NHS Ayrshire & Arran

Meeting:	**NHS Ayrshire and Arran Board**
Meeting date:	**Monday 10 August 2026**
Title:	**Quality and Safety- Mental Health**
Responsible Director:	**Caroline Cameron, Director North Ayrshire Health and Social Care Partnership**
Report Author:	**Julie Barrett, Associate Nurse Director Mental Health** **Lorna Copeland, QI Lead HSCPs and Governance** **Nina McGinley, Board Excellence in Care (EIC) Clinical Lead** **Stephanie Frearson, Interim QI Lead Complaints** **Debbie McCard, Risk Manager**

1. Purpose

This is presented to the Board for:
- Awareness

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

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 Health** – Supporting you to live a healthier life
- **Better Workplace** – Creating a great place for us to work
- **Better Care** – Improving your experience of care

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 Mental Health Services.

2.2 Background

Mental Health Services continue to operate within a context of increased demand, complexity and system pressure, while maintaining alignment with national priorities including the Scottish Patient Safety Programme (SPSP), Core Mental Health Standards and the Health and Care (Staffing) (Scotland) Act 2019. National

programmes such as SPSP, Excellence in Care and the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provide a structured framework for improving safety, consistency and person-centred care across inpatient and community settings.

2.3 Assessment

Significant progress has been made in:

- Embedding SPSP programmes, particularly Safety at Points of Transition and Adults in Hospital.
- Strengthening governance, reporting and oversight arrangements.
- Using national benchmarking, measurement and external assurance through Healthcare Improvement Scotland.
- Identifying priority improvement themes through self-assessment against Core Mental Health Standards.

While several programmes remain in early implementation phases, governance, measurement and assurance arrangements provide confidence in the sustainability of improvements.

2.3.1 Quality/patient care

Quality of care continues to be monitored through multiple data sources including Excellence in Care, SPSP, adverse events, complaints and local audits.
Key areas of assurance include:

- Improvements in least-restrictive practice supported by the Framework for Interventions guideline.
- Early signs of stabilisation or improvement in physical violence and restraint rates.
- Robust compliance with Food, Fluid and Nutrition (FFN) assessments and mealtime safety processes.
- High reported quality of practice learning environments for pre-registration nursing students.
- Structured approaches to reducing inpatient falls, particularly in community hospital settings.

Areas requiring continued focus include self-harm trends within specific wards, improvement in complaint handling timescales, and embedding learning from adverse events consistently into practice.

2.3.2 Workforce

Workforce availability remains a critical enabler of safe, effective care. Data indicates variable establishment variance reflecting national workforce pressures.
Positive developments include:

- Continued investment in quality improvement capability and leadership development.
- Use of national workforce metrics through Excellence in Care to triangulate quality and staffing data.
- Completion of an Allied Health Professional workforce review to identify risks and opportunities.
- Ongoing work to improve recruitment, retention, skill mix, job planning and released capacity.

Challenges remain, particularly around vacancy pressures, increasing clinical complexity, administrative burden and reduced training capacity; however, clear actions have been identified to mitigate these risks.

2.3.3 Financial

This report does not request additional funding; however, it highlights a number of financial considerations and cost pressures associated with the ongoing delivery of safe, effective and person-centred mental health services.

Investment in quality improvement capability, staff training and national improvement programmes (including SPSP, Excellence in Care and NCISH Safer Services initiatives) represents a planned and proportionate use of existing resources. Where possible, these activities are supported by national programmes and NHS Education for Scotland, reducing the need for additional local expenditure and supporting value for money through shared infrastructure, tools and expertise.

The report identifies inefficiencies that have financial implications, including administrative burden, multiple IT systems, travel time and non-direct clinical activity, particularly within community and Allied Health Professional services. Work is underway to explore released capacity, improved productivity and workforce sustainability within existing resources, recognising the constrained financial context.

Complaints handling and adverse event management carry indirect cost pressures related to staff time, governance oversight and potential escalation where timescales are not met. Improvements in complaint response quality, timeliness and learning are expected to reduce repeat concerns, escalation risk and associated resource impact over time.

Overall, while system pressures continue to present financial risk, particularly in relation to workforce sustainability, the use of structured quality improvement approaches, national programmes and a clear focus on harm reduction, efficiency and prevention provide assurance that resources are being used responsibly. Continued attention to workforce planning, productivity and prevention of adverse events will be critical to maintaining financial balance while delivering safe and high-quality care.

2.3.4 Risk assessment/management

Risk management arrangements continue to strengthen, with a clear shift towards personalised, formulation-based approaches.
Key developments include:

- A review of the Ayrshire Mental Health Risk Assessment Framework (ARAF) following Significant Adverse Event learning.
- Involvement in national NCISH Safer Services initiatives to support personalised risk management and family involvement.
- Removal of RAG-rated risk stratification from documentation, in line with national guidance.
- Enhancements to ARAF documentation and benchmarking of bespoke risk intervention training.
- Development of a comprehensive ARAF training package to support consistent, sustainable practice.

These actions provide assurance that local risk assessment practice is aligned with national standards and evidence-based approaches, with appropriate governance and workforce support in place.

2.3.5 Equality and diversity, including health inequalities

This report reflects services delivered to a population with significant and well-recognised health inequalities, including people with severe and enduring mental illness, neurodevelopmental conditions, learning disabilities, substance use issues, and those experiencing socioeconomic deprivation. These groups are disproportionately affected by poor physical health outcomes, reduced life expectancy and barriers to accessing timely, appropriate care.

The report demonstrates positive alignment with national priorities to address inequality through:

- A strengthened focus on person-centred, trauma-informed and least-restrictive practice, consistent with the Core Mental Health Standards.
- Increased emphasis on coproduction, personalised risk management and meaningful family and carer involvement, supporting equitable participation in care planning and decision-making.
- Participation in national improvement programmes (SPSP, NCISH Safer Services Toolkit), which are designed to reduce unwarranted variation and improve safety for high-risk population groups, particularly during transitions of care.

However, several equality-related risks require ongoing consideration:

- Access and waiting times, which remain a common theme in complaints, may disproportionately impact individuals from deprived communities, those with communication difficulties, and people requiring additional support to engage with services.
- Workforce pressures and staffing variability may affect continuity of care, therapeutic relationships and reasonable adjustments for people with complex needs, learning disabilities or neurodivergence.
- The report recognises rising demand and complexity, particularly in neurodevelopmental presentations, raising risks of inequity if capacity constraints limit preventative or early intervention approaches.
- Variability in digital maturity and data systems presents a risk of exclusion for people with limited digital access, reduced health literacy or language barriers.

The continued development of engagement frameworks, strengthened care planning assurance, improved use of outcome and experience data, and focused work on personalised risk formulation provide assurance that equality and health inequality impacts are being considered as part of ongoing service improvement.

2.3.6 Best Value

The report demonstrates alignment with Best Value through effective use of national improvement programmes and shared infrastructure, supporting harm prevention, least-restrictive practice and informed prioritisation of resources. These approaches contribute to cost avoidance and efficient use of available capacity. However, achievement of Best Value is challenged by ongoing workforce inefficiencies, including vacancies, supplementary staffing and administrative burden, and by delays in adverse event reviews and complaints handling, which increase avoidable system

cost. Continued focus on workforce sustainability, productivity and timeliness of assurance processes is required to mitigate these risks.

- Vision and Leadership
  Improvement activity described is aligned with NHSAA and national objectives for person-centred, trauma-informed and least-restrictive care, supported by a learning-focused approach to leadership and continuous improvement. Leadership impact is evidenced through sustained investment in quality improvement capability, multidisciplinary working and shared learning, and the active engagement of service users and carers as partners in care. However, leadership capacity remains vulnerable to operational pressure, with senior clinical and managerial staff required to balance service delivery alongside improvement and governance responsibilities, presenting an ongoing sustainability risk.

- Governance and accountability
  The report demonstrates strengthening governance arrangements through clear national and local oversight. Governance is further evidenced by the review and refinement of group remits, including the Quality and Safe Observation Group. However, residual risks remain in relation to the timeliness of adverse event and complaints processes, reliance on stretched clinical and managerial capacity to deliver assurance functions, and variability in data quality and digital systems, which may impact consistency and transparency if not addressed.

