NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting Date:	**Monday 8 June 2026**
Title:	**Quality & Safety Report - Maternity Services**
Responsible Director:	**Jennifer Wilson, Executive Nurse Director** **Vicki Campbell, Director of Acute Services**
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

This supports the following Corporate Objectives:

- Better Value – Delivering innovative and sustainable services for everyone
- Better Care – Improving your experience of care. This paper supports Better Care by 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 Maternity Services.

2.2 Background

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

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

2.3 Assessment

- NHSAA stillbirth rate continues to demonstrate sustained improvement with every stillbirth reviewed using the Perinatal Mortality Review Tool (PMRT).
- Percentage of Maternity Early Warning Score (MEWS) charts completed, and frequency met, demonstrates a consistent compliance above 85%.
- Rate of Postpartum haemorrhage (PPH) >1.5 litres median of 58.5 per 1000 births with improvement work underway.
- Hand hygiene compliance for Maternity Services demonstrates compliance between 90-100% across all areas.
- NHSAA caesarean birth rate averages 92 per month which is below the national average of 99 per month.
- 34 Care Opinions responses have been received, which were all responded to by. 33 were positive and one had a level of criticality.
- HIS Inspection of Maternity Services identified 50 actions of which 25 (50%) are complete, with 25 actions (50%) in progress within agreed timescales.
- HIS Maternity Standards published in February 2026: review and impact assessment underway.

2.3.1 Quality/ patient care

Quality Improvement work contributes to improving outcomes and reducing inequalities in outcomes by providing a safe, high quality care experience for all women, babies and families.
NHSAA are participating in the Scottish Patient Safety Perinatal Programme (SPSP), with the aim of improving outcomes and reducing inequalities by providing a safe, high quality care experience for all women, babies and families across all care settings.
NHSAA submit data and narrative to Healthcare Improvement Scotland (HIS) to share learning and benchmark against other NHS Scotland Board performance.

NHSAA submit the following data:

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

2.3.2 Workforce

The service remains assured with maternity staffing levels and succession planning, ensuring safe staffing levels remain a priority for the service. This is detailed in Appendix 1.

2.3.3 Financial

There may be financial implications identified as national recommendations are identified and require implementation. This is assessed and monitored by the Senior Management Team.

2.3.4 Risk assessment/management

Participation in national improvement and assurance programmes aim to reduce harm within Maternity Services. Not participating in the programmes could impact on the provision of a safe service and reputation of the organisation.

2.3.5 Equality and diversity, including health inequalities

An EQIA has not been completed however, national programmes of work have completed an EQIA considering all elements of the programmes.

2.3.6 Best Value

This paper support Best Value across the following themes.

- Vision and Leadership: through clear priorities for improving quality and safety across Maternity Services
- Effective Partnerships: aligning with national programmes such as SPSP and Excellence in Care and by working collaboratively with clinical teams and wider stakeholders.
- Governance and accountability: enhanced through robust oversight structures, regular data scrutiny, and clear reporting on risks, performance, and assurance
- Use of resources: targeting improvement activity where harm, cost, and impact are greatest, supporting efficient and sustainable service delivery
- Performance management: evidenced through continuous monitoring of safety measures, complaints, and adverse events, enabling focused action and improvement.

2.3.7 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.

2.3.8 Communication, involvement, engagement and consultation

Engagement and consultation include:

- A partnership agreement between SPSP and NHSAA
- Regular clinical governance and operational group reporting
- Discussion at bi-monthly Perinatal QI Group meeting.

2.3.9 Route to the meeting

A version of this paper has been discussed at the Quality Improvement meeting and the Maternity Clinical Governance meeting, Acute Services Clinical Governance Steering Group, 9 April 2026 and Healthcare Governance Committee, 12 May 2026

2.4 Recommendation

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

3. List of appendices

The following appendices are included with this report:
Appendix 1 – Maternity Services Quality and Safety Update

APPENDIX 1

Maternity Services Quality and Safety Update

1. Introduction

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

- Stillbirth rates
- Maternal Deterioration
- Postpartum haemorrhage (PPH) rates >1.5 litres
- Excellence in Care
- Maternity Activity
- HIS Maternity Standards
- Service User Contribution
- Complaints
- HIS Maternity Inspection

2. Scottish Patient Safety Programme (SPSP)

NHSAA are participating in the SPSP Perinatal Programme, which aims to improve outcomes and reducing inequalities by providing a safe, high quality care experience for all women, babies and families. Data is submitted to Healthcare Improvement Scotland (HIS) to support learning and benchmark performance.

