NHS Ayrshire & Arran

Meeting: **Ayrshire and Arran Board**

Meeting date: **Tuesday 7 April 2026**

Title **Quality and Safety - Neonatal Services**

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1. Purpose

This is presented to the Committee for:

- Awareness

This paper relates to:

- Annual Operational Plan

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

- 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 Neonatal 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

2.3a 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.

We continue to review trends on a weekly basis as part of our Quality Assurance meetings.

Staffing

Our rosters for Nursing and Midwifery are compliant with British Association of Perinatal Medicine (BAPM) standards by 98%. The national average is 84%. The Qualified in Specialty (QIS) training is a national discussion as the university that used to provide this in Scotland has ceased provision. As a result all boards are sourcing the training in England which has a larger cost implication. In order to provide Neonatal nursing care and conform to BAPM guidance, Neonatal Qualified in specialty training is required. For NHS Ayrshire and Arran we are currently 75% compliant with this requirement. We are scoping alternative training methods in Scotland at present such as QIS students released to NHS Lanarkshire on month placements to complete their competencies.

Medical Staffing

Tier 2 middle grade cover has been supported as a business case by the board. The recruitment for this is to follow. Consultant cover remains appropriate with 6 resident Neonatal consultants to support the service.

2.3b Quality Control

Infection Prevention and Control (IPC)

Women and Children's Services have commenced the submission of the PC 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. There has been positive results in our Infection control compliances for the Neonatal service from which we are assured.

Training and Development

Recent vacancies within the neonatal qualified in speciality (QIS) staff group have identified a 5% reduction in the required 70% BAPM level of registered staff with this qualification. We are supporting a programme to increase this back to the 75% compliance with releasing staff to other boards to complete the learning programme.

Within Women and Children’s services recorded completion of PDP /PDR has historically been low. There has been focused work 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% from a 27% position.

Mandatory and Statutory Training (MAST) compliance is 95%

2.3c Quality Assurance

Data September 2025

Maternity and Neonatal complaints 01/04/2024 – 31/03/2025

	TOTAL
Stage 1	9
Stage 2	11

Primary Theme	Stage 1	Stage 2
Treatment / Clinical	4	8
Staff Attitude	2	3
Communication	2	
Delays	1	

Maternity and Neonatal compliments 01/04/2024 – 31/03/2025

We received four direct compliments during this period highlighting positive care given by staff. We also received feedback from 28 members of the public on Care Opinion. Seven of these had a negative element, however, positivity for compassionate staff was also noted on these. All 28 correspondence were responded to by the Director or Head of Midwifery. The average time to respond was 33 hours with fifteen responded to <24 hours.

Maternity and Neonatal Adverse Event

Within Neonatal services we noted 40 Adverse Events. 14 (35%) were due to Neonatal incidents between 01/04/2024 – 31/03/2025. There is an agreed Neonatal incident criteria that is followed and reported under Each Baby Counts. These include unexpected admission to Neonatal unit, Cooling therapy, baby born before arrival to hospital, weight loss in the postnatal period or undiagnosed neonatal abnormalities. We have not had any themes for this period that require escalation.

2.3d Quality Improvement

NHSAA are participating in the Scottish Patient Safety Programme (SPSP) Perinatal Programme (which includes neonatal services). The overall aim of the programme is to improve outcomes for Mothers and Babies across Scotland

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

Core

- Reduce 'term' admissions to the NNU
- To optimise the management of care of pre-term babies

Supplementary information included in the Excellence in Care measures

- Percentage of infants with a measured documented temperature within one hour of admission

Reduce 'term' admissions to the NNU
Since 2021, improvement work was focused on the reduction of term admissions, which resulted in the observation of a reduction on the number of term admissions to the Neonatal Unit. We tested and implemented the use of the warm bundle, Introduced Transitional Care and provided training to all new doctors with the purpose of increasing confidence when assessing babies to avoid needless admissions to the Neonatal Unit, however this improvement was not sustained.

All term admissions admitted to the unit for less than 24 hours are reviewed by the Unit Coordinator and hot week Consultant. A proforma was developed to assist in identifying any themes. The data is variable at present. We are currently further scrutinising the data to establish why babies are being admitted to the unit at term, where from and their length of stay. A full report on this data will be generated and discussed at the next Perinatal Quality Improvement meeting in March 2026.

