

NHS Ayrshire & Arran

Meeting:	NHS Ayrshire and Arran Board
Meeting date:	Monday 12 October 2026
Title:	Quality and Safety – Acute Services
Responsible Director:	Vicki Campbell, Director of Acute Services Jennifer Wilson, Executive Nurse Director
Report Author:	Edmund Tabay, Interim Deputy Nurse Director (Acute) Karen McCormick, Chief Nurse

1. Purpose

This is presented to the NHS Ayrshire and Arran Board for:

- Awareness

This paper relates to:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland 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 Acute Services.

2.2 Background

NHS Ayrshire Arran is participating in the Scottish Patient Safety Programme (SPSP), a national programme aimed at improving the safety and reliability of health and social care services and reducing avoidable harm. 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 phases, providing a refreshed framework for improvement and collaboration across NHS Scotland. The national safety priorities for 2025–2027 are:

- Deteriorating patient
- Falls

- Pressure ulcers
- Medicines in hospital (diabetes medicines management at transitions of care) which is in development.

NHSAA continues to implement the national assurance [programme and framework](#), Excellence in Care (EiC). Commissioned by the Scottish Government in response to the Vale of Leven Inquiry recommendations, EiC provides clinical teams with the tools and oversight required to assure the quality and safety of care. NHSAA reports monthly quality of care data to Public Health Scotland via the Care Assurance and Improvement Resource (CAIR) dashboard and submits a bi-annual EiC implementation report to the Scottish Government, providing an overview of progress against key deliverables.

2.3 Assessment

A range of site and ward level data continue 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 have remained reduced and are below the current Scottish national median rate of 7 (per 1,000 OBD's at 4.7).

Pressure Ulcers: Despite improvement efforts, no reduction in incidence of Grade 2–4 PU's is demonstrated across both acute sites.

Cardiac Arrest: UHC cardiac arrest rate demonstrates normal variation with 6 points below the median and UHA cardiac arrest rate demonstrates a sustained reduction

Nutrition & Hydration: Monthly review of FFN data supports local and national reporting requirements and enables targeted quality improvement initiatives to enhance patient safety, nutritional care planning and escalation of nutritional risk. Overall performance reflects continued commitment from clinical teams to ensuring patients receive timely nutritional screening and assessment on admission.

Complaints: Following the success of Phase 1 of the Complaints Improvement Sprint, Phase 2 commenced on 22 June 2026 and delivered significant progress.

Significant Adverse Events: 82 Local Management Team Reviews (LMTR's) and 250 action plans are overdue. 45 Significant Adverse Event Review (SAER) reports and 57 action plans are overdue. Work continues to address the 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 Quality management of the 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 complemented by the EiC assurance programme. NHSAA have accepted an offer to participate in the SPSP Adults in Hospital Programme 2025–2027.

2.3.2 Workforce

Sustainable improvement in patient care can only be achieved when staff are fully engaged and empowered. Active participation in both SPSP, EiC, management of complaints and learning from adverse events is essential to enhancing patient

experience, improving clinical outcomes, and delivering 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 PU's are associated with extended lengths of stay, increased 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, lead to potential litigation, 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 across the following themes.

- Vision and Leadership
- Effective Partnerships
- Governance and accountability
- Use of resources
- Performance management

2.3.7 Other impacts

- Compliance with Corporate, Nursing midwifery and allied health professionals (NMAHP) and Quality Strategy Objectives.

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. To date, stakeholder involvement has included:

- Regular updates to relevant governance and improvement groups
- Participation in local and national SPSP/EiC learning activity
- Provision of access to local and site-level data to inform decision-making and 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, 8 September 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 appendices are included with this report:

- Appendix 1. Acute Quality and Safety Update

Acute 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 to group members the current progress and plans going forward in relation to patient safety measures including:

- Falls
- Falls with harm
- Pressure Ulcers
- Cardiac Arrest
- National Early Warning Score
- Food Fluid and Nutrition
- Excellence in Care
- Complaints/ feedback
- Adverse Event Activity
- Multi-Drug-Resistant Organism
- Quality Management Practice Learning Environment (QMPLE)

2. Scottish Patient Safety Programme (SPSP)

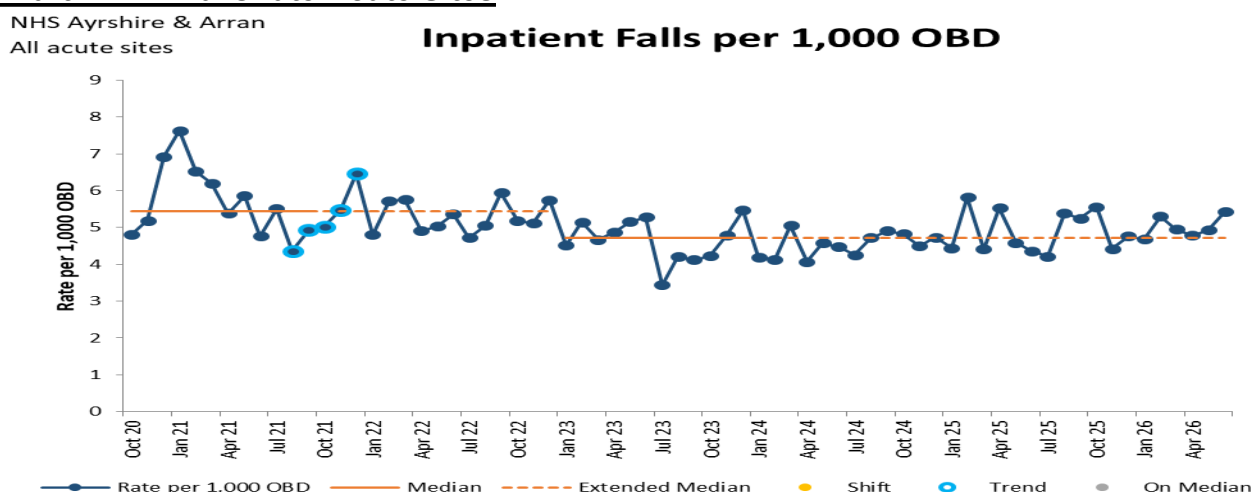
NHS Ayrshire and Arran (NHSAAA) is participating in The Scottish Patient Safety Programme (SPSP), a national programme aimed at improving safety and reliability of health and social care services and reducing avoidable harm. The national safety priorities for 2025-2027 are:

- Falls
- Pressure ulcers
- Medicines in hospital (focus on diabetes medicines management) – in development
- Deteriorating Patient

2.1 Falls

Quality improvement work continues across both acute sites to support further reduction in falls and falls with harm. The current median rate for falls across both acute sites is 4.7 falls per 1,000 occupied bed days (Chart 1). This has been sustained since January 2023 and remains stable demonstrating normal variation. The median rate is lower than the national median rate of 7 falls per 1,000 OBD.

Chart 1 – All Falls rate Acute Sites



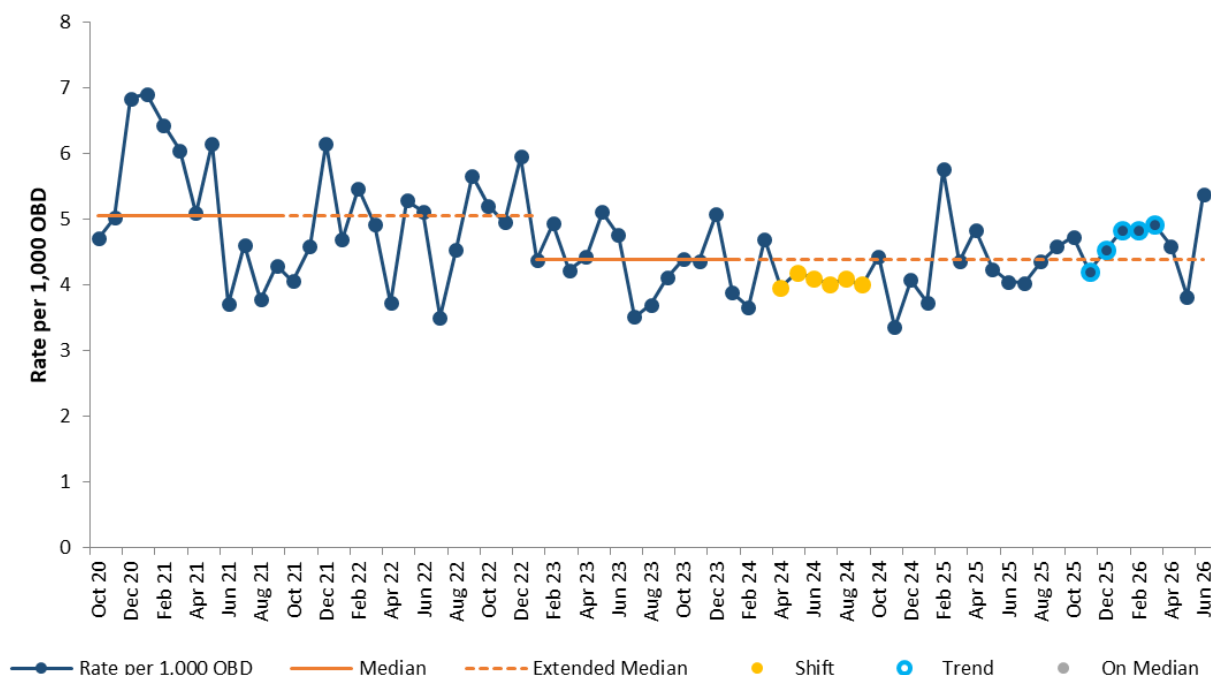
Data for UHC demonstrates normal variation with 6 of the last 7 points above the median of 4.4 falls per 1,000 OBD (Chart 2)