2.3.7 Other Impacts

Compliance with Corporate, NMAHP and Quality Strategy Objectives.
The activity outlined is strongly aligned with national mental health strategy priorities, the Core Mental Health Standards, SPSP patient safety objectives and NHS Ayrshire & Arran commitments to improvement, safety and experience. Clear and consistent links are evident between identified risks, targeted improvement actions and governance oversight, demonstrating effective alignment between local priorities and national direction.

2.3.8 Communication, involvement, engagement and consultation

The report demonstrates that communication, involvement, engagement and consultation are integral to service delivery and improvement within Mental Health Services. There is clear emphasis on strengthening communication at key points of care, particularly transitions between inpatient and community services, and on improving the quality and clarity of information shared with service users, families and carers. National programmes and local initiatives support increased involvement through personalised care planning, risk formulation and family engagement, while structured engagement mechanisms such as complaints feedback, lived-experience frameworks, student feedback and staff quality improvement forums provide multiple routes for consultation and learning.

2.3.9 Route to the meeting

This report would normally have been presented to the Mental Health Governance and Development Group prior to discussion at Healthcare Governance Committee; however, this was not achievable within the required timescales on this occasion. In recognition of this, and to ensure appropriate oversight and assurance, the paper has been shared with relevant senior managers, directors and leaders to secure endorsement ahead of its presentation.

2.4 Recommendation

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

3. List of appendices

The following appendix is included with this report:
Appendix 1- Mental Health Quality and Safety Paper

APPENDIX 1

Mental Health Services Quality and Safety Report

1. Introduction

This paper outlines progress within NHSAA Mental Health (MH) Services in relation to national and local quality improvement programme, Excellence in Care (EiC), complaints and adverse events. It describes progress and next steps in relation to:

- MH quality improvement work
  - SPSP Safety at Points of Transition Work Stream
  - SPSP Adults in hospital Programme
  - Implementation of NHSAA Framework for Interventions Guideline
  - Rates of physical violence
  - Rates of incidents of restraint
  - Rates of incidents of self-harm
  - Core Mental Health Standards
  - Building Quality Improvement (QI) Capacity and Capability
  - Quality Improvement and Innovation Group (QI and I)
- Excellence in Care
  - In-Patient Falls Rate
  - Food, Fluid and Nutrition
  - Early Warning Score Accuracy and Frequency
  - Quality Management Practice Learning Environment (QMPLE)
  - Workforce
- Complaints Performance
- Adverse Event Activity

2. Mental Health Quality Improvement

2.1 SPSP Safety at Points of Transition Work Stream

The Scottish Patient Safety Programme (SPSP) Mental Health Programme is a national quality improvement programme led by Healthcare Improvement Scotland, established in 2012, with a clear focus on preventing serious harm for people with severe and enduring mental health conditions. The programme aligns with national mental health policy, the National Core Mental Health Standards, and local improvement priorities, providing a structured and evidence-based approach to delivering safer care.

Earlier phases of the programme focused on point-of-care improvement and have delivered sustained improvements in key safety areas, including reductions in restrictive practices and strengthened observation processes. These improvements have contributed to enhanced patient safety, greater therapeutic engagement and improved staff confidence in delivering least-restrictive care.

<u>Safety Risk Identification and Improvement Focus</u>

SPSP have undertaken discovery work which incorporated analysis of national standards, local benchmarking assessment findings and multi-disciplinary stakeholder engagement to establish next steps. This work identified transitions between inpatient and community mental health services as a high-risk point for service users, consistent with national learning on serious adverse events.

In response, a new SPSP Safety at Points of Transition work stream was developed and launched in October 2025. The work stream will run until March 2027 and is

targeted at reducing the risk of serious harm within the first seven days following discharge from inpatient care, while improving patient experience and continuity of care.

Programme Delivery and Implementation

Initial test sites have been agreed at Ward 10, Woodland View Hospital, and the South Ayrshire Community Mental Health Team (CMHT). These sites provide a representative interface between acute and community services and enable testing of improvement activity across organisational boundaries.

Early improvement work includes:

- Completion of an inpatient-to-community journey process-mapping exercise to identify variation, gaps and points of risk.
- A structured cause-and-effect analysis, identifying key contributory themes and priority areas for improvement.
- Development of a driver diagram and associated measurement plan to ensure improvement activity is purposeful, measurable and aligned to patient safety outcomes.

This work provides a clear understanding of current system performance and establishes a robust foundation for implementation and evaluation.

Tests of Change and Safety Controls

A suite of proposed tests of change has been identified, these include:

- Introduction of a triage system to support timely identification and prioritisation of urgent, high-risk and complex multi-agency transitions.
- Development of a communication protocol to ensure consistent, accurate and timely information sharing between inpatient and community teams.
- Embedding co-production tools within MDT processes, including Safety Planning Frameworks, to strengthen patient involvement and ownership of risk management.
- Consistent inclusion of transition-specific content within care plans and MDT review documentation to support proactive planning and continuity of care.

These interventions are designed to strengthen system reliability, reduce unwarranted variation and provide additional safeguards at known risk points.

Governance, Measurement and Assurance

A measurement plan is in place, with outcome measures and qualitative narrative updates reported to Healthcare Improvement Scotland on a quarterly basis. This ensures transparency, enables shared learning and provides external assurance that improvement activity is progressing as intended.

Local assurance through existing mental health governance structures ensures alignment with organisational priorities, risk management arrangements and quality improvement frameworks. The Quality and Safe Observation Group, a subgroup of the Mental Health Governance and Development Group, is currently reviewing its role and remit to ensure robust governance arrangements are in place for each programme of work. This includes oversight of planning, measurement, monitoring of impact, and sustained control, ensuring that improvements delivered through the framework continue to support safe, effective and person-centred care.

Progress

- Key patient safety risks at points of transition have been clearly identified and prioritised.
- Governance arrangements are in place, with monitoring, reporting and external assurance established.

- Improvement activity is proportionate, evidence-based and focused on reducing serious harm.

2.2 SPSP Adults in Hospital

Launched in November 2025, the Scottish Patient Safety Programme (SPSP) *Adults in Hospital* programme has expanded its remit beyond acute inpatient settings to include community hospitals, reflecting national recognition of the safety risks experienced by adults across all hospital environments. This expansion supports a whole-system approach to reducing preventable harm and improving reliability of care.

Marchburn Ward at East Ayrshire Community Hospital is participating in the programme with a specific focus on reducing inpatient falls, a recognised patient safety priority within community hospital settings. The ward team is actively engaged with the programme in the exploratory phase, which is enabling staff to build improvement capability, assess current practice, and select interventions that are proportionate to patient need and ward environment.

Data and qualitative narrative updates will be submitted to Healthcare Improvement Scotland on a quarterly basis, supporting ongoing monitoring, shared learning and external assurance that the programme is contributing to safer inpatient care within the community hospital setting.

<u>Implementation of NHSAA Framework for Interventions Guideline</u>

The NHSAA *Framework for Interventions* Guideline, published in June 2025, provides a structured, continuum-based approach to individualised care delivery. The framework ensures that interventions are proportionate to a service user's current presentation and are reviewed dynamically as needs improve or deteriorate. Care is personalised and delivered in line with least-restrictive practice principles, supporting therapeutic engagement while maintaining patient and staff safety.

A core component of the framework is proactive activity planning, designed to reduce incidents of violence and aggression and to minimise the use of restrictive interventions, including restraint and seclusion. Since the pilot implementation within Woodland View, Ayrshire Central Hospital, staff evaluation has demonstrated clear improvement in care delivery. Feedback indicates a reduction in restrictive practices, improved patient engagement, and increased flexibility in responding to changing clinical presentations. Nursing staff report greater confidence to adjust support in real time, improving responsiveness and reducing reliance on delayed medical review.

