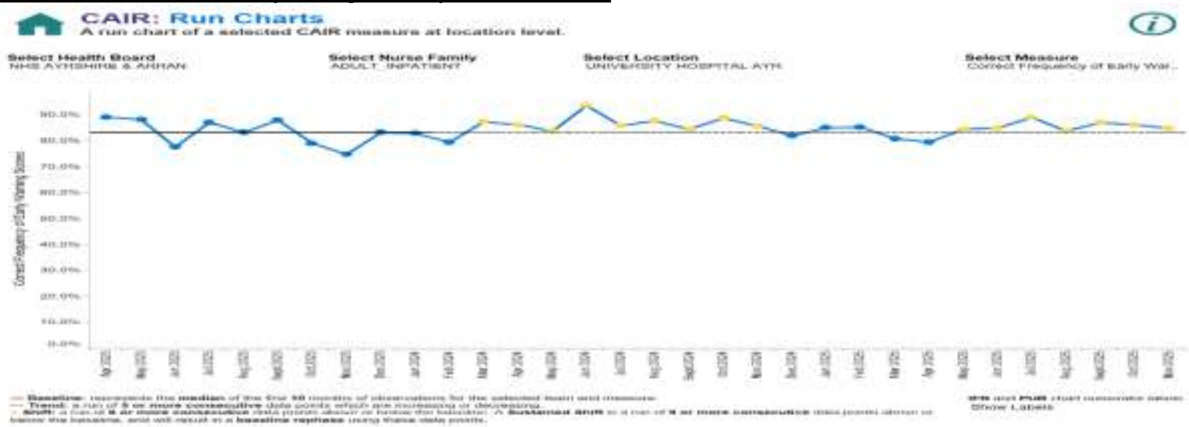
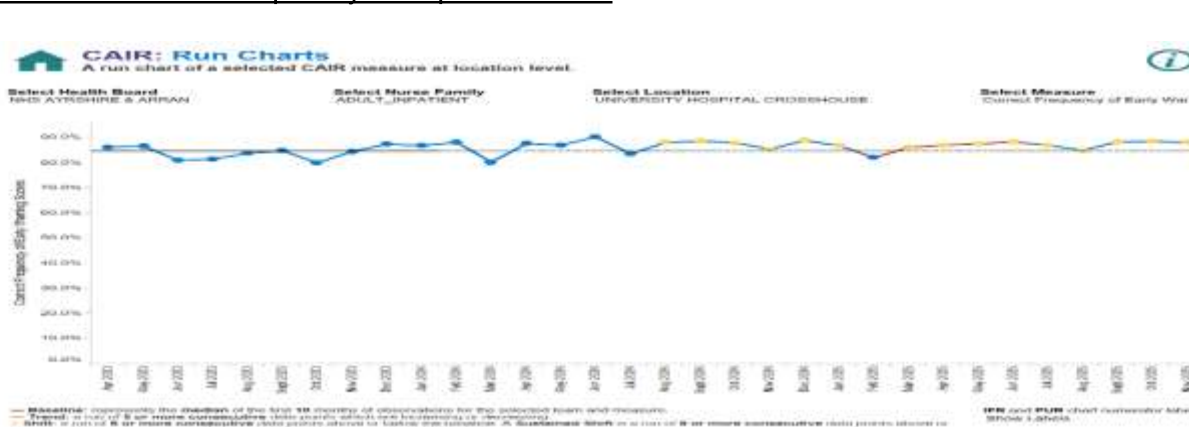


Chart 9: NEWS Frequency Compliance UHC



Oversight of the quality of pre-registration learning and development of the future nursing workforce is provided via the percentage score of Quality Management Practice Learning Environment (QMPLE). This provides a measure of the quality of the learning environment, offering assurance of strong educational governance whilst highlighting the culture, support, and conditions that enable students to thrive. Data scrutiny of QMPLE score signals an improvement in Practice Learning Environments at UHA and UHC, with a median of 90% and 89%, respectively. The recent introduction of Student Education Forums, by the Practice Education Facilitators team has enhanced student experience, complemented by practice learning in clinical environments.