Chart 2 – All falls rate UHC

NHS Ayrshire & Arran

University Hospital Crosshouse

Inpatient Falls per 1,000 OBD



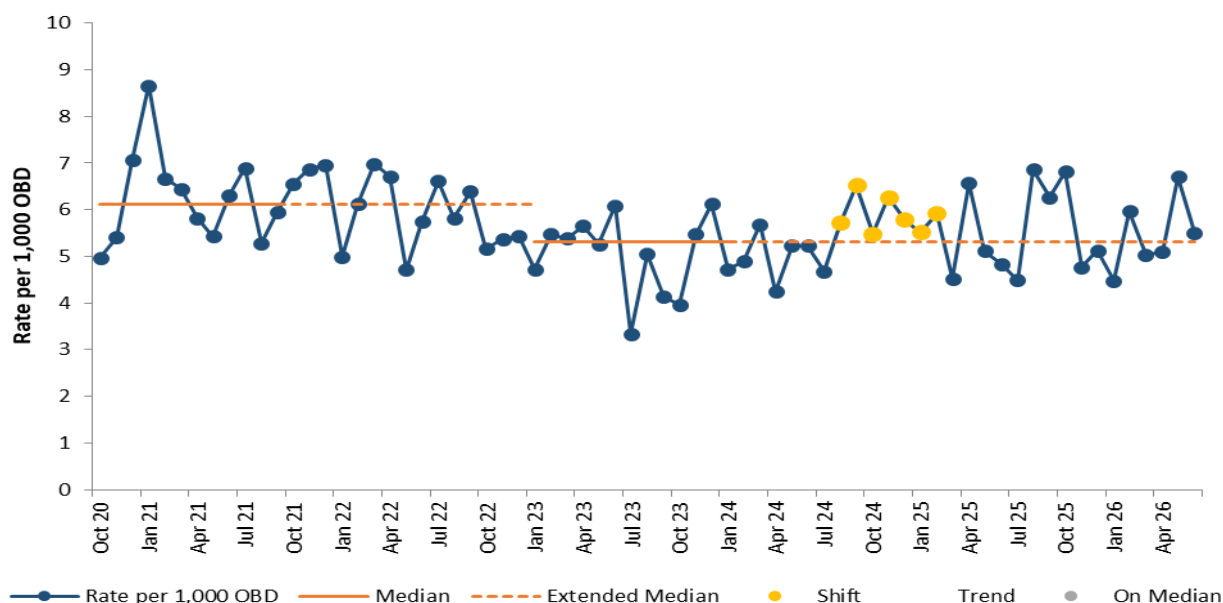
Data for UHA demonstrates normal variation with a median of 5.3 falls per 1,000 OBD (Chart 3)

Chart 3 – All falls rate UHA

NHS Ayrshire & Arran

University Hospital Ayr

Inpatient Falls per 1,000 OBD



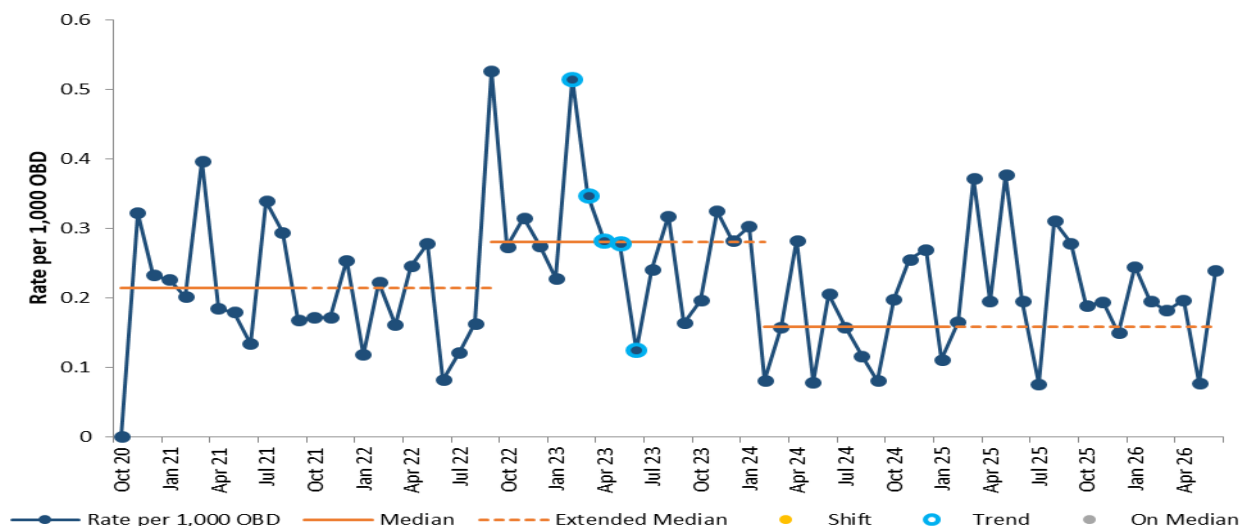
2.2 Falls with harm

The incidence of falls with harm (FWH) has decreased on both acute sites since February 2024, the median rate is 0.15 per 1,000 OBD's with no new signals of improvement (Chart 4).

Chart 4 – Falls with harm rate all acute sites

NHS Ayrshire & Arran
All acute sites

Inpatient Falls with Harm per 1,000 OBD

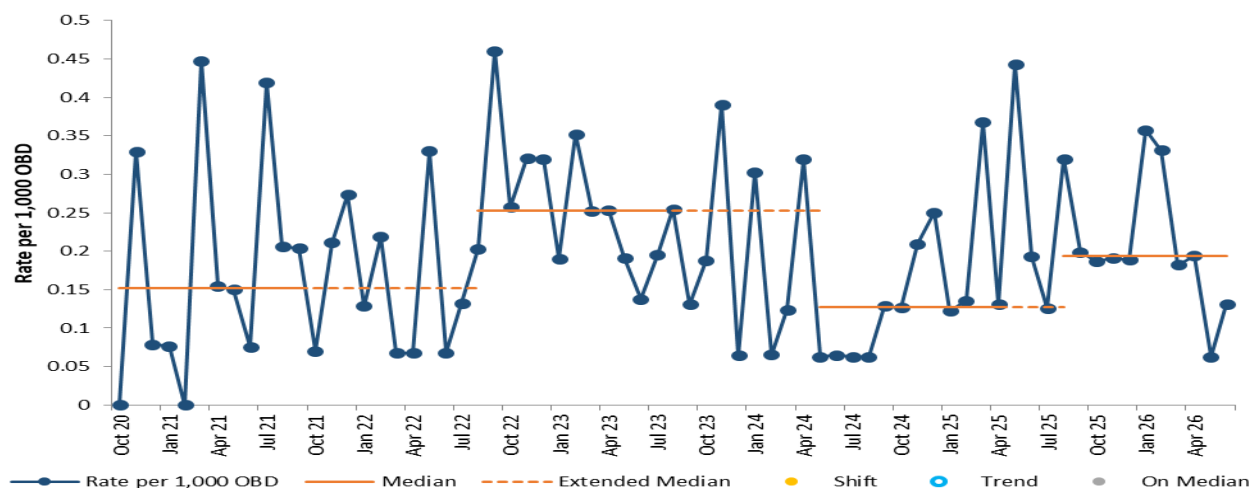


Data for UHC demonstrates an increase in falls with harm with a median of 0.19, following a sustained reduction (Chart 5).

Chart 5 – Falls with harm rate UHC

NHS Ayrshire & Arran
University Hospital Crosshouse

Inpatient Falls with Harm per 1,000 OBD

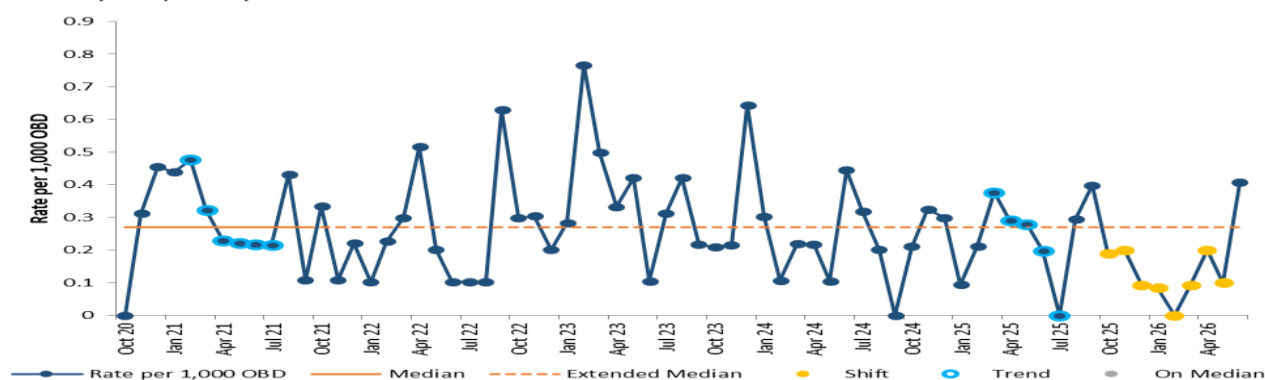


Data for UHA demonstrates normal variation with a median of 0.27. An improvement noted October 25 to May 26 has not been sustained. (Chart 6).