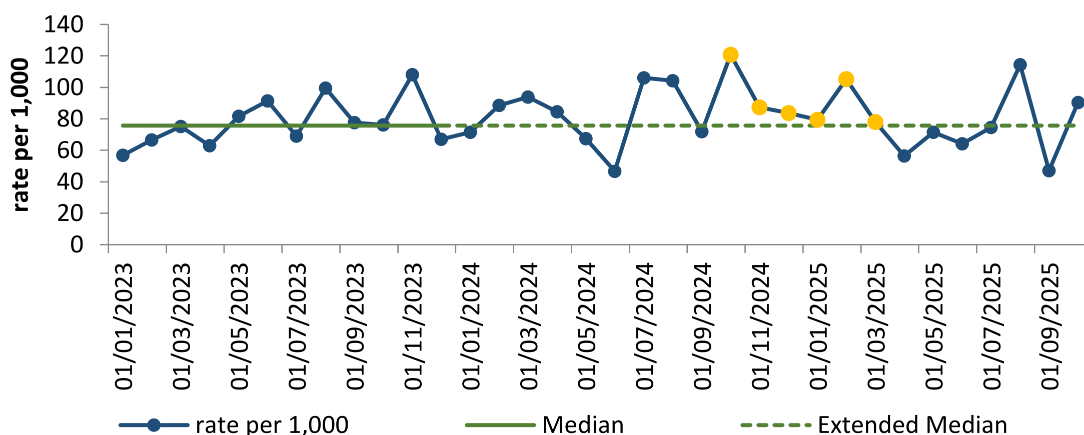
We have been monitoring the number of babies who come into the Unit with a stay of less than 24 hours. Since January 2025, these admissions have accounted for 39% of all term babies, however, for the most, these admissions were appropriate.

Early indications would suggest almost half the term admission stay for less than 24 hours, and the main reason for admission is respiratory distress.

In 2022, new guidance on steroid administration to support respiratory function in the Neonate was released nationally. The guidance focussed on the side effects the steroid administration can have on the mother when given antenatally. As a result the women are not consenting to administration if they are due to have a preterm birth. Our admissions to Neonatal unit for premature babies will increase for respiratory support and steroid therapy and we believe this had an impact on maternal decline for steroid therapy, which can have an impact on the baby, who may require care in the neonatal department.

Figure 2 below, has been taken from the new SPSP Toolkit and present data since January 23. We are currently sitting on a median of 75.7 / 1000 term babies admitted to the Neonatal Unit.

Figure 2. Term Admission to the NNU



Perinatal Wellbeing Package
Clarity has been sought with the national team on some of the aspects of this measurement package, as it has been noted that compliance with the pre-term wellbeing package is not always achievable due to an imminent delivery:

- <27 weeks born in NICU
- <30 weeks magnesium sulphate within 24 hours
- <34 weeks antenatal steroids (within 1 week of birth)

This was discussed at length at a meeting with SPSP. As the national measures are based on the National Neonatal Audit Programme (NNNAP), these cannot be changed. SPSP extract their data from the NNAP national dashboard.

Benchmarking with national figures, our compliance, although variable, is in keeping with Health Boards of a similar size and reflects the small data set.

As this is an all or nothing bundle the mum / baby must receive every aspect to meet the criteria of a pass.

Below is the data held on the National Dashboard. Any area in red denotes where data was missing from the BadgerNet system at the time of collation

Figure 3. <30 weeks magnesium sulphate in 24 hours prior to delivery

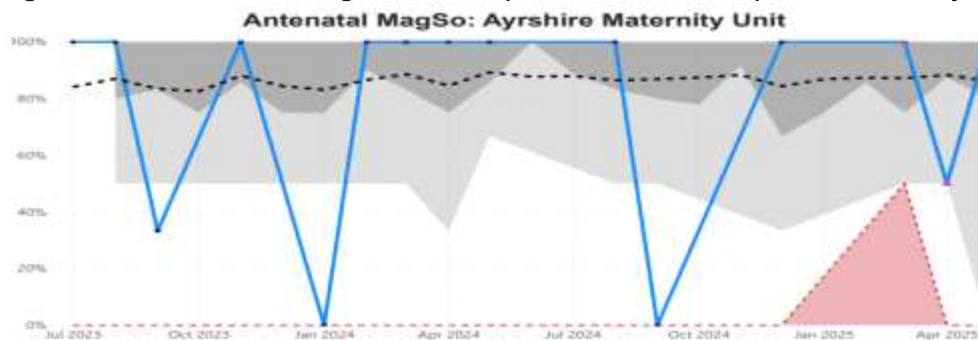


Figure 4. Mothers with babies born between 22 and 33 weeks receive a full course of antenatal corticosteroids within 1 week prior to delivery