Chart 10: QMPLE Score UHA – Median 90%

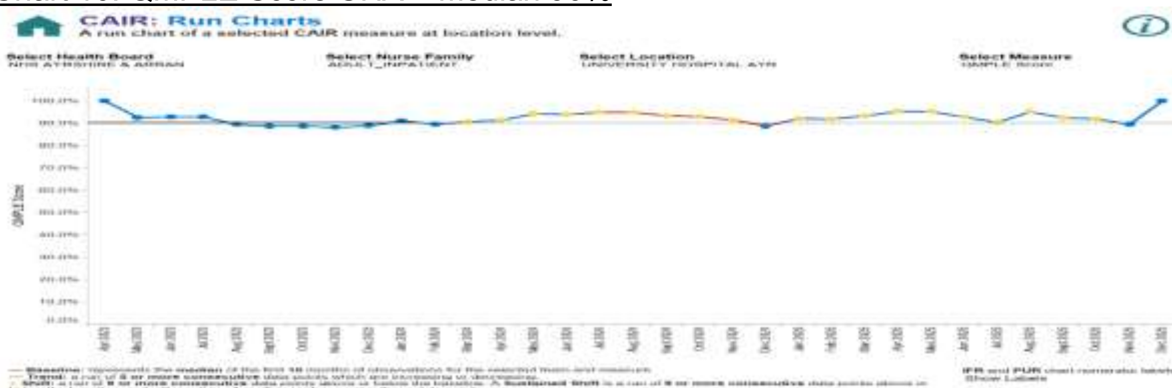
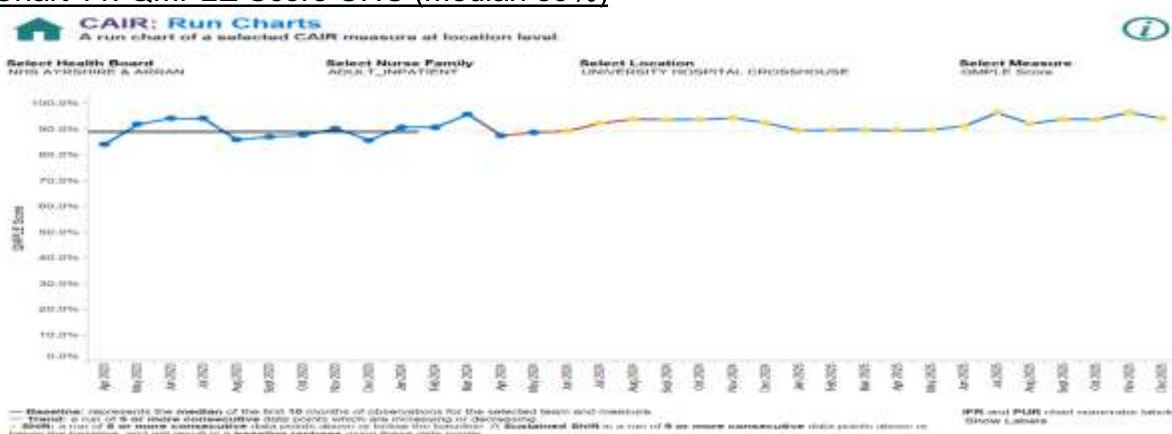


Chart 11: QMPLE Score UHC (Median 89%)



MDRO screening at point of admission and transfer is imperative to reducing hospital acquired infections. NHSAA have an agreed process to screen within 24 hours of admission. The EIC national definition is under-review with proposed change to 24 hours. Current local assurance is achieved via local audit process for all areas with direct admission to hospital. Audit data is suggestive that reliability with MDRO screening is variable. However, early scoping has indicated audit usability and understanding of language may have influenced lower compliance results. The audit tool will be adapted by the EiC team by March 2026 in alignment with a wider documentation review to ensure standardisation of audit surveillance and understanding.

Key EiC highlights for reporting period:

- Development of a Quality of Care (QoC) data monthly highlight report to improve access to QoC data for clinical teams.
- Implementation of Care Assurance workshops for Senior Charge Nurses aligned to organisational implementation of Quality of Care reviews.

- Introduction of standardised induction/orientation handbook for all newly appointed nursing and healthcare support workers.
- Progression of in-patient nursing documentation review with target implementation by end March 2026.

Key EiC challenges for reporting period:

- Accuracy of quality of care data for assurance is limited by completion of Business Objects system development. This can result in variance of reportable data for improvement, assurance and identification of risk.