Chart 6 - rate of falls with harm per 1,000 OBD on University Hospital Ayr site

NHS Ayrshire & Arran
University Hospital Ayr

Inpatient Falls with Harm per 1,000 OBD



2.3 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. The initiative was led by the Lead Nurse for Emergency Care and Orthopaedic Trauma, with support from Falls Coordinators and the QI team. An evidence-based workbook approach was adopted to guide change, complemented by a series of interactive workshops. Topics covered so far include continence and delirium and nutrition. Following the conclusion of this work, a revised improvement plan has been developed in collaboration with key stakeholders. The proposal targets the key contributing factors to inpatient falls, with a focused approach to enhancing supervision practices and improving support for activities of daily living. Aligned with the national ambition of a 10% reduction in falls, successful achievement would reduce NHSAA median rate from 4.7 to 4.2 falls per 1,000 OBD.

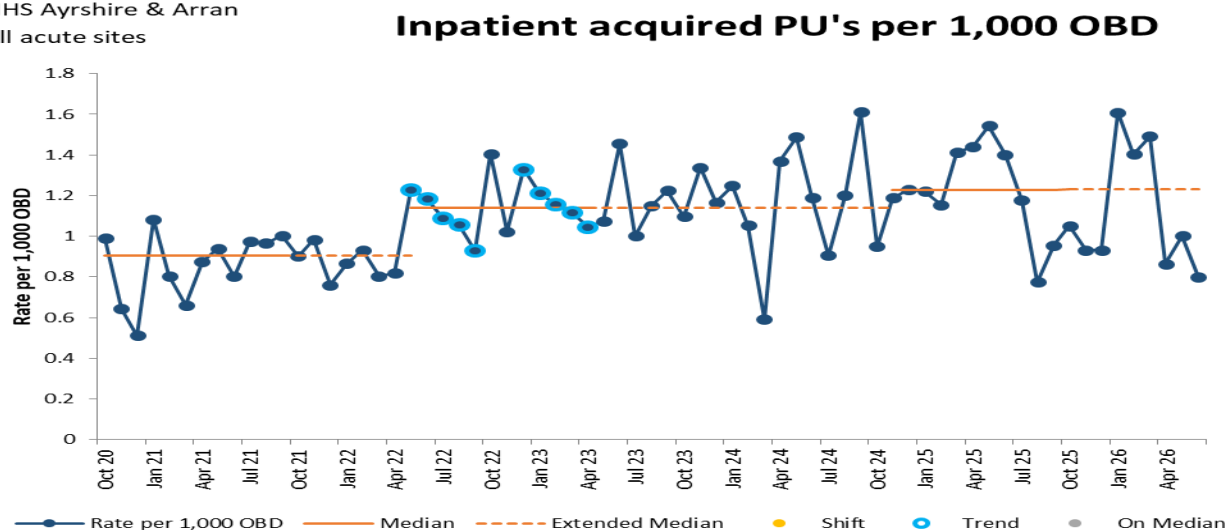
3. Pressure Ulcers

Quality improvement work continues across both acute sites to support reduction in pressure ulcers (PU's). An acute improvement plan, RECAP (Risk to Review Pressure Ulcers), has been developed in collaboration with key stakeholders with the aim of reducing pressure ulcers 25% by June 2028. The plan sets out a "back to basics" approach across all acute sites. Its focus is on strengthening core nursing processes, including risk assessment, care planning, implementation of preventative measures, and ongoing evaluation of care. By reinforcing these fundamental elements, the intention is to improve consistency and reliability in pressure ulcer prevention. RECAP will be launched in July 2026.

The current median rate for pressure ulcers across both acute sites is 1.23 per 1,000 OBD's (Chart 7).

Chart 7 – rate of acquired pressure ulcers all acute sites

NHS Ayrshire & Arran
All acute sites



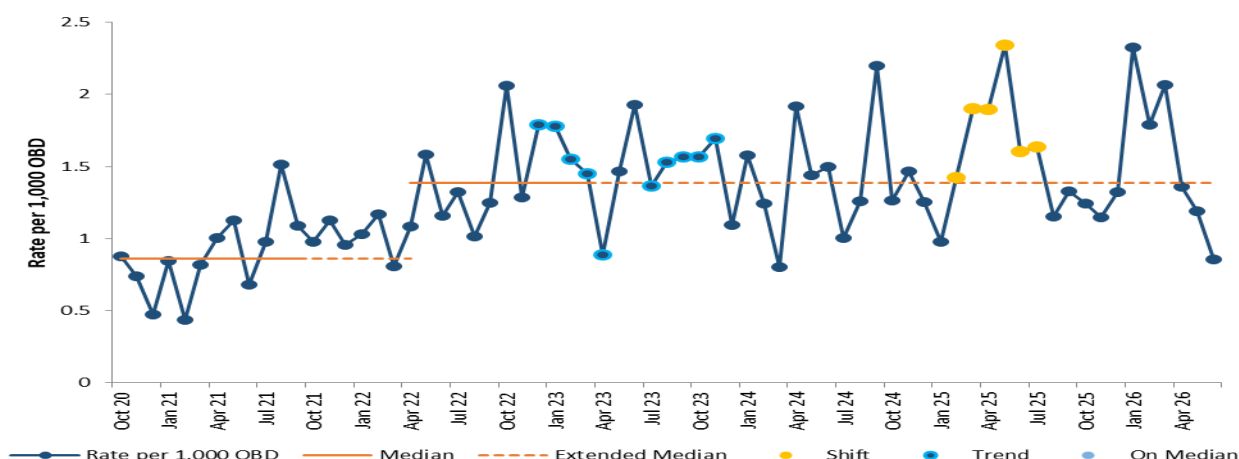
Data for UHC demonstrates normal variation with the last 3 points below the median following a previously reported increase (Chart 8).

Chart 8 – rate of acquired pressure ulcers per 1,000 OBD on University Hospital Crosshouse

NHS Ayrshire & Arran

University Hospital Crosshouse

Inpatient acquired PU's per 1,000 OBD



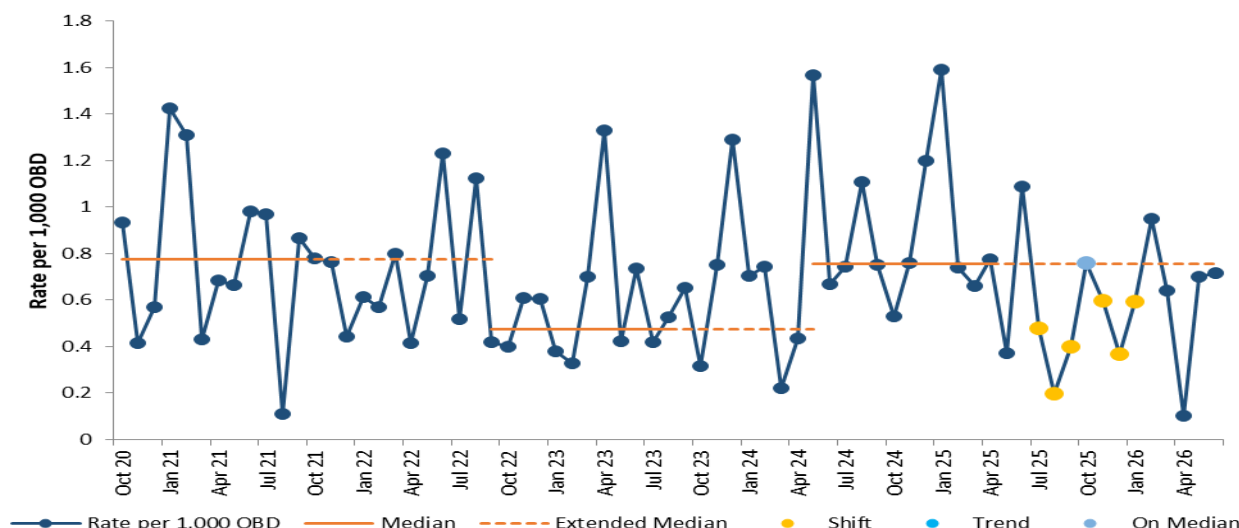
Data for UHA demonstrates normal variation with 7 of the last 8 points below the median of 0.7 (Chart 9).