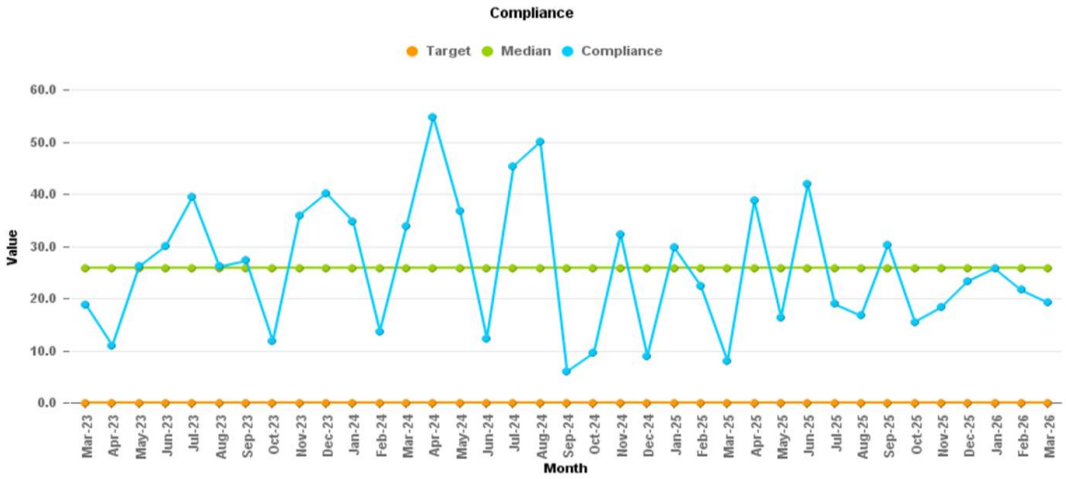
The introduction of the structured *clinical pause* has further strengthened proactive risk management and activity planning. This has supported earlier identification of escalation, more timely intervention, and improved safety outcomes for both patients and staff. The positive findings from the pilot phase have provided assurance that the framework can be implemented safely and effectively, supporting its phased rollout across Woodland View with appropriate governance oversight.

This work will report via the Quality and Safe Observation Group and local governance groups with escalations to Mental Health Care and Governance & Development Group if required.

2.3 Physical Violence

Chart 1 illustrates the rate of physical violence at Woodland View per 1,000 Occupied Bed Days (OBD), with a median of 25.9. The most recent six data points fall on or below the median, indicating early signs of improvement.
During this period, changes to ward configuration occurred, most notably the temporary closure of Ward 7A on 14 July 2025. Following this closure, 8 of the subsequent 9 data points were below the median.

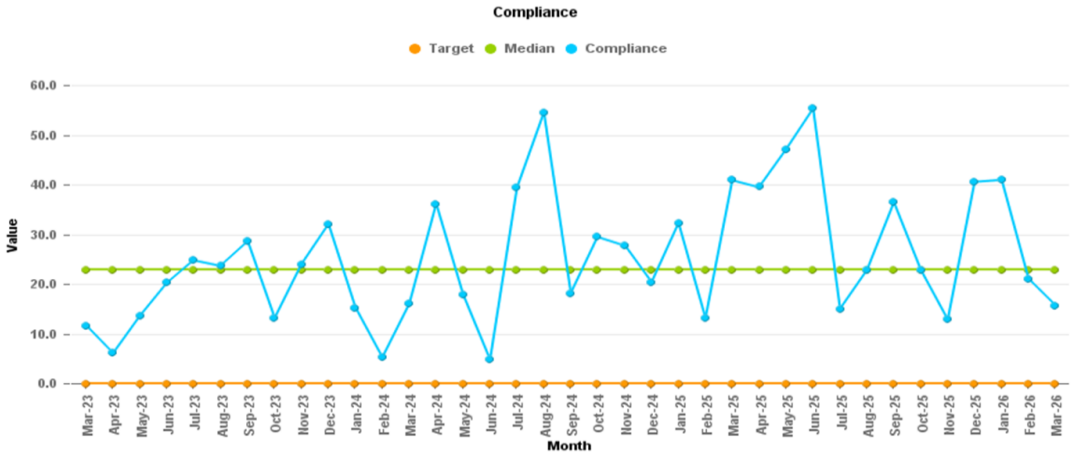
Chart 1 Rate per 1000 OBD of Physical Violence for Woodland View Site



2.4 Restraint

Chart 2 presents the rate of incident of at Woodland View per 1,000 OBD, with a median of 22.9. Four data points were demonstrated above the median from March to June 2025, this increase was not sustained.

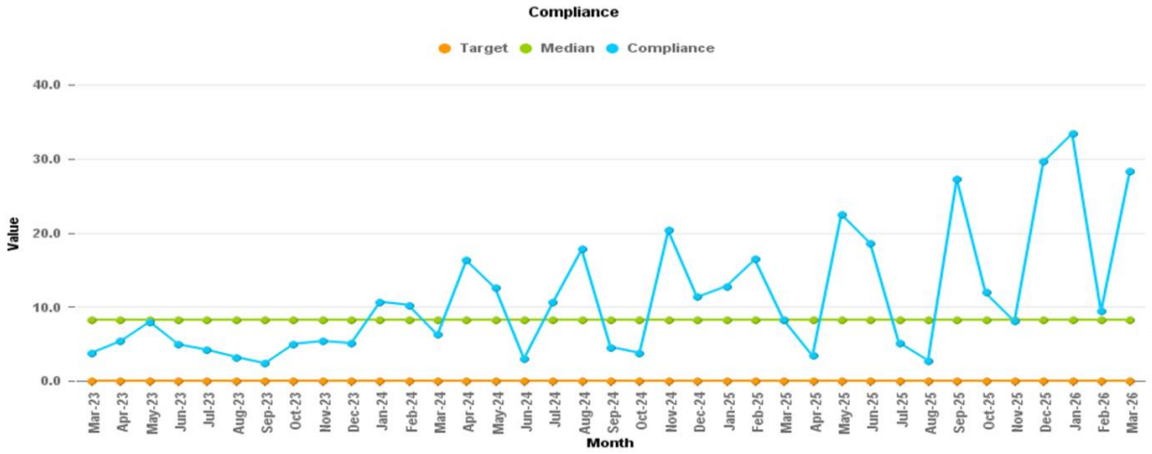
Chart 2 - Rate of incidences of restraint Woodland View Site



2.5 Self-harm

Chart 3 presents the rate of self-harm at Woodland View per 1,000 OBD, with a median of 8.3. Between September 2025 and March 2026 there is increased activity above the median. The increased incidence of self-harm was attributable to a small number of individuals across two wards and has been monitored by the Adverse Event Review Group. This has included liaison with relevant clinical areas and the identification of opportunities for focused improvement activity.

Chart 3 Rate of incidents of self-harm Woodland View Site



2.6 Core Mental Health Standards

Scotland's *Core Mental Health Standards*, published in September 2023, establish clear national expectations for the quality, safety, and consistency of adult secondary mental health services. The standards aim to ensure person-centred, trauma-informed care and to reduce unwarranted variation across Scotland.

The Core Mental Health Standards support individuals, families and carers to understand what they can expect from mental health services in relation to:

- Access to care
- Quality and safety of treatment
- Person-centred and trauma-informed practice
- Consistency of service delivery
- Accountability and continuous improvement

The standards apply across adult secondary mental health services, including community mental health teams, psychology services and eating disorder services, and are a key national mechanism for quality assurance and service improvement.

NHS Ayrshire & Arran, supported by Healthcare Improvement Scotland (HIS), completed a self-assessment against the standards in March 2025. This benchmarking exercise has enabled the identification of key strengths and priority areas requiring improvement. Pan Ayrshire basis, three priority improvement themes were agreed with a range of improvement work now underway.

Overall assurance is moderate and improving**.** Clear priorities have been identified, improvement activity is in progress, and governance structures are strengthening. Further assurance will be achieved as actions mature, audit findings are embedded into practice, and outcome data is increasingly used to inform service design and delivery.

The following priority areas for improvement were agreed across Pan Ayrshire adult mental health services:

1. Strengthening person-centred care and co-production
    - Improving meaningful service user and carer involvement, choice and shared decision-making.
2. Improving the use of patient outcome data and experience
    - Strengthening how outcome measures and lived-experience feedback are used to inform service planning, delivery and improvement.

3. Enhancing care planning quality and assurance
    - Improving care plan audit activity and ensuring learning from audits is used consistently to inform service development and practice.