8. Feedback and Complaints

8.1 Complaints Performance and Outcomes

Chart 12 demonstrates the number of concerns and stage 1 complaints received over the last 12 months demonstrating normal variation. The average number of Stage 1 complaints received each month was 54.

Chart 12: Concerns and Stage 1 Complaints

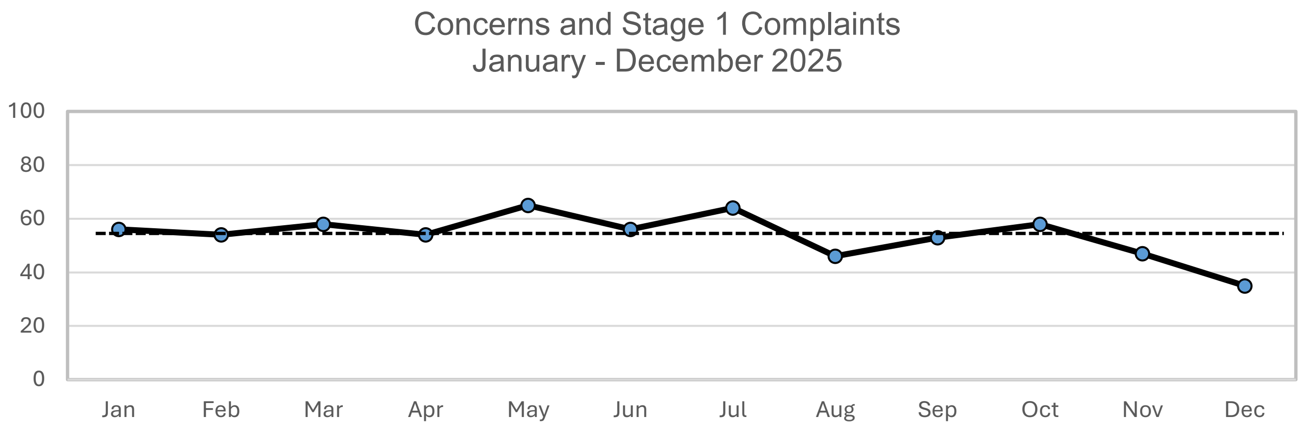


Chart 13 displays the total number of Stage 2 complaints received in the last 12 months. The average number of complaints received was 35 per month.

Chart 13: Stage 2 Complaints

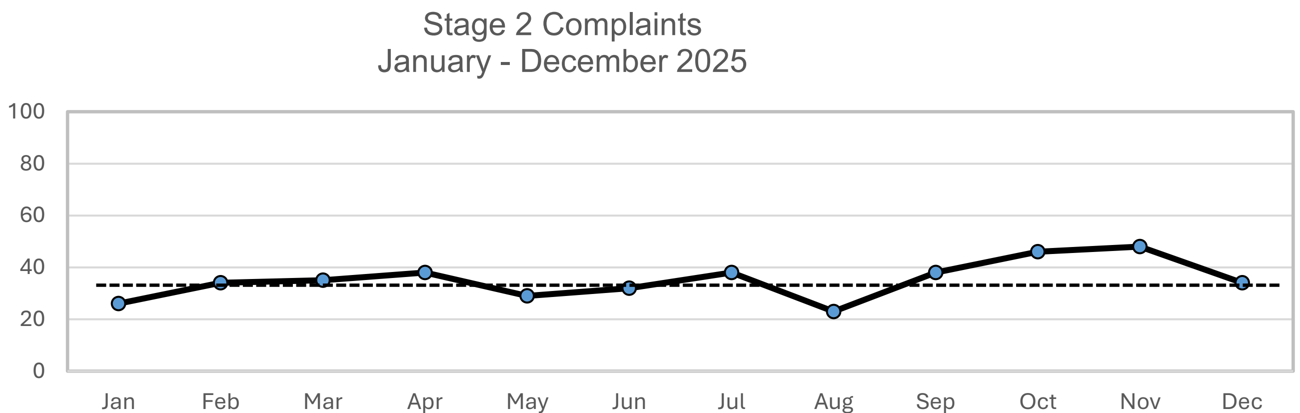
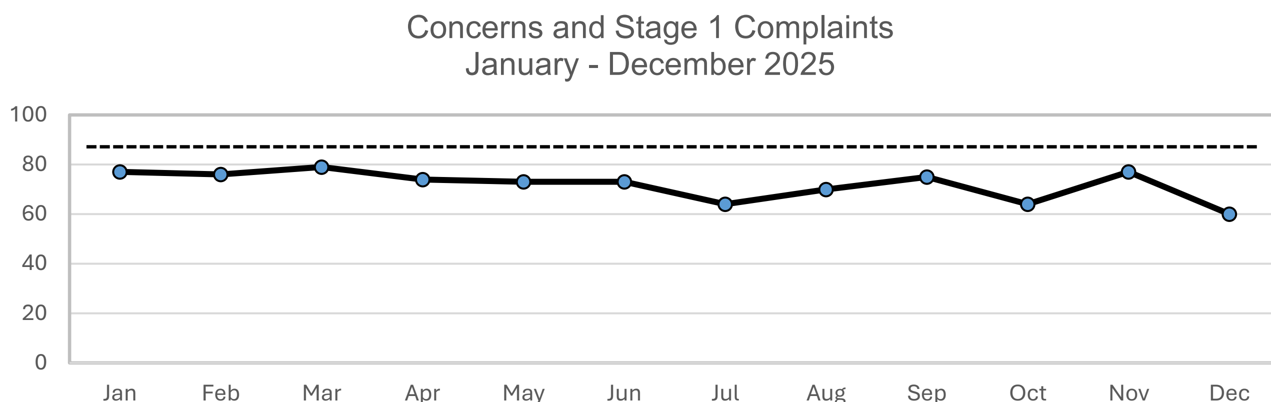