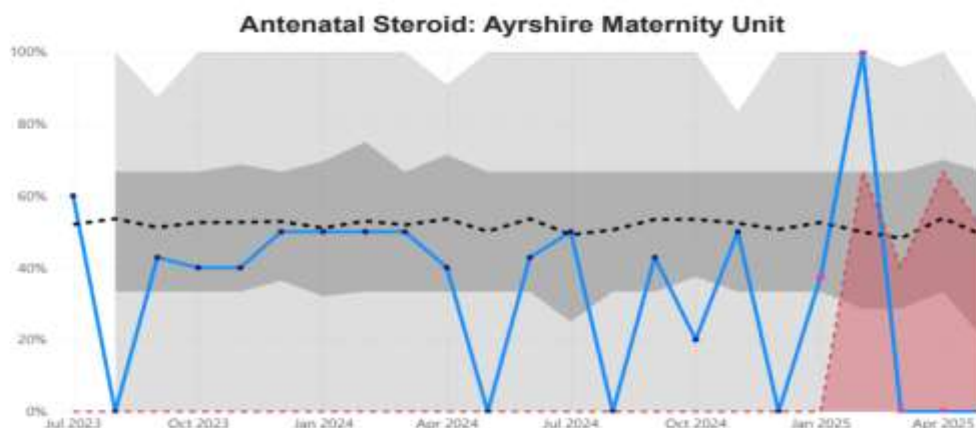


Figure 5. <34 weeks cord clamping at or after 60 seconds

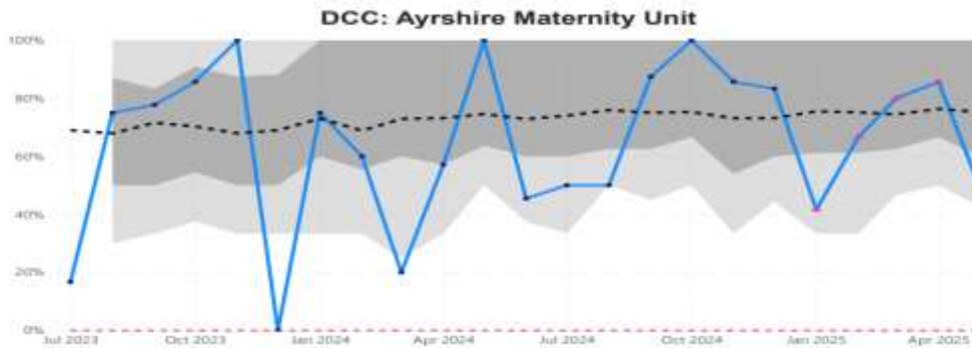
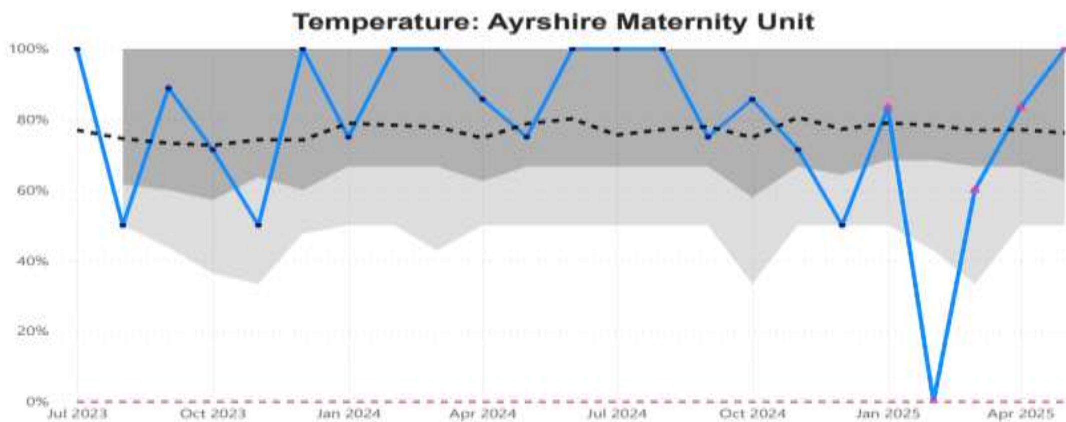