Assurance and Audit

- Record-keeping and care-planning audit tools are being strengthened to ensure robust and consistent data collection.
- South Ayrshire Mental Health Services have led on updating audit tools and have agreed to share these across Pan Ayrshire.
- Senior Nurses across Mental Health and Learning Disability Services are supporting embedding of these tools into routine practice to improve care quality, safety and assurance.

Service User and Carer Engagement

- As lead partner, North Ayrshire Mental Health Services have developed a Mental Health Services Engagement Framework, setting out a clear approach to co-production and engagement with people with lived experience and carers. While not fully Pan Ayrshire in scope, it has been agreed that learning and intelligence relating to East and South Ayrshire services will be shared appropriately, supporting consistency and system-level learning.

Digital and Data Governance

- The Pan Ayrshire Mental Health Services Digital Transformation Group has been re-established in line with the updated national digital strategy. Draft terms of reference have been developed and are pending ratification.
- The group will provide strategic leadership, oversight and assurance for digital, data and information governance activity supporting safe, effective and person-centred care across Mental Health, Learning Disability and Addiction Services.

Service Review and System Adaptation

- Mental health services across Pan Ayrshire are reviewing roles and remits to improve efficiency, accessibility and clarity of purpose.
- North Ayrshire Community Mental Health Services are undertaking a review of adult and older adult services to ensure alignment with the Core Mental Health Standards.
- Services across Ayrshire are working collaboratively to respond to increasing demand related to neurodevelopmental conditions, including consideration of third-sector and independent-sector support, in line with the Scottish National Neurodevelopmental Specification.

Governance and Oversight

Governance arrangements are strengthening through:

- Alignment with national standards and HIS oversight
- Development and embedding of audit and measurement frameworks
- Re-establishment of strategic groups to oversee digital, data and quality improvement activity

Further assurance will be provided through continued audit activity, shared learning across localities, and clearer reporting of outcomes and impact.

Overall Assurance Statement

There is reasonable and improving assurance that NHS Ayrshire & Arran is responding appropriately to Scotland's Core Mental Health Standards. Priority risks

have been clearly identified, improvement actions are underway, and governance arrangements are being strengthened to support sustainability.

Continued focus on embedding audit findings, enhancing co-production, and using outcome data effectively will be essential to provide full assurance of consistent, safe and person-centred care across Pan Ayrshire adult mental health services.

2.7 QI Capacity and Capability

There is continued focus on increasing QI capacity and capability within Mental Health Services. This includes supporting staff to undertake eLearning modules provided by NHS Education for Scotland (NES), and participation in NHS Ayrshire and Arran Improvement Foundation Skills Programme (AAIFS) and the Scottish Improvement Leadership Programme (SCIL).
Within Mental Health Services:

- 33 staff have completed AAIFS
- 5 staff have commenced in cohort 12, starting April 2026.
- 2 staff have a lead level qualification (SCIL)

2.8 Quality Improvement and Innovation Group (QI and I)

The Quality Improvement and Innovation Group (QI and I) is a multidisciplinary group that shares progress and learning from improvement work and provides a mechanism to learn about QI. The group delivered a roadshow to increase staff engagement, especially during periods of clinical pressure ensuring accessibility and encouraging broad staff participation.

In response to feedback Conversation Cafes have been developed**.** The first Café, hosted in North Ayrshire at Woodland View, was well attended with multiple QI projects discussed and developed. The second cafe was held in April, which will be evaluated and shared as appropriate with key presentations and opportunities for learning at our Celebration event on 24th October 2026.

3. Excellence in Care

NHSAA participate 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 Falls

Chart 4 demonstrates normal variation with a falls rate median for Ailsa Hospital of 13.1 per 1000 OBD.

Chart 4 Inpatient falls rate per 1,000 OBD Ailsa Hospital

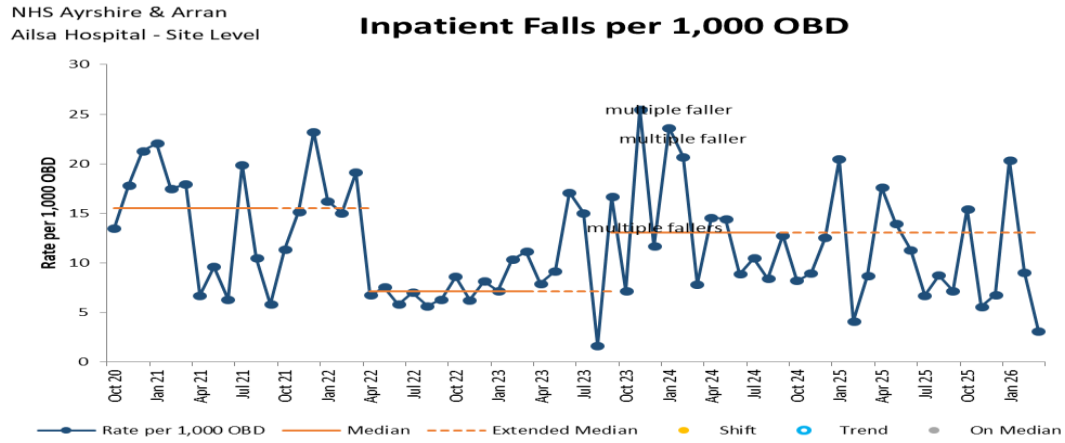


Chart 5 demonstrates a falls median for Marchburn Ward (East Ayrshire Community Hospital) of 13.1 per 1000 OBD. There was an increase in falls between February and July 2025 which was attributed to a small number of patients with significant disease progression despite interventions and risk assessment.

Chart 5 Marchburn Ward Inpatient falls rate per 1,000 OBD

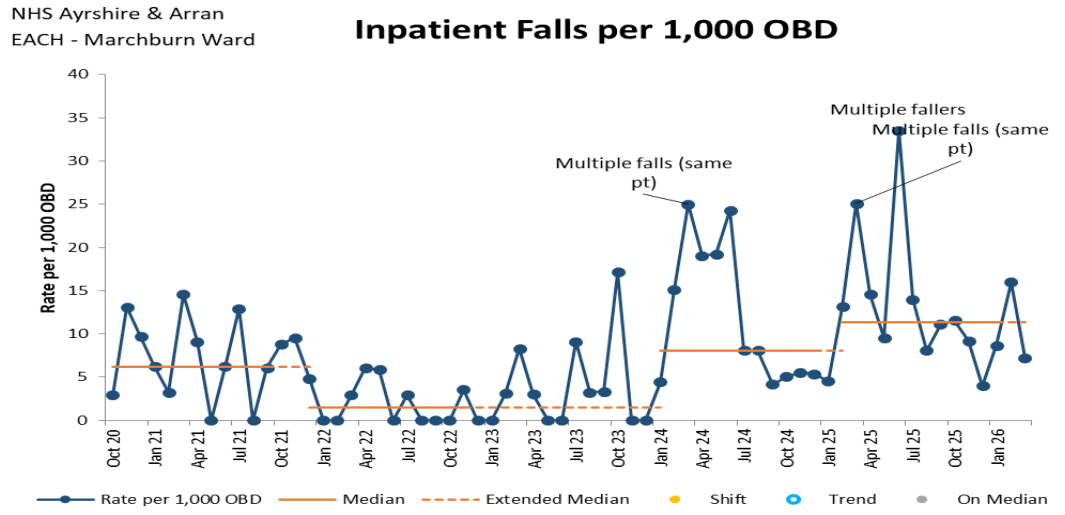
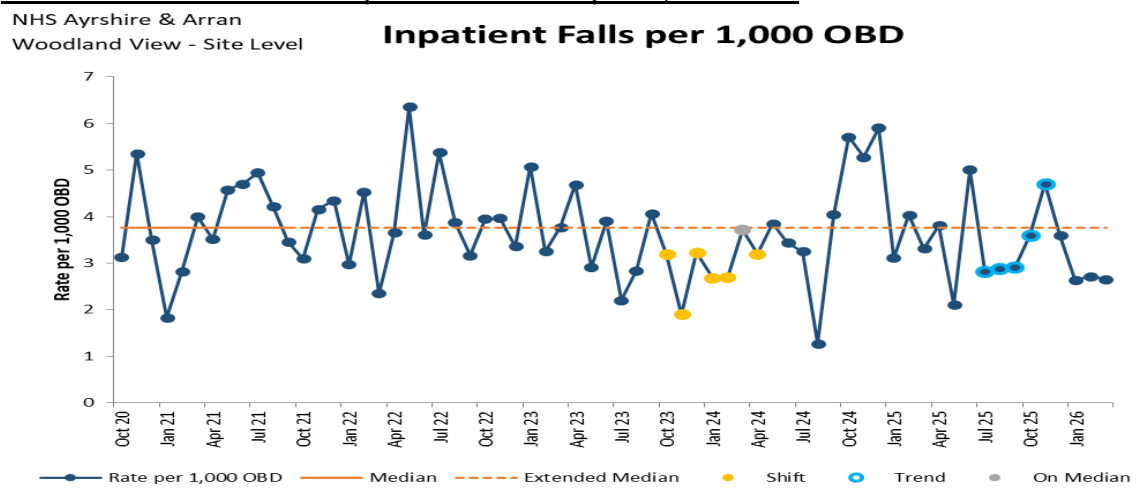


Chart 6 demonstrates normal variation with a falls median for Woodland View site of 3.8 per 1000 OBD.