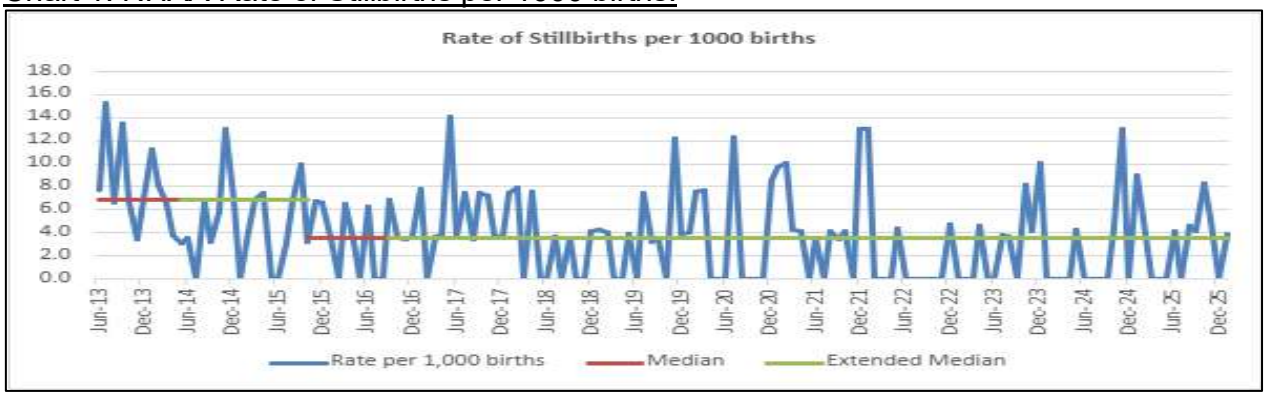
The Maternity Services report on the following agreed measures:

- Stillbirth rates
- Maternal deterioration: Percentage of Maternity Early Warning Score (MEWS) charts completed, and frequency met.
- Postpartum haemorrhage (PPH) rates >1.5 litres

2.1 Stillbirth rates

NHSAA stillbirth rate continues to demonstrate sustained improvement (Chart 1).

Chart 1: NHAA Rate of Stillbirths per 1000 births.



2.2 Maternal deterioration

The Maternity Early Warning Score (MEWS) tool provides a standardised score to determine illness severity and supports consistent clinical decision making and early recognition and escalation of deteriorating patients. Across all maternity areas data demonstrates a median of 99.5%, with consistent compliance above 85% (Chart 2).

Chart 2: Percentage of Maternity Early Warning Score (MEWS) charts completed/ frequency met