Chart 9 – rate of acquired pressure ulcers per 1,000 OBD on University Hospital Ayr

NHS Ayrshire & Arran

University Hospital Ayr

Inpatient acquired PU's per 1,000 OBD



4.0 Deteriorating Patient

4.1 Cardiac Arrest

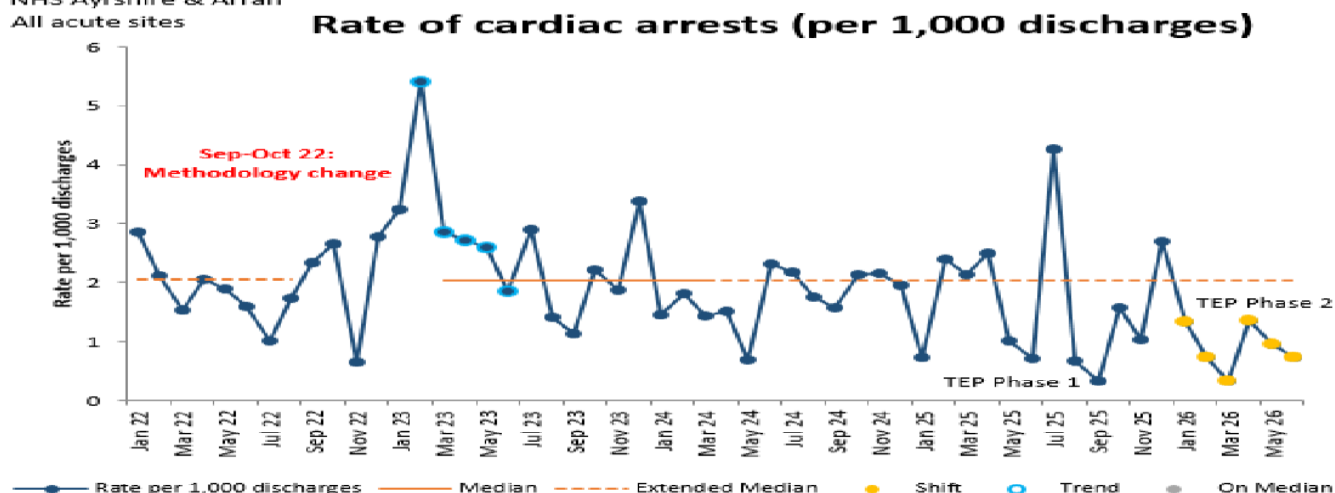
Reducing cardiac arrests is a key area for improvement within Acute Services. Previously an aim of a 25% reduction in cardiac arrests by December 2025 was set, this has not been achieved. A reduction of 2% has been achieved (58 to 57, 2024 to 2025).

A revised aim of 10% reduction in cardiac arrests by December 2026 was endorsed by the Deteriorating Patient Steering Group (DPSG) in May 2026. To meet this aim, a reduction of six cardiac arrests a year would be required. If this reduction is achieved, NHSAA would sit below the national median.

Acute Site cardiac arrest rate data during phase 1 of the TEP collaborative continued to demonstrate normal variation, however from January 2026, at the beginning of phase 2 of the TEP collaborative until June 2026 there is evidence of a reduction in cardiac arrest rates with 6 points below the median (Chart 10).

Chart 10 Acute Site Cardiac Arrest Rate January 2022-June 2026

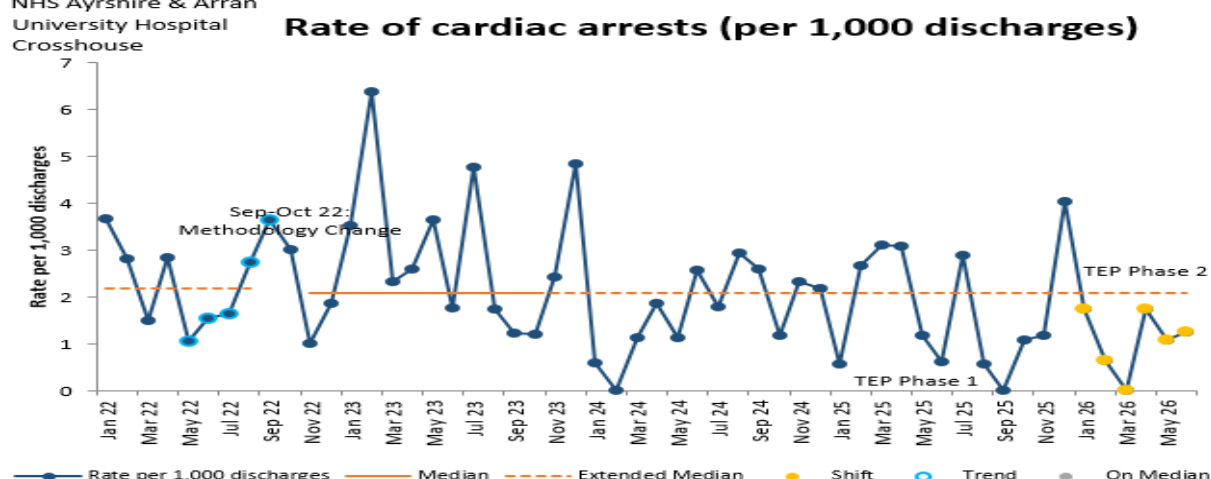
NHS Ayrshire & Arran
All acute sites



UHC cardiac arrest rate demonstrates normal variation with 6 points below the median.
(Chart 11)

Chart 11 Cardiac Arrest Rate January 2022-June 2026 University Hospital Crosshouse

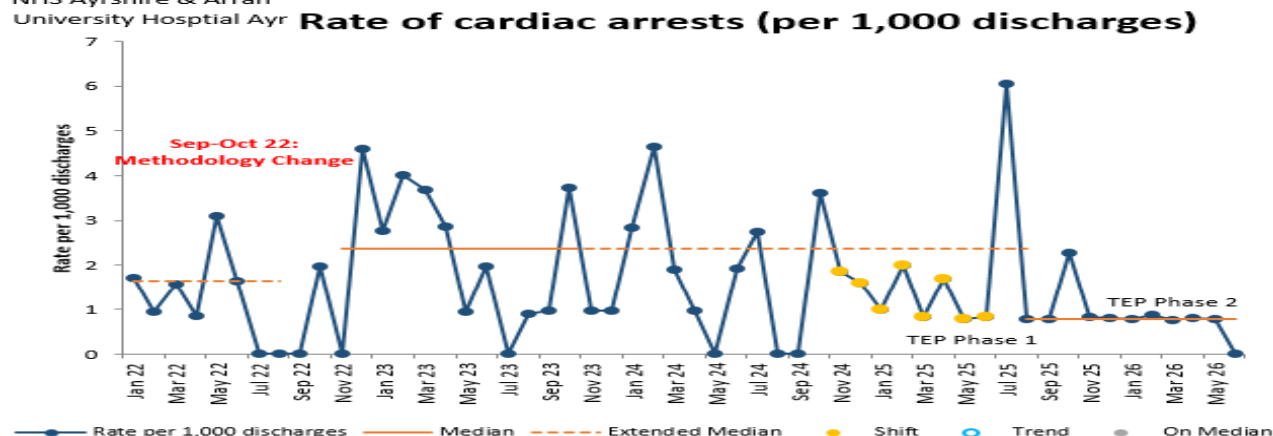
NHS Ayrshire & Arran
University Hospital
Crosshouse



UHA cardiac arrest rate demonstrates a sustained reduction with the median reducing to 0.79 from August 2025. (Chart 12)

Chart 12 Cardiac Arrest Rate January 2022-June 2026 University Hospital Ayr

NHS Ayrshire & Arran
University Hospital Ayr



4.2 National Cardiac Arrest Audit (NCCA)

National Cardiac Arrest Audit (NCCA) data (1st April 2025 -31st December 2025) for UHA demonstrates a 5% survival to discharge rate which is a decrease from the last report where survival to discharge was 7.1%.

UHC data survival to discharge rate for the same period is 5% this has reduced from last reports survival to discharge rate of 9.1%. Data from both sites continue to demonstrate rates significantly below the national average for survival to discharge which is 26.4%.

Initial survival at UHC is 35% (compared to national average of 55.5%) and of that 44.4% had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) placed immediately post return of spontaneous circulation (ROSC) this a reduction from the last report where 50% were placed immediately post ROSC.

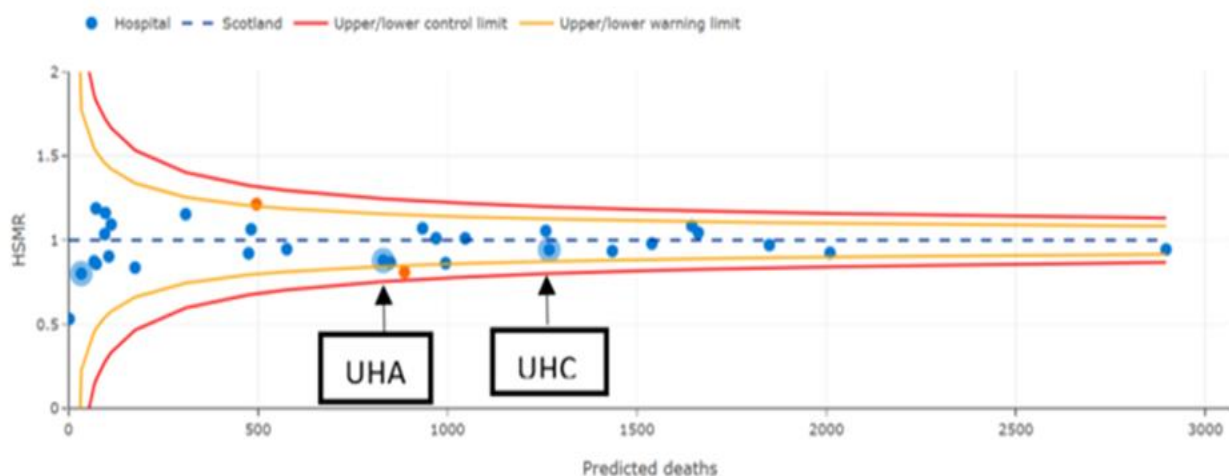
Similar hospitals have a 13.9% post ROSC DNACPR implementation rate and nationally the rate is 29.3%. Both UHA and UHC are significantly above this UK wide benchmark.