Chart 6 Woodland View Inpatient falls rate per 1,000 OBD



3.2 Food Fluid and Nutrition

Excellence in Care data demonstrates reliable risk assessment and ongoing care planning within Mental Health Services, with all process measures at site level demonstrating over 95% compliance (Chart 7, Chart 8 and Chart 9).

Chart 7 Ayrshire Central Hospital– Food Fluid and Nutrition (FFN) - Compliance % of FFN MUST Score Process Measure

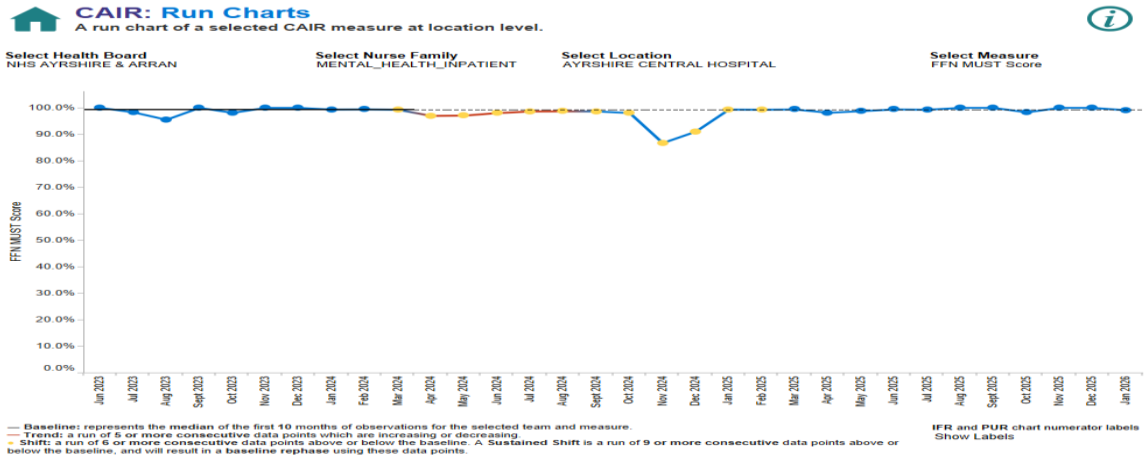


Chart 8 Ailsa Hospital– Food Fluid and Nutrition (FFN) - Compliance % of FFN MUST Score Process Measure

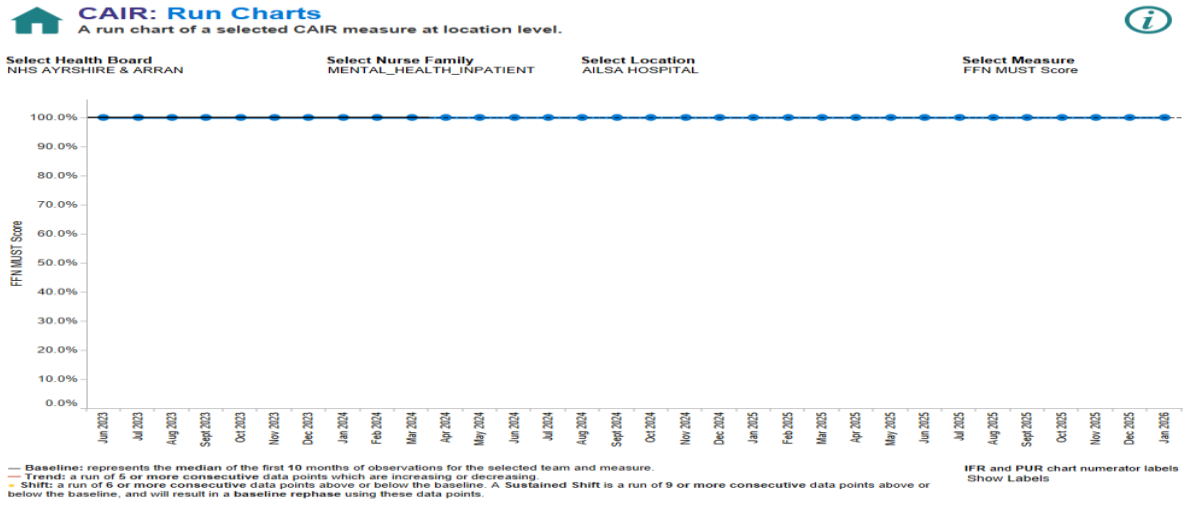
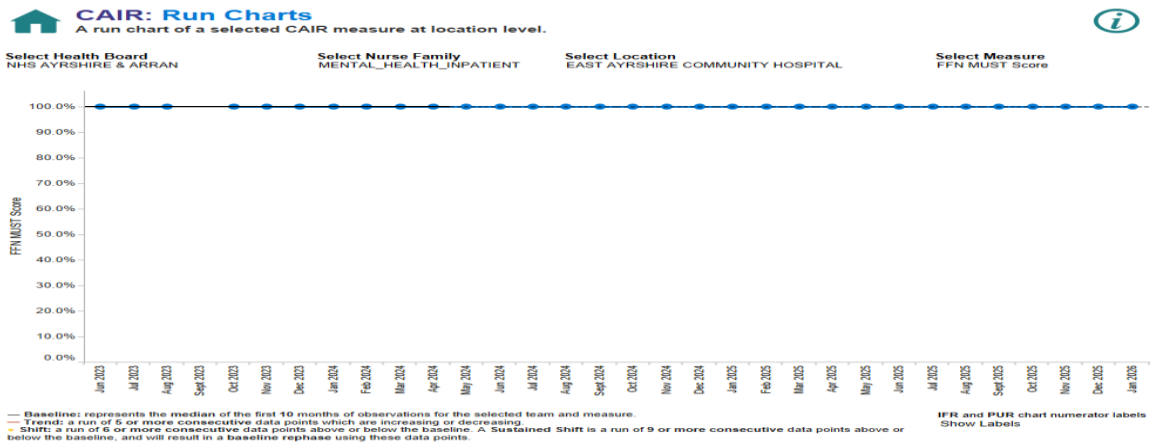
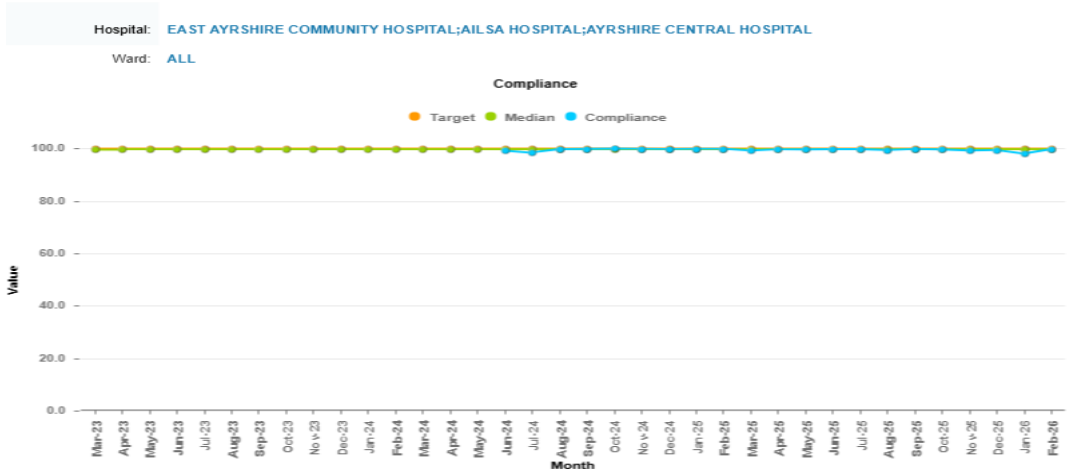


Chart 9 East Ayrshire Hospital– Food Fluid and Nutrition (FFN) - Compliance % of FFN MUST Score Process Measure



Safe delivery of meals is supported by the mealtime co-ordinator (MTC) role with monthly audit data collated and reviewed by clinical teams. Since implementation in June 2024, a 100% compliance rate of all elements of MTC role and safe food provision within Mental Health Services has been demonstrated (Chart 10).