Figure 6. Babies <34 weeks a temperature of 36.5-37.5 measured within 1 hour of birth

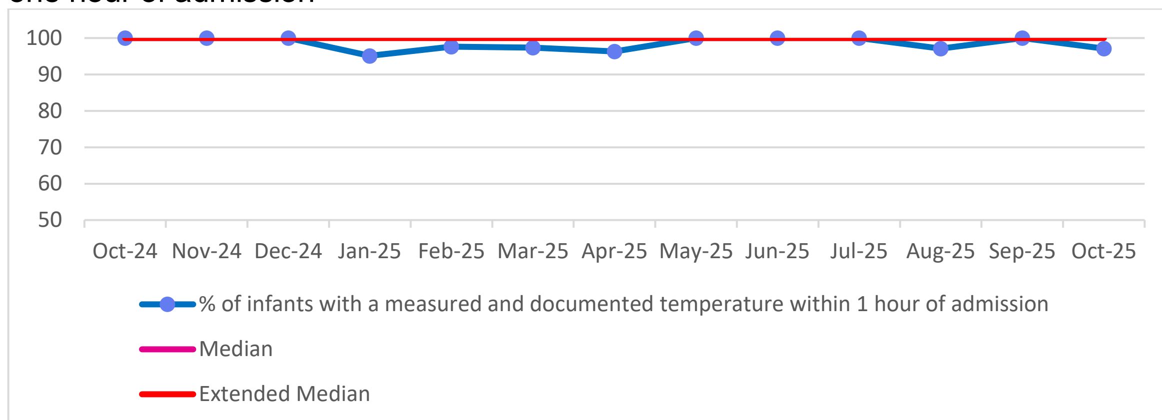


Neonatal Temperature (included in the EiC measures)
Excellence in Care quality of care outcome measures have identified neonatal temperature as a key quality indicator. Hypothermia has long been recognised as a serious risk to newborn babies, especially premature and low birth weight infants. The provision of effective thermal care within one hour of birth will decrease the likelihood of hypothermia and deterioration. Timely recording of temperature of all babies (<24hours old) within one hour of admission to the neonatal unit supports the assessment and plan of care to promote normothermia. Neonatal temperature is recorded on Badgernet, which the EiC team extract, however the Neonatal staff also keep a separate record of this, which is presented below.

We note the data extracted by EiC may not always be accurate as the data may not be on the system or recorded elsewhere at the time of extraction. This issue has been discussed and is now presented at the resident Tier 1 and 2 Doctors Induction training within the Unit.

Since October 2024, data has noted that documented recording of the baby's temperature within one hour of admission has always been above the target achievement of >95%, 100% is observed in over half of occasions.

Figure 7. Percentage of all infants with a measured documented temperature within one hour of admission



Governance surrounding the Neonatal measures
A training package has been devised and delivered to all residents to prevent term admissions to the NNU. There is ongoing work around use of the Life Start trolley and the importance of delayed cord clamping. This includes sessions at induction for all new doctors

The Respiratory Bundle has been re-introduced and education of junior staff to prevent term admissions. We set up a short life working group to look further into 'avoidable' term admissions to the NNU.

A training package has been devised and shared with medical and nursing staff on the utilisation of the warm bundle to prevent hypothermia in infants.

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 Neonatal 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 neonatal services 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 neonatal 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.

2.3.3 Financial

There may be financial implications identified as new National Standards of care are identified. This will be discussed as the programme progresses. 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-compliance with 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 toward 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 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

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

- A partnership agreement between SPSP and NHS Ayrshire & Arran in relation to the way forward with new measurements was signed off and sent to all relevant parties in November 2024.
- Regular reporting through approved governance routes for neonatal 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, with the Paediatric Clinical Governance Group having sight of this also.

2.3.9 Route to the meeting

This subject is a rolling update for this paper. The work detailed in this paper is tabled at the Acute Service Clinical Governance Steering Group meeting. It is also discussed at the bi-monthly Perinatal Quality Improvement Meetings and the Maternity / Paediatric Clinical Governance meetings as a standing item on the agenda.
This paper was presented to Healthcare Governance Committee on 2 March 2026.

2.4 Recommendation

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