4.3 Hospital Standardised Mortality Ratio

Hospital Standardised Mortality Ratio (HSMR) quarterly data published by Public Health Scotland on the 12 May 2026 shows UHA and UHC to be within the control limits (chart 13). UHA has a HSMR of 0.88 and UHC 0.93, both acute sites HSMR rate is below previously reported rate.

Chart 13 - HSMR for Deaths within 30 days of admission to hospital January – December 2025

HSMR for deaths within 30 days of admission by hospital: January 2025 to December 2025



The HSMR review Annual Report inclusive of thematic analysis from reviews was presented at ASCGG on the 5 June 2026 and then at HCG on the 14 July 2026. To improve the HSMR process and learning from reviews, Resuscitation Services have completed a literature review, benchmarking with other NHS Boards, and engagement with multidisciplinary teams to evaluate the current HSMR review process and identify opportunities for improvement. Findings will inform the redesign of the process to strengthen learning and better align outcomes with organisational priorities. A multidisciplinary project group, including human factors specialists, will lead the co-design, testing, and evaluation of an enhanced review framework.

4.4 Cardiac Arrest Reviews

Resuscitation Services reviewed all true cardiac arrests for both acute sites (exclusion criteria areas – Critical Care Unit, Coronary care Unit, Theatres, Emergency Department and Day cases) between 1 January and 31 June 2026. Table 1 displays key findings:

Table 1- Key findings from Cardiac Arrest Reviews UHA and UHC January-June 2026

Finding	UHC	UHA
Resuscitation was appropriate	63.6%	66.7%
DNACPR would have been appropriate	18.2%	33.3%
Failure to recognise deterioration	9.1%	0%
Cardiac arrest was preventable with a different intervention	0%	0%
Recognised deterioration but failure to escalate	0%	0%
CPR not appropriate as patient had a DNACPR decision in place	9.1%	0%
Treatment Escalation Plan in Place	27%	0%

This data is consistent with previously reported cardiac arrest review outcome data, with 'DNACPR would have been appropriate' categorised as the key theme for improvement.

Treatment Escalation Planning continues to be an area requiring targeted improvement. TEPs are designed to support the decision-making process and ensure continuity of care. Cardiac Arrest reviews demonstrated no patients at UHA and 27% of patients at UHC who sustained a cardiac arrest had a Treatment Escalation Plan (TEP) in place, this has improved from the previous report when UHC had 10% of TEPs in place. UHA data has shown a reduction in TEPs in place from previous data that demonstrated 11% of patients had a TEP in prior to cardiac arrest.

HSMR reviews, NCAA survival to discharge and post ROSC DNACPR implementation data continue to reinforce the need for targeted improvement work around early decision making. The leading suspected causes of cardiac arrest at UHC is cardiac and the leading cause at UHA is unknown. The average age of patients sustaining cardiac arrest at UHA is 76 and UHC is 69.

Learning identified from cardiac arrest reviews continues to be shared with SCNs from the area where the cardiac arrest occurred and wider with key groups. This data also continues to inform deteriorating patient improvement projects.

A process for cardiac arrest review teams to escalate cases for further review to the Adverse Event Review Group (AERG) is established with no cardiac arrests at UHA and 9% at UHC escalated to AERG for review in the reporting period. There is a decrease in the percentage of cases escalated to AERG when compared with the previous report (UHA – 9% and UHC-15%).

Review of the cardiac arrest cohort for January to June 2026 demonstrates high levels of NEWS2 compliance across both acute sites. At University Hospital Crosshouse (UHC), full compliance with NEWS2 was achieved in 82% of cases, with 9% demonstrating 75% compliance and 9% demonstrating 50% compliance. This represents a 10% improvement in full NEWS2 compliance compared with the previous reporting period.

At University Hospital Ayr (UHA), full NEWS2 compliance was achieved in 75% of cases, while the remaining 25% of cases demonstrated 75% compliance. This reflects a 5% reduction in full compliance compared with previous data, which showed 80% of cases achieving full NEWS2 compliance. This is demonstrated in Table 2 below.

Consistent with previous reviews, the most frequently identified area of non-compliance across both sites relates to the required frequency of patient observations. This continues to be a key focus for improvement to ensure timely recognition and escalation of patient deterioration.

Table 2- NEWS2 compliance UHA and UHC January-31 June 2026

Compliance with NEWS2	UHC (%)	UHA (%)
100% compliance	82%	75%
75% compliance	9%	25%
50% compliance	9%	0%

4.5 Improvement Work

4.5.1 Treatment Escalation Planning (TEP)

The TEP improvement collaborative was launched June 2025 with the aim of 90% of patients admitted to test sites having a TEP in place within 72 hours of admission. Whilst no test sites have reached 90% compliance, 3 out of the 5 test areas have demonstrated improvement in the number of TEPs completed within 72 hours of admission, with 3 areas achieving over 70% compliance.

A workshop was held to bring together Phase 1 test sites (CAU both sites, 5D, 2B and St8) and Phase 2 test sites (ACCU both sites, 3B and St12) to share learning and plan for next steps.

Learning from the workshop identified:

Enablers

- CONnECT course attendance supported TEP work
- MDT reviews of cardiac arrests to establish learning
- Placement of TEP forms in close proximity to admission documentation
- Use of posters and patient information leaflets

Barriers

- Clinical and staffing pressures
- Overly ambitious project aim and number of change ideas identified.
- Changeover of medical staff

Phase 2 project plans are underway, with Phase 1 teams continuing as part of the collaborative to progress further improvement work. A 3rd workshop will bring together all test sites in September 2026 to share learning.

4.5.2 Conversations on Emergency Care and Treatment (CONnECT) Course

Resuscitation services alongside the clinical lead for ReSPECT have supported the development of the CONnECT course. The course has been co designed to support health care professionals to consider a values-based approach to shared decision making around future care planning with patients and their families. Since January 2025 13 courses have taken place with 294 places offered and 163 candidates across Nursing, Medical, AHPs and Paramedics attended. 10 dates are planned for 2026 and are well subscribed. Immediate feedback demonstrates 100% of participants reported a positive impact, with the majority rating the impact as high or very high on their attitudes, knowledge and skills.

4.5.3 Sepsis

Sepsis crude rate of deaths within 30 days of admission from sepsis at UHC demonstrates a median of 30% (Chart 14) and UHA demonstrates a median of 29% (Chart 15). Medians at both sites are higher than the national median which is 24%.

Chart 14: Crude Rate (%) of Deaths within 30 Days of Admission from Sepsis for UHC 2018-2026

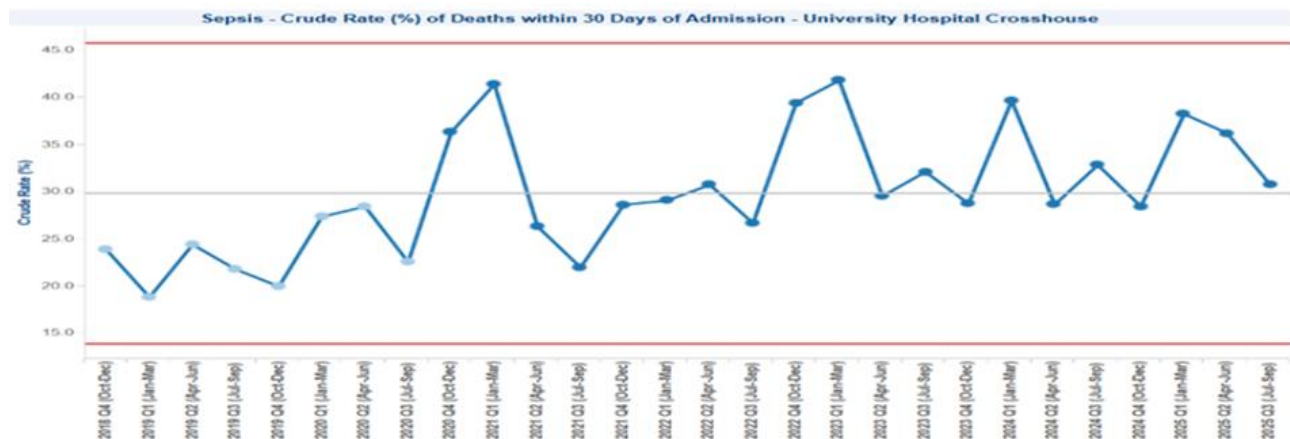
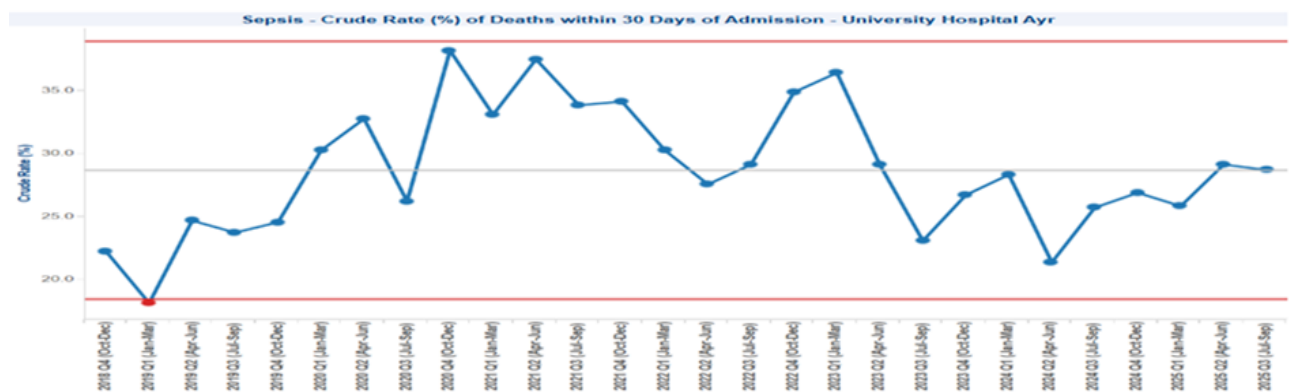