Chart 10 Food Fluid and Nutrition - % Compliance of Meal-Time Co-Ordinator Process Measure

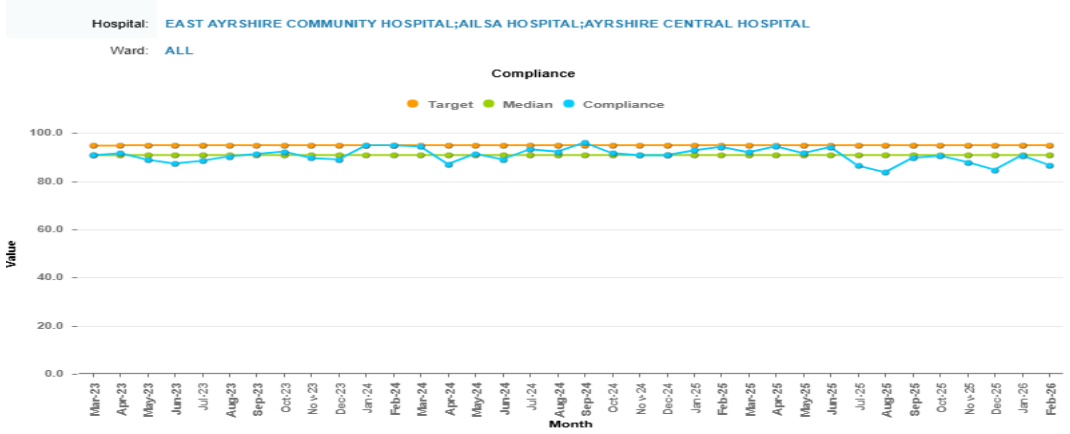


3.3 National Early Warning Score

The National Early Warning Score (NEWS2) tool provides a standardised score to determine illness severity and supports consistent clinical decision making and early recognition and escalation of deteriorating patients. It has been recognised that NEWS2 score and escalation processes may not be applicable to all MH patient groups due to NEWS2 being utilised as an ad-hoc vital signs recording chart, as opposed to a tool to recognise early recognition of deterioration.

Chart 11 demonstrates % compliance of NEWS2 score calculation accuracy and correct frequency of reassessment for Ailsa, East Ayrshire and Ayrshire Central Hospitals., demonstrating normal variation with a median of 91%.

Chart 11: Cross-Site -Monthly % compliance with early warning score assessment



3.4 Quality Management Practice Learning Environment

NHSAA is affiliated with University of West of Scotland and provides practice learning environments (PLE) for Mental Health Pre-Registration Nursing students. On completion of a PLE students are requested to provide feedback that is weighted by section. The four sections and their total possible scores are:

- Orientation and induction (8).
- Support and supervision (26).
- Learning environment (41).
- Support and belonging (25).

NHSAA Quality Management Practice Learning Environment (QMPLE) feedback is reported 3 monthly to PHS via a digital extraction to CAIR. Average QMPLE Score for Mental Health Services is reported at 97%, highlighting the positive learning environment experienced by pre-registration nursing staff within the directorate. However, it should be noted that only 28% of eligible students have submitted feedback. Ongoing improvement between the Practice Education Facilitator and EiC teams to improve rate of submission continues.

A specific focus on student feedback was undertaken by Alcohol and Drug Services in North Ayrshire between January and March 2026 with feedback shared below.

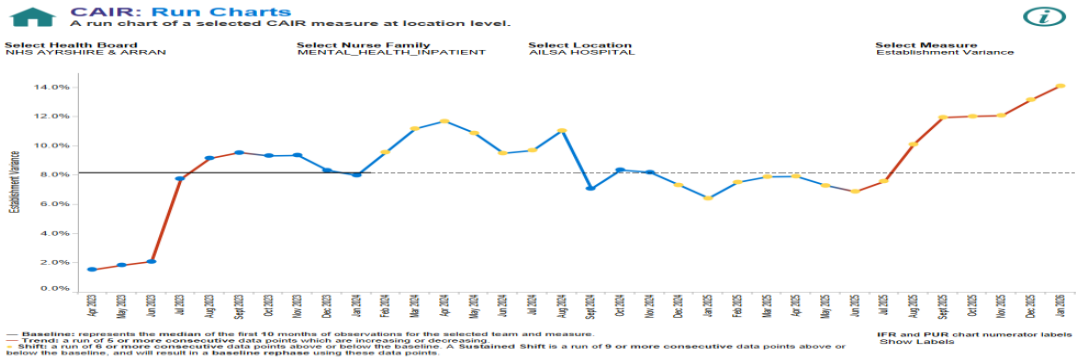
3.5 Workforce

Workforce staffing levels directly correlate to quality of care. Triangulation of quality of care and workforce data intelligence is a fundamental component of the Health and Care (Staffing) (Scotland) Act 2019 through the common staffing method. Workforce data is reported nationally monthly via EiC.

It is recommended that workforce and quality of care data is used in triangulation to identify causative or influencing factors that contribute to the delivery of safe, effective and person-centred care. A variable picture of workforce staffing within Mental Health

Services is demonstrated with establishment variance baseline across sites between 8-9%, with Ailsa Hospital indicating a trend of 8 data points related to staffing deficit between funded and in-post WTE (chart 12).

Chart 12 Workforce data Ailsa Hospital – Establishment Variance



3.6 Allied Health Provision in North HSCP

Allied Health Professions include Dietetics, Occupational Therapy, Podiatry, Physiotherapy, and Speech and Language Therapy. The AHP teams sit across the organisation and work closely with health and social work teams, often with some embedded roles in other services. During October 2025, an AHP workforce review exercise was completed using a workforce tool shared by Healthcare Improvement Scotland, which will be used on an annual basis as part of the Health Care Staffing Act responsibilities.

It was agreed that for this first exercise, where there were professions with multiple service areas, initial focus would be on Mental Health and Learning Disability Services. It was also agreed that this exercise would be repeated for all remaining services in March 2026 and thereafter on an annual basis. As part of this exercise, staff were asked to complete a workforce tool over a two-week period between 29 September and the 10 October 2025. The intention is that following this report, each service will develop an action plan to address/ mitigate any issues identified.

Each team identified a range of challenges in delivering safe and effective care. This included challenges such as:

- Number of referrals received
- Increased complexity and acuity of clinical presentations
- Increased number of patients that require 2 or 3 person visits due to complexity, clinical acuity or risk.
- Prioritisation of referrals with greatest risk to ensure patient safety has been required in all services and as a consequence, the threshold for referrals with the lowest risk has been raised. Although people are offered information, advice and in some services, community-based group activities or universal supports, this does limit the potential for preventative based treatment and support by specialist staff.
- Legacy funding allocations that influenced focus of specific posts and gaps in areas without dedicated funding
- Legacy funding decisions to pay for posts from recurring underspend are increasingly under pressure as the financial context of whole system pressure and overspend has resulted in a different risk appetite for funding permanent posts from service underspends

- Staffing pressures due to vacancies and difficulty filling some posts within a context of national workforce challenges
- Small teams where even minimal absence rates can have disproportionate impact on service delivery
- Small teams have limited resilience and many have clinical activities that are single person dependant
- Reduced working week – initial reduction of 30mins and future reduction of further 1 hour
- Systems and processes that are cumbersome, often requiring duplicate entry on multiple systems.
- Recognition that community-based staff will be working across different clinical and information systems that hold different information in each. This therefore requires checking of each system and assimilation of information from multiple sources to support clinical decision making.
- Significant capacity required to participate in non-direct clinical activity e.g. MDT meetings, liaison with other services, arranging and ordering equipment, arranging hospital admissions etc that reduces available time for direct clinical care
- Significant time spent travelling across North Ayrshire for clinical appointments that reduces time for direct clinical care
- Significant time spent travelling across Ayrshire and Arran for clinical appointments by Pan-Ayrshire services.
- Significant time spent on clinical record keeping, especially where this is required in multiple systems
- Prioritisation of clinical activity has resulted in a reduction in time spent on professional activities and training. This is not sustainable in the longer term as we require to have staff that are adequately skilled, trained and supported in their role.