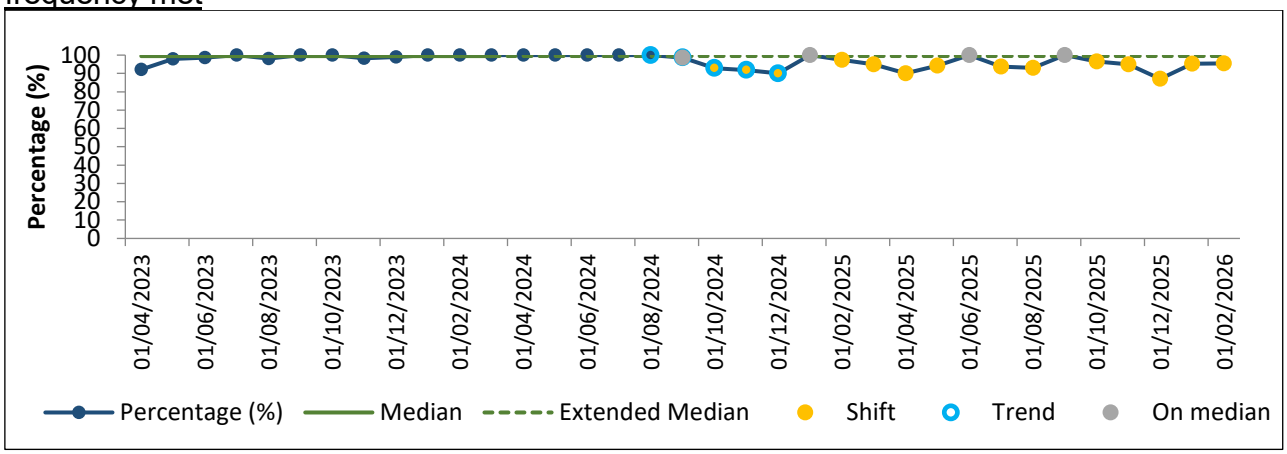
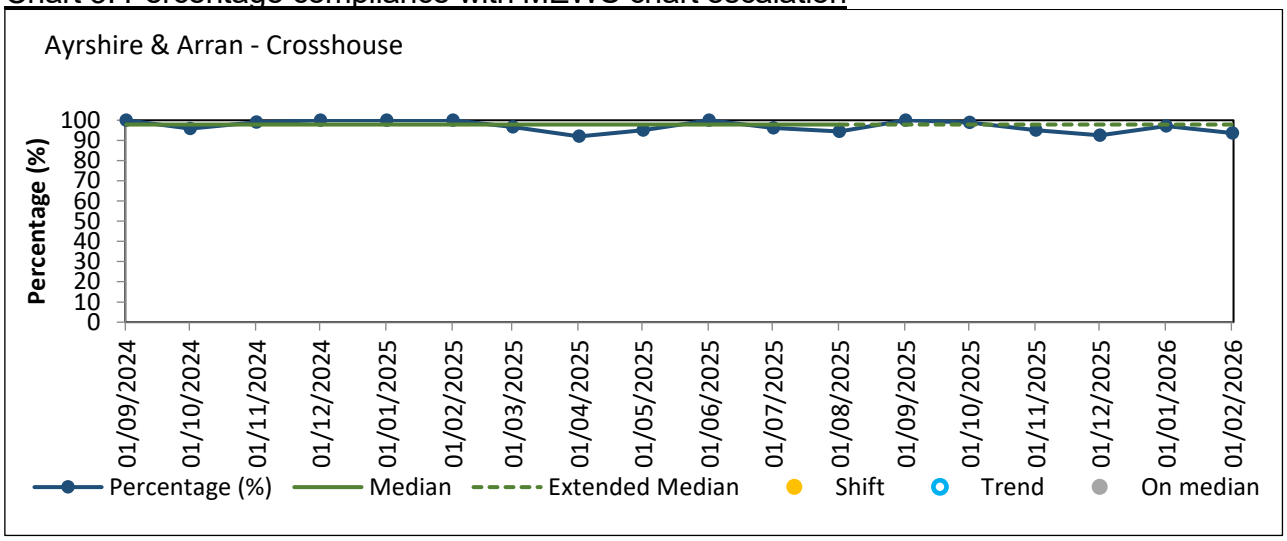


Chart 3 demonstrates compliance with MEWS escalation. Across all maternity areas data demonstrates a median of 97.8%, with consistent compliance above 92%.

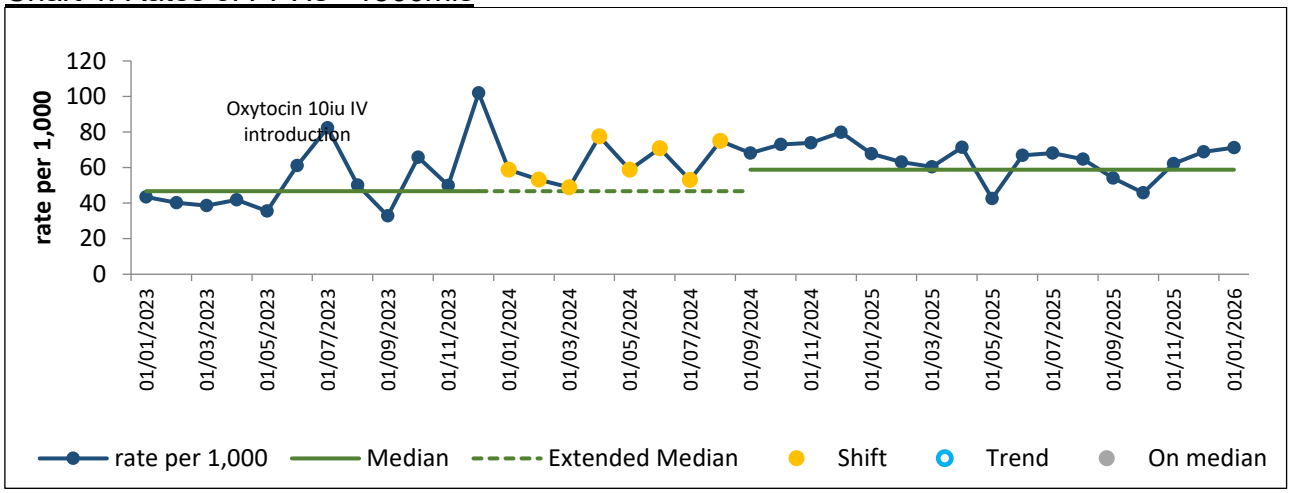
Chart 3: Percentage compliance with MEWS chart escalation



2.3 Postpartum haemorrhage (PPH) rates >1.5 litres

The rate of postpartum haemorrhage (PPH) >1.5 litres demonstrates a median of 58.5 per 1000 births (Chart 4). Improvement work is underway to implement a risk assessment tool for stratifying PPH prophylaxis medication and review of the number PPHs >1500mls for vaginal births v caesarean birth which has demonstrated an increase in PPH in women who have a Caesarean Section.