Chart 15: Crude Rate (%) of Deaths within 30 Days of Admission from Sepsis for UHA 2018-2026



Planning for targeted improvement work is underway at UHC, CAU and ED. A driver diagram, process map for each area and a data collection tool aligning to the SPSP sepsis change package have been progressed, initial change ideas identified include:

- A sepsis sticker to prompt recognition and document early bundle elements
- Exploring the NEWS2 auto calculating function on symphony to support identification of high-risk patients
- Whiteboard prompts in CAU to highlight patients meeting sepsis criteria

The project group will reconvene in early August 2026 to share local baseline data collected from test sites, agree timescales for testing of change ideas and data collection timelines.

4.5.4 Resuscitation council UK Guidelines 2025

The Resuscitation Council UK (RCUK) guidelines are reviewed every 5 years, with the most recent update published December 2025. Resuscitation services have completed the update of emergency trolley prompt cards and posters for all acute and community clinical areas. Both in hospital and out of hospital Adult Basic Life support pre course videos has also been re-filmed, edited and published to reflect new guidelines.

4.5.5 Anaphylaxis Grab Bags

Resuscitation Services have concluded the roll out of new anaphylaxis grab bags for all Acute and Community Sites, supporting a safer and consistent approach to the management of life-threatening anaphylaxis.

5.0 Food Fluid and Nutrition (FFN)

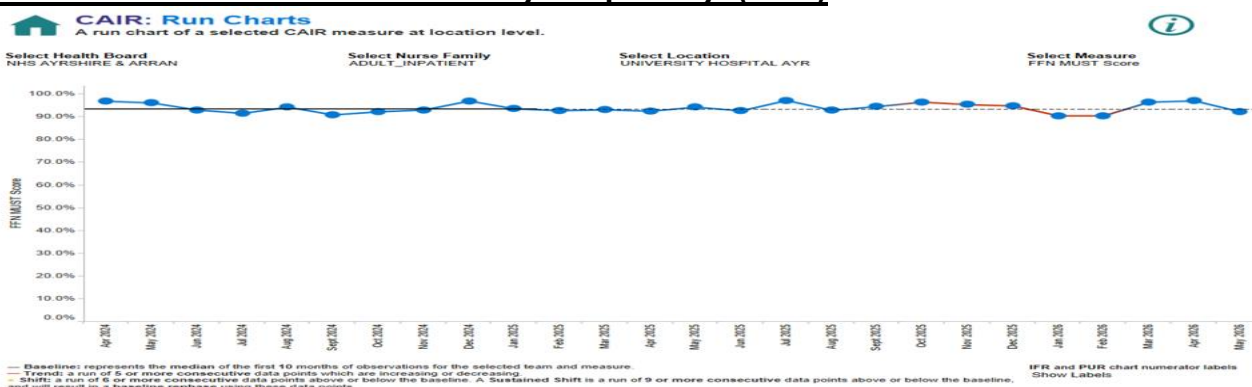
The Ayrshire Nutrition Strategic Group (ANSNG) has been revamped to provide strategic leadership, governance assurance, and system-wide oversight for food, fluid and nutritional care across NHS Ayrshire and Arran.

The group will ensure that services deliver safe, effective, person-centred nutritional care. Comply with Healthcare Improvement Scotland (HIS) Standards, including Food, Fluid and Nutritional Care Standards, Complex Nutritional Care Standards, Food in Hospitals Specifications and will drive continuous quality improvement and reduction in variation across the system with specific sub-group.

Food, Fluid and Nutrition standards data are collected monthly across 32 inpatient wards within both acute sites. The FFN measurement tool supports staff to monitor, measure and improve the quality of nutritional care and drive local quality improvement initiatives.

Compliance with Malnutrition Universal Screening Tool (MUST) completion and nutritional risk assessment is audited, reviewed and reported monthly both locally and nationally. Data analysis continues to look at timely and accurate MUST screening and calculation within 24 hours of admission and weekly to support early identification and mitigation of nutrition related risk. As well as the appropriate escalation of identified patients at risk of malnutrition.

Chart 16 FFN MUST Score University Hospital Ayr (UHA)

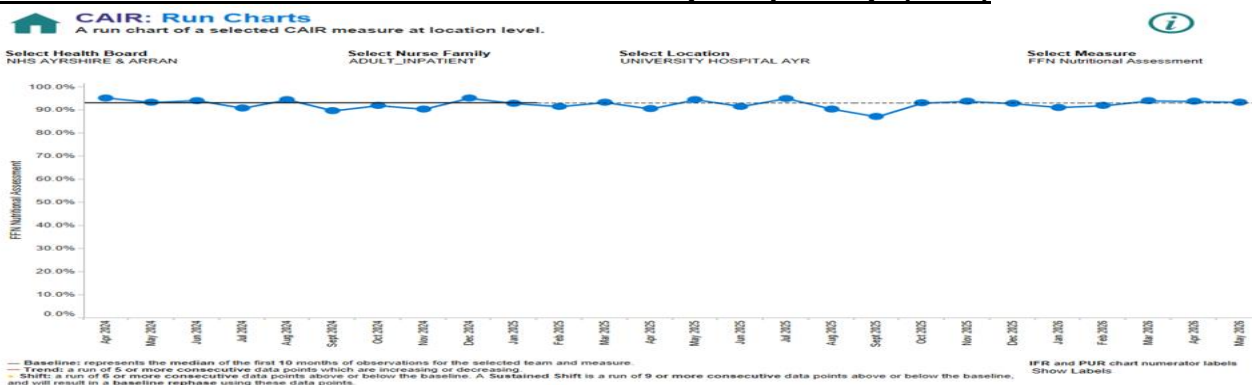


Compliance Score: **92%**

Numerator: Number of valid MUST scores completed within 24hrs of admission

Denominator: Total number of patient records reviewed

Chart 17 FFN Nutritional Assessment University Hospital Ayr (UHA)

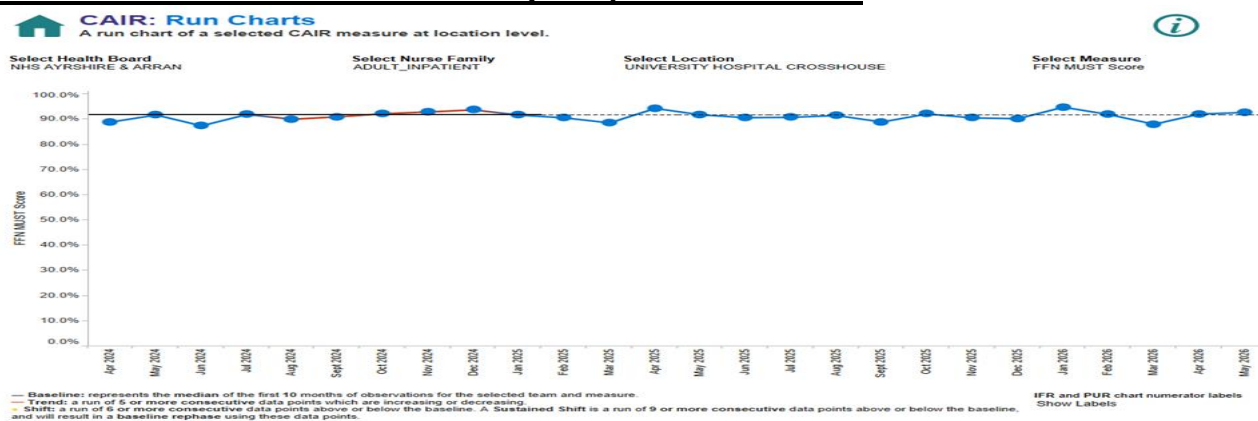


Compliance Score: **93%**

Numerator: Number of nutritional assessments completed within 24 hours of admission or transfer to ward