However, the implications and possibilities for change are also potentially far reaching, particularly in the financial context of limited opportunity for additional staffing and predicted, increased demand.

Further work is required in the following areas to explore potential for released capacity:

- Use of multiple systems and technological opportunities to “pull through” relevant data for staff
- Systematic review of processes to eliminate steps that do not add value to the overall flow of the pathway
- Review of administrative processes for clinical and non-clinical activities
- Identify technological opportunities to rationalise and reduce unnecessary administrative burden
- Review non-direct clinical activity to ensure best use of time
- Continue to embed job planning across services
- Review opportunities to offer remote clinical activity, particularly where travel time is high
- Where reduction of travel is not possible, review opportunities to streamline travel to ensure maximum efficiency.
- Continue to monitor impact of RWW and legacy funding
- Continue to explore opportunities to enhance opportunities to recruit staff e.g. adjust skill mix, offer development posts, offer supportive student placements

- Continue to explore opportunities to enhance opportunities to retain staff e.g. effective job planning, continued professional development, addressing inefficiencies

4. Feedback and Complaints- Mental Health Services

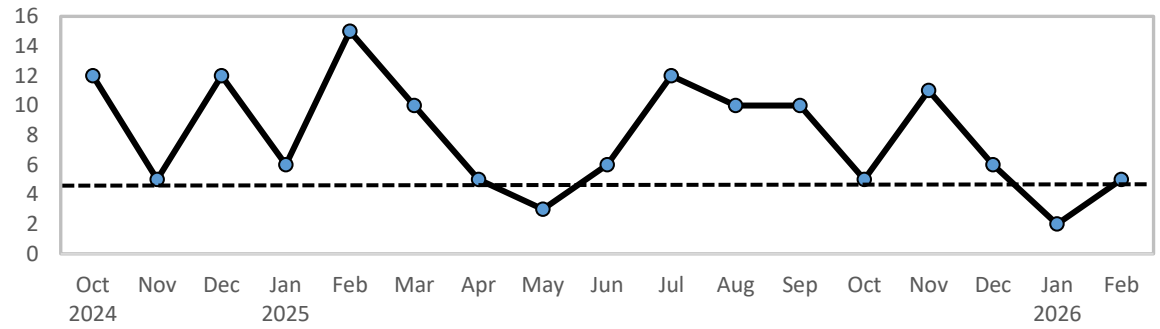
Complaints Performance and Outcomes

Performance in key areas of complaint handling, highlighting outcomes and providing detail on complaint themes for all complaint activity across Mental Health Services from October 2024 until February 2026 is outlined below.

4.1 Complaints Performance and Outcomes Stage 1 Complaints

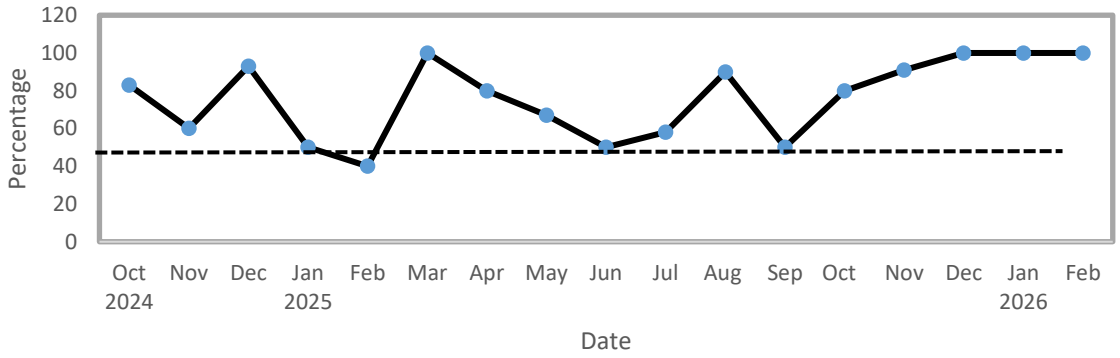
A total of 135 Stage 1 complaints were recorded during the reporting period, this averages eight complaints per month. Chart 13 data demonstrates normal variation with a reduction noted in the number of complaints reported since December 2025. Continued monitoring and targeted improvement activity are required to achieve sustained improvement.

Chart 13 Concerns and Stage 1 Complaints



The data demonstrated in Chart 14 demonstrates an increase in the percentage of Stage 1 complaints and concerns closed on targe and is being sustained above the local target of 85%. Continued monitoring is required to confirm this improvement is sustained.

Chart 14: Percentage Stage 1 and Concerns closed on target



4.2 Complaints Performance and Outcomes Stage 2 Complaints

Chart 15 displays the number of Stage 2 complaints between October 2024 and February 2026. A total of 150 Stage 2 complaints were received, with an average of 9 complaints per month. Stage 2 complaints have increased in early 2026 which require further investigation and management.

Chart 15: Stage 2 Complaints Received October 2024-February 2026

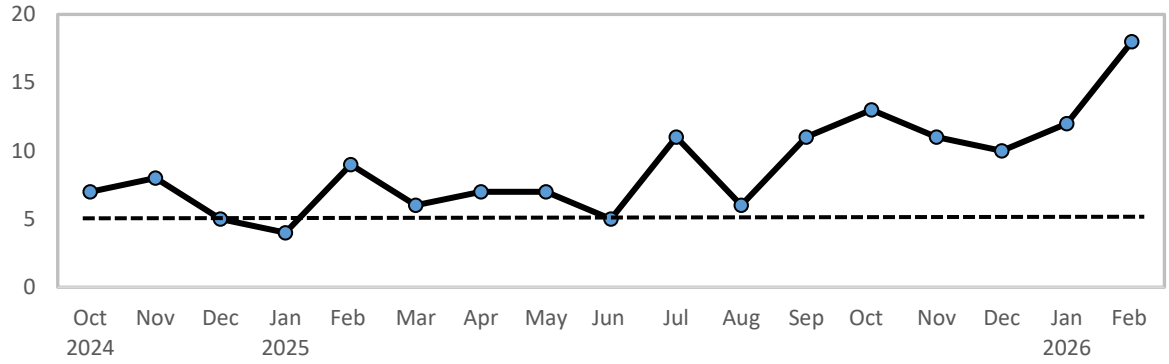
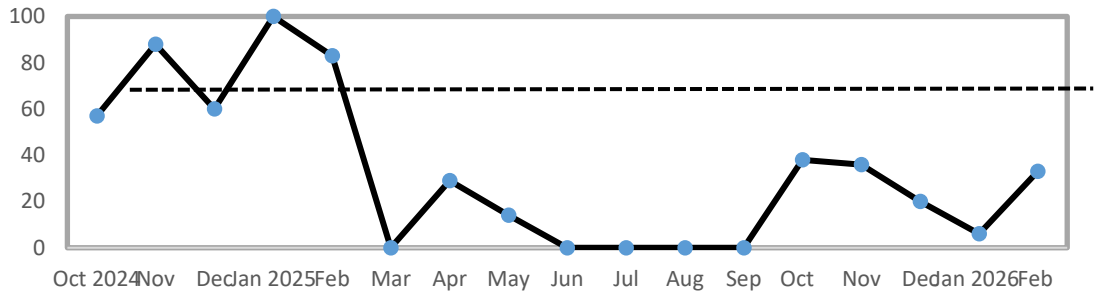


Chart 16 demonstrates performance against the 20-working-day Complaints Handling Performance target for Stage 2 complaints. Following a marked deterioration from March 2025, intermittent improvement is observed from October 2025 onwards with performance remaining below the 75% local target with no evidence of sustained recovery.