Chart 4: Rates of PPHs >1500mls



3. Excellence in Care

NHSAA participates in Excellence in Care (EiC), the national care assurance programme, with quality-of-care measures reported 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.

3.1 QIMPLE

NHSAA is affiliated with University of West of Scotland and provides practice learning environments (PLE) for Midwifery Pre-Registration students. On completion of a PLE students are requested to provide feedback that is weighted by section. Average QMPLE Score for Maternity Services NHS Ayrshire and Arran is reported at 92%, highlighting the positive learning environment experienced by pre-registration midwifery students within the directorate.

4. Maternity Activity

Chart 5 displays Maternity Assessment Unit and Triage services activity, demonstrating normal variation in activity.

Chart 5: Maternity Assessment activity including Triage per month

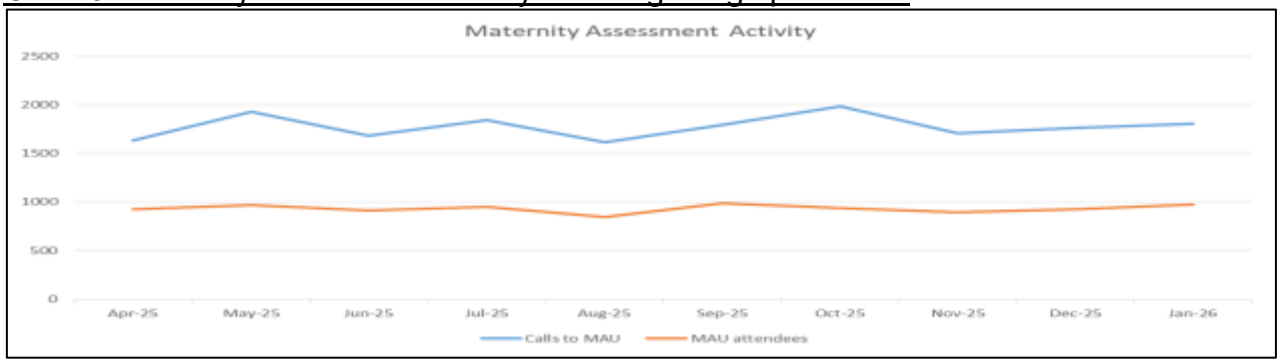
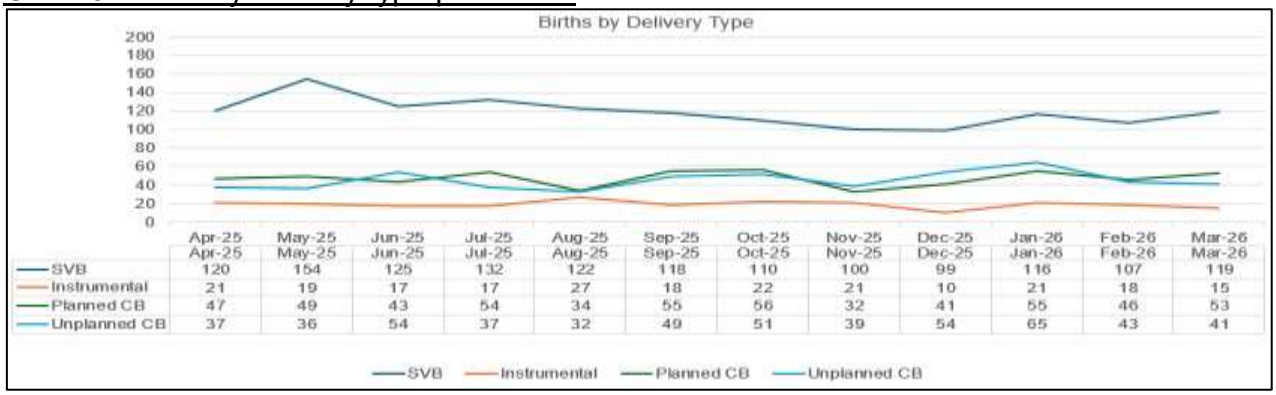


Chart 6 displays births by delivery type excluding home births. NHSAA Caesarean birth rate averages 92 per month compared to the national average of 99 per month.