Denominator: Total number of patient records reviewed

Chart 18 FFN MUST Score University Hospital Crosshouse

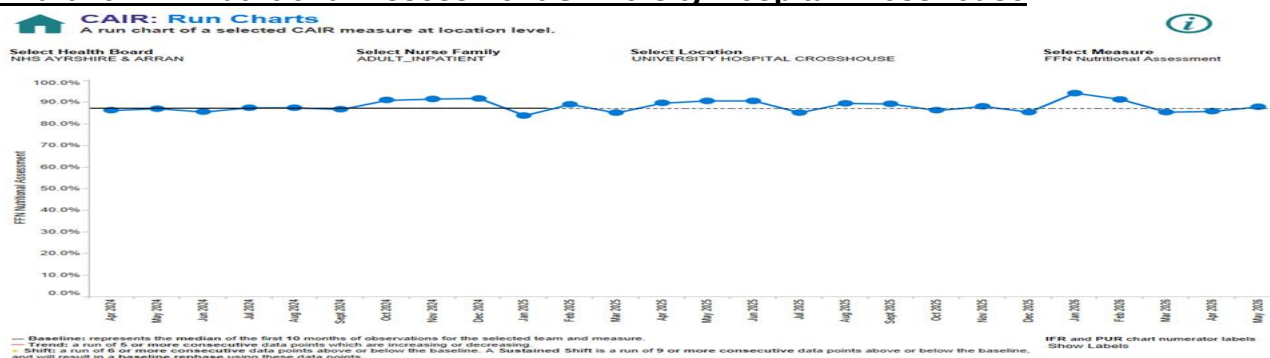


Compliance Score: **92%**

Numerator: Number of valid MUST scores completed within 24hrs of admission

Denominator: Total number of patient records reviewed

Chart 19 FFN Nutritional Assessment University Hospital Crosshouse



Compliance Score: **87%**

Numerator: Number of valid MUST scores completed within 24hrs of admission

Denominator: Total number of patient records reviewed

6. Quality and Safety Oversight Group

The introduction of the Quality and Safety Oversight Group in 2023 has provided a robust approach to the monitoring and scrutiny of Quality and Assurance process, outcome data and service improvement activity. The redesigned approach completed in June 2026 aims to strengthen quality governance arrangements through enhanced oversight, improved scrutiny of performance data, and targeted commissioning of improvement work. Collectively, SPSP and EiC measures provide the Quality and Safety Oversight Group with a balanced view of both patient safety outcomes and quality of care assurance, supporting early identification of risk, targeted improvement activity, and organisational assurance regarding the delivery of safe, effective and person-centred care. Group membership is inclusive of Acute Services Senior Nursing Leadership, Quality and Care Governance, Excellence in Care and Health and Safety, with subject matter outcome reporting by Resuscitation Services, Infection Prevention and Control, Pharmacy and Food Fluid and Nutrition Lead.

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 within Acute Services. The revised Terms of Reference support a more data focussed, action-oriented approach to assuring and scrutinising safe, effective, person-centred care within Acute Services, with agreement that Excellence in Care Quality of Care reviews will be commissioned by the group for any areas of concern.

7. Excellence in Care (EiC)

Key EiC highlights for reporting period:

- Continued development of a Quality of Care (QoC) data monthly highlight report to improve access to data for clinical teams, inclusive of Infection Prevention Control, Adverse Events (including Cardiac Arrest, Falls with Harm, Pressure Ulcers and Medication related incidents) and Personal Development Review (PDR) compliance.
- Inclusion of Care Assurance workshops to the NMAHP Leadership Programme to enhance foundational knowledge of care assurance and support preparation for Quality of Care review
- Development of a Quality of Care Handbook for Senior Charge Nurses to complement Care Assurance workshops and professional development for newly appointed and aspiring senior charge nurses.
- Development of a bespoke Healthcare Support Worker Induction programme commencing in August 2026 aimed at newly appointed healthcare support workers.
- Progression of in-patient nursing documentation review with target implementation by end November 2026. This has been restricted due to several factors.
- The Scottish Government commissioned the national team of the EiC programme to develop a person-centred measure that underpins and strengthens the delivery and continuous improvement of person-centred care. A six-question relational EiC PREM survey tool has now been co-designed with service users and subject matter experts across Scotland to support national assurance and improvement. NHSAA are a pilot site for national testing of the tool, which is being tested in Day Surgery and Outpatients at University Hospital Ayr.
- Working with senior nurses within Acute Services to test the National Quality of Care review tools. This will be concluded in August 2026 to allow a planned programme to be rolled out in autumn of 2026.

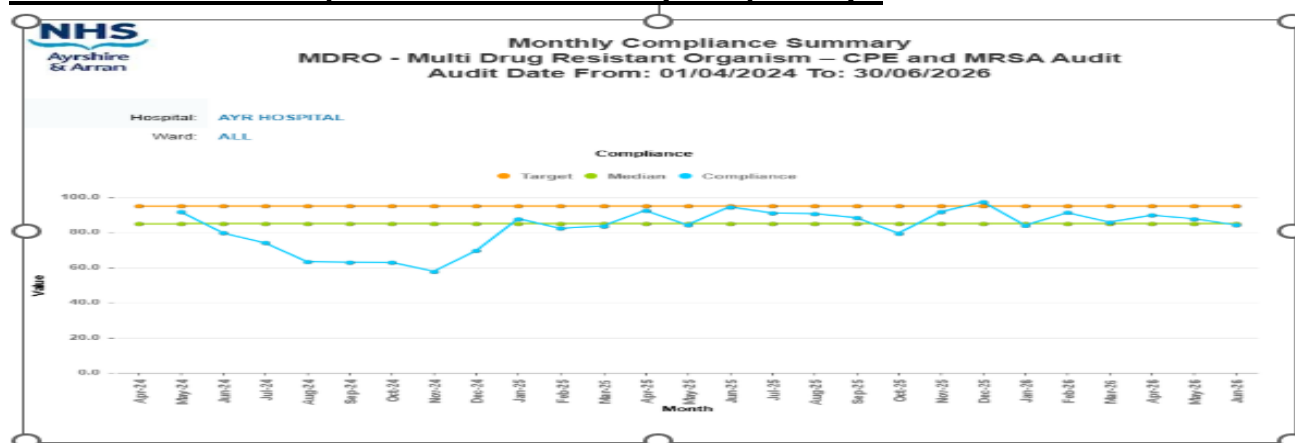
Key EiC challenges for reporting period:

- Accuracy of quality of care data for assurance is limited by an outstanding action for completion of Business Objects system development. Clinical areas who have moved physical location such as Critical Care, 4B and Station 10 adverse event data is not currently extracted to include in local and national reporting. This can result in variance of reportable data for improvement, assurance and early identification of risk.

7.1 MDRO Compliance

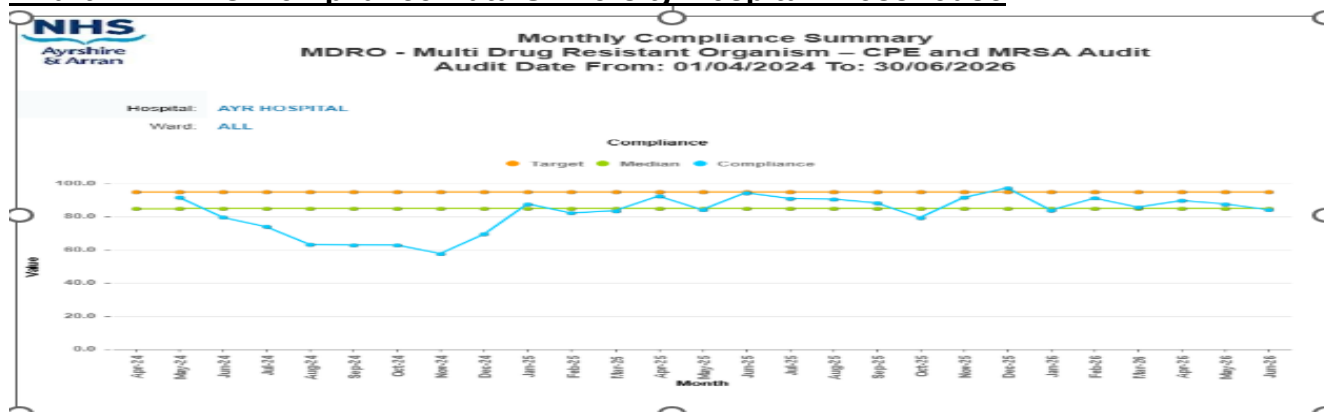
Admission screening by infection prevention and control clinical risk assessment (CRA) allows for the early identification of patients who are colonised or at increased risk of being colonised with Carbapenemase-producing Enterobacteriaceae (CPE) and methicillin-resistant *Staphylococcus aureus* (MRSA). Both are multi-drug-resistant organisms (MDRO) and whilst both can lead to serious infections, CPE is associated with high risk of death and illness. Early screening allows for to be pre-emptively managed with the appropriate infection prevention and control precautions while microbiology specimen testing results are awaited. MDRO is core submissible measure for EiC programme. However, it should be noted that this measure has been reviewed and awaiting national ratification.