Chart 14 demonstrates compliance for concerns and stage 1 complaints. Overall performance remains below the 85% target throughout 2025.

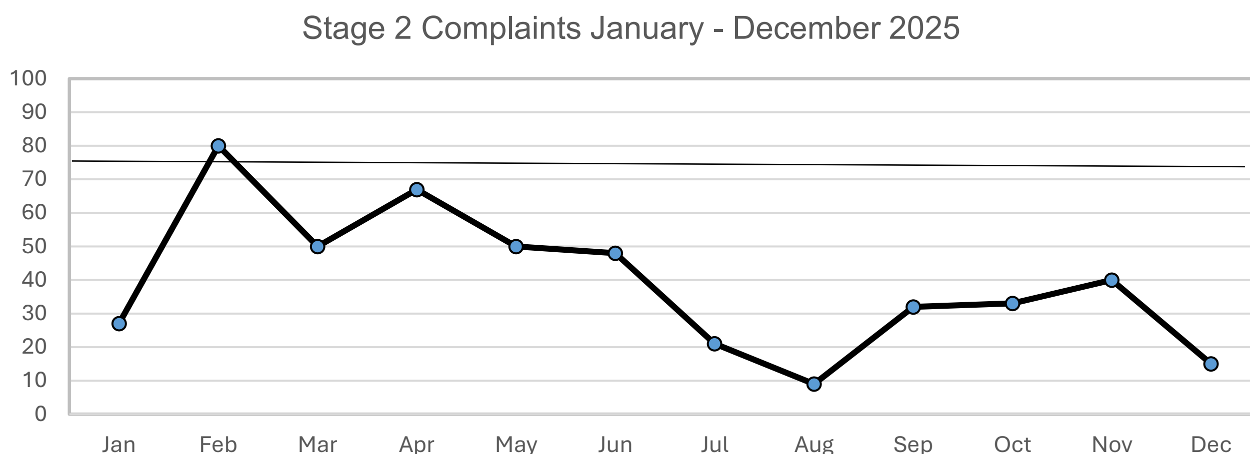
Chart 14: Percentage Concerns and Stage 1 Complaints Closed on Target



Boards are currently set a target of 75% compliance for stage 2 complaints. Performance against the target response time should be interpreted with caution for the first half of the year, as figures from January to June were based solely on closed complaints. From July the reporting method was strengthened to include both open and closed complaints.

Complaint handling performance for Stage 2 complaints is presented in Chart 15.

Chart 15: Percentage of Stage 2 Complaints Closed on Target



A significant amount of work has progressed and continues to improve acute complaint handling. Out of time complaints have been allocated to service managers and members of the wider management team to assist in drafting responses. Whilst the quality of those responses does need some work, the volume of work being undertaken will support a reduction in out of time activity. The impact of this work is being reported on a weekly basis, and the work has extended to in time activity.