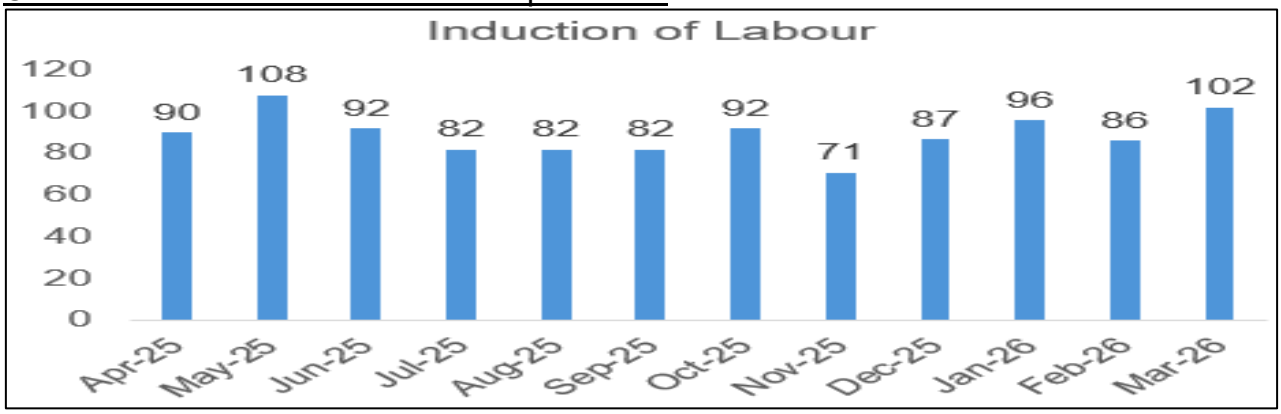
Chart 6: Births by delivery type per month



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
SVB	120	154	125	132	122	118	110	100	99	116	107	119
Instrumental	21	19	17	17	27	18	22	21	10	21	18	15
Planned CB	47	49	43	54	34	55	56	32	41	55	46	53
Unplanned CB	37	36	54	37	32	49	51	39	54	65	43	41

Chart 7 displays monthly induction of labour figures. These are in line with national average for boards of this size.

Chart 7: Induction of Labour numbers per month



5. HIS Maternity Standards

HIS National Maternity Standards were published in March 2026. There are 11 standards which are currently undergoing impact assessment.

6. Service User Contribution

The Maternity Voices Partnership (MVP) was established in November 2025 to ensure voices of service users and third-sector partners are central to the development, delivery, and continuous improvement of local maternity services.

The MVP has a diverse and inclusive membership, reflecting the communities we serve. Current representation includes:

- Travelling community
- Dad's Rock
- Refugee and Asylum Seeker support workers
- Recent maternity service users
- Midwifery representatives, including colleagues from; community midwifery, outpatient service, inpatients services, intrapartum and medical staff from the obstetric team

The MVP is committed to fostering open dialogue, promoting equitable access to services, and ensuring that feedback from all communities, particularly those who may be seldom heard to directly contribute to improving maternity care. The feedback received has contributed to developing our approach to complaints communication and resolution.

7. Complaints

Complaints are being handled timeously with analysis for themes and trends. For this quarter, the key theme was communication and managing expectations linked to adverse press reports.

A total of 34 Care Opinions responses have been received all of which were responded to by the service, 33 of these were positive and only one had a level of criticality which the service reached out to contributor and offered the opportunity to meet and discuss.

8. HIS Maternity Inspection

In August 2024 Health Improvement Scotland (HIS) announced they would be undertaking unannounced inspections of all maternity units in Scotland from January 2025. NHSAA were inspected on the 8th and 9th October 2025 with a further follow up inspection on 27th October 2025. During this time the HIS Team visited:

- Inpatient ward
- Labour ward
- Maternity Assessment Unit

The inspection found areas of good practice, including cohesive multidisciplinary practice, positive leadership, staff feeling supported throughout the Unit. It was noted that women and their babies were receiving a good standard of care and families consistently expressed positive views regarding the care provided. Women advised that they felt listened to and supported in making decisions about their care and described positive experiences of communication and compassionate interactions with staff and would be happy to recommend NHSAA Maternity Services.

This inspection resulted in 10 areas of good practice, 2 recommendations and 16 requirements. An action plan has been agreed and currently being progressed within agreed timescales.