Chart 16: Percentage of Stage 2 Complaints Closed on Target



4.3 Complaints Current Activity

The data presented in Chart 17 is a point in time position and is provided as a reference for current activity. This was extracted on 6 April 2026 and shows the number of complaints that were out with timescale on that date. A total of 57 Mental Health complaints across the Health and Social Care Partnerships (HSCPs) remained open beyond the 20 working day timescale

Chart 17: Number of Complaints > 20 Working Days

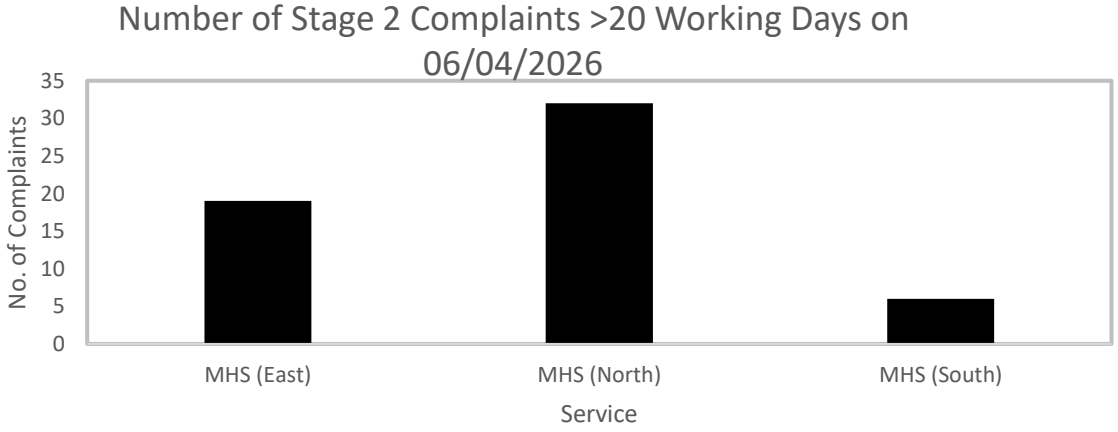


Table 1 describes current stages of each out of time complaint.

Table 1: Current Status

Service	20-30 days	30-40 days	Over 40 days	Comments
Mental Health (East)	0	0	19	17 x approval stage 2 x investigation stage
Mental Health (North)	5	6	21	20 x approval stage 12 x investigation stage
Mental Health (South)	0	0	6	3 x approval stage 3 x investigation stage

Service Managers allocated as Investigation Leads are responsible for drafting written responses. Further delays can arise where responses require additional drafting by the Complaints Team to ensure detailed responses are provided. Improving the quality of written complaint responses is a key priority. The Interim QI Lead is engaging with Senior Managers to discuss all aspects of complaint handling and offer tailored guidance on complaint response writing, with the aim of supporting consistency, improving quality, and reducing avoidable delays.

4.4 Complaint Outcomes

Table 2 demonstrates the complaint outcomes for all complaints received in the reporting period.

Table 2: Complaint Outcomes

	Not Upheld	Partially Upheld	Fully Upheld	Still Open
Concern/ Stage 1	118	11	6	0
Stage 2	47	13	7	60

4.5 SPSO Referrals and Investigations

There is currently 1 SPSO referral in relation to Mental Health Services that is active and awaiting decision regarding investigation progression.

4.5 Complaint Themes

The top three themes identified from complaints continue to be clinical treatment, communication and waiting times. The most frequently reported issue was within the Clinical Treatment category and related to disagreement with treatment or care plans, accounting for 132 complaints. Table 3 displays the complaint themes.

Table 3: Complaint Themes

Themes	Total
Clinical treatment	248
Communication	91
Waiting times	39
Environment / domestic	14
Procedural issues	12
Other	2
Delays	1
Total	407

5 Significant Adverse Events

The number of Significant Adverse Events (SAER's) year on year remain stable with 33 commissioned in the last full financial year (2025/26). Due to continuing system pressures, there are 20 overdue SAERs as of the 15th April 2026, these were commissioned between 2023-2026. Table 4 provides an overview of current SAER status.

Table 4: Mental Health Services SAER's 2020-2026 (as at 15.04.26)

No of SAERs Active by Commissioned Date								
Year	Total No Commissioned	Report		Action Plan		Learning Summary		Whole Process Complete
		Overdue	On Target	Overdue	On Target	Overdue	On Target	
20/21	25	0	0	3	0	0	0	22
21/22	24	0	0	2	0	0	0	22
22/23	28	0	0	3	0	0	0	25
23/24	30	4	0	3	1	0	0	22
24/25	25	5	0	6	0	1	0	13
25/26	33	11	16	2	0	0	0	4
26/27	3	0	3	0	0	0	0	0

The number of Local Management Team Reviews (LMTRs) has decreased from 14 in 2024/25 to 13 in 2025/2026. Currently there have been no LMTRs commissioned in the new financial year (2026/27). There are 13 overdue LMTR's from 2022-2026. Table 5 provides an overview of the current LMTR status.

Table 5: Mental Health Services LMTR's 2019-2026 (as at 15.04.26)

No of LMTRs Active by Commissioned Date						
Year	Total No Commissioned	Report		Action Plan		Whole Process Complete
		Overdue	On Target	Overdue	On Target	
19/20	24	0	0	3	0	21
20/21	20	0	0	2	0	18
21/22	19	0	0	1	0	18
22/23	24	4	0	0	1	19
23/24	9	1	0	1	0	7
24/25	14	0	0	3	2	9
25/26	13	8	1	0	0	4

5.1 Adverse Events Key Learning

- 20% of SAERs approved between October 2025 and March 2026 had learning points for services to consider
- 53% of SAERs approved between May and September 2025 provided a recommendation(s) for the service to develop and implement specific action plans

Themes include:

- Risk Assessment, Patient Safety & Clinical Decision-Making
  - Face-to-face assessments for high-risk mental health presentations

    - Use and updating of ARAF, safety plans and NEWS2
    - Clear documentation of rationale for clinical decisions
    - Escalation pathways and oversight
- Record Keeping, Documentation & Information Quality
    - Accurate, timely and complete records
    - Standardised documentation
    - Audit and compliance with professional standards
- Communication & Involvement of Families / Carers
    - Next-of-kin involvement
    - Carer communication and support
    - Use of collateral information
- Operational Governance
    - Clear, standardised pathways
    - Robust governance for new initiatives
    - Process mapping and SOP development
- Workforce capability
    - Joint working between clinicians and managers
    - Multidisciplinary learning culture
    - Clear roles and responsibilities
    - Mandatory and refresher training

5.2 Personalised Risk Management

Following a Significant Adverse Event recommendation, a short-life working group was established to review best practice guidance relating to the Ayrshire Mental Health Risk Assessment Framework (ARAF) and to assess its alignment with current national standards, with particular emphasis on risk formulation. This work has strengthened assurance that local approaches are consistent with emerging best practice. As part of a continuous improvement ethos, NHS Ayrshire & Arran (NHSAA) is actively engaged as a learning partner in national initiatives linked to the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Safer Services Toolkit, supporting a stronger focus on personalised risk management and meaningful family involvement.

Clear and proportionate recommendations for service improvement have been developed by NHSAA Mental Health Services. These include enhancements to the ARAF documentation framework and benchmarking of the local Bespoke Risk Intervention Training and Evaluation programme. This work has been undertaken with the support of NHS Education for Scotland, providing further assurance that developments are aligned with national priorities and evidence-based practice.

In line with national guidance and contemporary best practice, risk assessment documentation has been updated to remove the stratification of risk using RAG ratings, supporting more nuanced, formulation-based clinical decision-making.

A comprehensive ARAF training package has been developed to support consistent implementation across services and is prepared for roll-out. Arrangements are in place to ensure staff are supported during implementation, reinforcing confidence in the sustainability and effectiveness of these improvements.