8.2 Complaints Current Activity

This data represents a point in time and is provided as a reference for current activity. The data in Table 2 and Table 3 were extracted on 23 January 2026. Total number open complaints = 199

Table 2: Current Open Stage 2 Complaints

Breakdown	Current	Percent
In time	31	19%
No. >20 Days	131	81%
Total	**162**	**100%**

Table 2 demonstrates a breakdown of current open stage 2 complaints that are 80 working days and over. This data was extracted on 28 January 2026.

Table 3: Current Open Stage 2 Complaints over 80 WD

Status	Number	Percent
Number at approval stage	33	42%
Number awaiting information from Service	16	20%
Number awaiting response being drafted	30	38%
Total	**79**	**100%**

Service managers who are allocated as Investigation Leads are responsible for investigating complaints and sharing the findings to the Complaints Team to draft the response. There are currently delays both at the investigation stage and drafting the responses. This aspect of complaint handling is a priority for improvement, and the Quality Improvement Lead is meeting with Divisional General Managers to discuss all aspects of complaint handling.

8.3 SPSO Referrals and Investigations

There was a total of 28 SPSO referrals received in the last 12 months relating to Acute Services and none have progressed to investigation. The SPSO is being impacted by the rise in complaint activity and are advising they have delays of up to 12 months to review referrals. We may therefore see a rise in future quarters.

8.4 Complaint Themes

Themes across Acute Services are reflective of the top five themes across all complaints. Table 5 displays the top themes and most common subthemes.

Table 5: Complaint Themes & Sub themes

Clinical Treatment	**Total**
Disagreement with treatment / care plan / wrong diagnosis	111
Co-ordination of clinical treatment	52
Poor medical or nursing treatment	51
Problems with medication	12
Waiting Times	
Unacceptable time to wait for the appointment	102
Test results delayed / mislaid	23
Cancellation of appointment /admission	4
Communication	
Attitude and Behaviour	77
Communication (written)	13
Communication (oral)	17
Competence	2

9. Significant Adverse Events

The current status of Significant Adverse Events within Acute Services is shown in Table 6 (Local Management Team Reviews) and Table 3 (Significant Adverse Event Reviews)

Table 6: Status of Local Management Team Reviews – Acute Services

No of LMTRs Active by Commissioned Date						
Year	Total No Commissioned	Report		Action Plan		Whole Process Complete
		Overdue	*On Target	Overdue	*On Target	
18/19	80	0	0	5	0	75
19/20	68	0	0	21	0	47
20/21	50	0	0	20	0	30
21/22	183	9	0	78	3	93
22/23	112	10	0	49	6	47
23/24	128	18	0	72	3	35
24/25	88	27	0	31	15	15
25/26	84	56	6	2	19	1
Total	**793**	**120**	**6**	**278**	**46**	**343**

* *On Target - within timescales as defined by HIS Framework*

Table 7: Status of Significant Adverse Event Reviews – Acute Services

No of SAERs Active by Commissioned Date						
Year	Total No Commissioned	Report		Action Plan		Whole Process Complete
		Overdue	*On Target	Overdue	*On Target	
18/19	21	0	0	0	0	21
19/20	15	0	0	0	0	15
20/21	22	0	0	5	0	17
21/22	19	1	0	9	0	10
22/23	18	4	0	11	0	6
23/24	29	15	0	18	2	5
24/25	33	24	0	13	3	2
25/26	39	0	15	0	0	0
Total	**196**	**44**	**15**	**56**	**5**	**76**

**On target – within timescales as defined by HIS Framework*

9.1 Adverse Events Key Learning

Learning identified through completion of SAERs is developed into an action plan and this is monitored by the appropriate division/service until completion. The themes identified from SAERs approved in recent months are:

- Clinical escalation and referral pathways
- Communication (internal, external and documentation standards)
- Clinical monitoring, assessment and early recognition of deterioration
- Clinical procedure safety, infection prevention and competency
- Capacity management, safety of additional beds and operational governance

Work is planned over the next quarter to develop an improvement plan to address the overdue action plans. Themes for learning will be identified and actioned via appropriate forums.