Chart 20 MDRO Compliance Data University Hospital Ayr



Demonstrates a median of 85% compliance with breakdown of data indicating low compliance of sample being sent following admission screening, being the influencing factor.

Chart 21 MDRO Compliance Data University Hospital Crosshouse

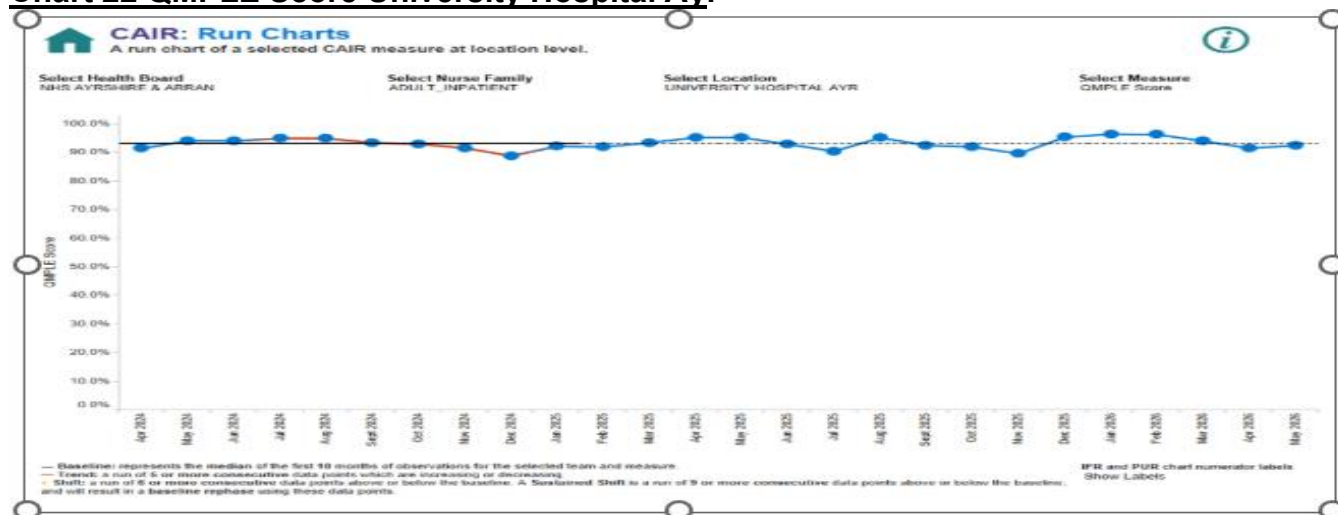


Demonstrates a median of 83% compliance with breakdown of data indicating low compliance of screening within 24 hours of admission being the influencing factor.

7.2 Quality Management Practice Learning Environment

Assurance of pre-registration Nursing and Midwifery practice learning experience is obtained via the Quality Management Practice Learning Environment (QMPLE) platform. Within Acute Services, QMPLE data is also used alongside Practice Learning Environment audits and other Excellence in Care measures to support review, scrutiny and assurance of practice learning environments, helping to identify risks, inform improvement activity and demonstrate the quality of educational experiences provided to students. Both UHA and UHC have demonstrated a shift above the baseline of 90%, highlighting the positive learning experience by pre-registration nursing students. However, it should be noted that percentage of feedback submitted by students continues to be below 50%. Ongoing activity, in collaboration with Practice Education Facilitators and University of West of Scotland, is targeting promotion of completion of QMPLE feedback to support learning.

Chart 22 QMPLE Score University Hospital Ayr

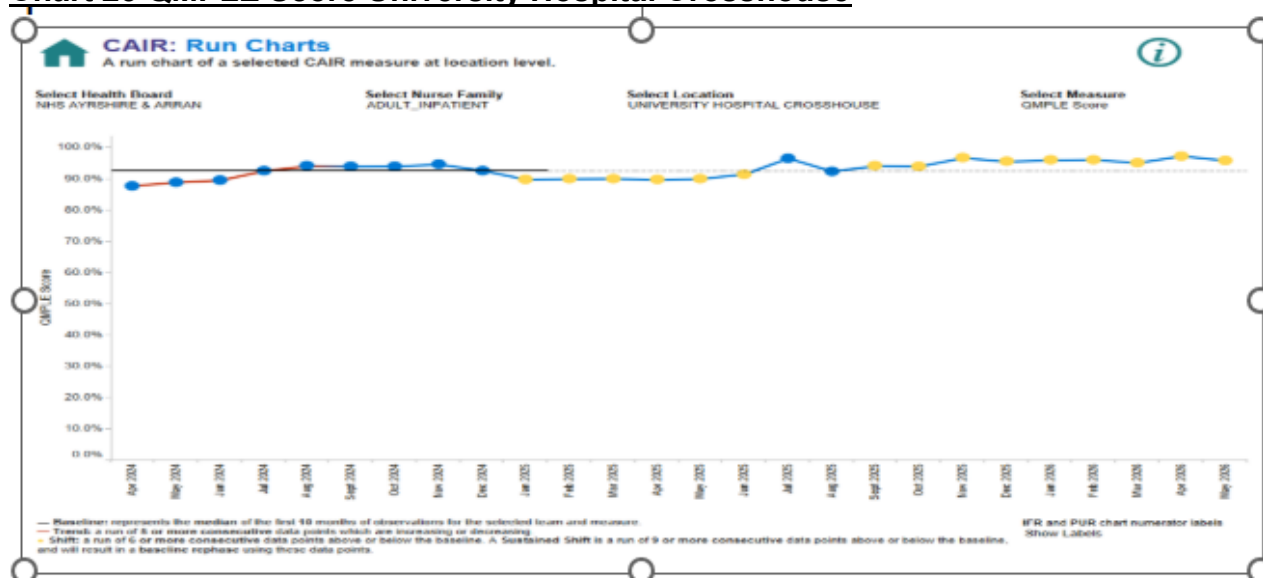


QMPLE Score: 92.4%

Numerator: The sum of all response scores for questions in all four sections of the QMPLE questionnaire returned by students in the previous 3 month period

Denominator: The sum of all maximum possible scores for questions in all four sections of the QMPLE questionnaire returned by students in the previous 3 month period

Chart 23 QMPLE Score University Hospital Crosshouse



QMPLE Score: 95.7%

Numerator: The sum of all response scores for questions in all four sections of the QMPLE questionnaire returned by students in the previous 3-month period

Denominator: The sum of all maximum possible scores for questions in all four sections of the QMPLE questionnaire returned by students in the previous 3 month period

8. Feedback and Complaints

Complaints Improvement Sprint Phase 1

As of 12 May 2026, NHSAA had a total of 272 open complaints of which 262 were out of time. Within Acute Services there were 182 open acute complaints, including 172 that were out of time. This reflected significant pressures within the complaints management system. The largest backlogs were within Surgical, Emergency Care and Trauma, and Medical Services, with many complaints delayed at investigation, drafting and approval stages.

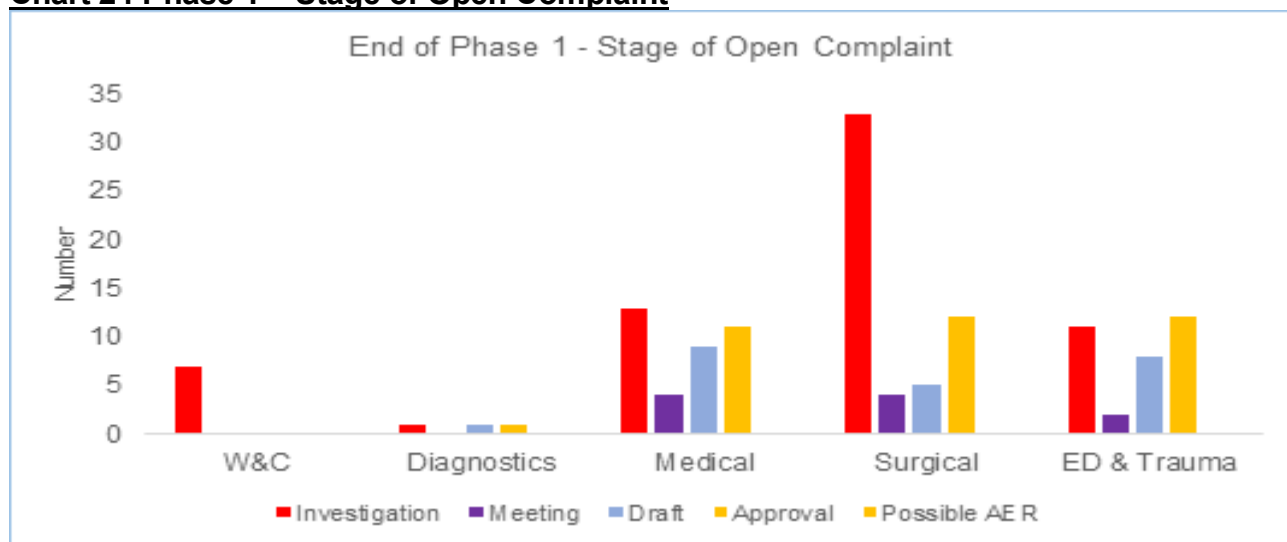
To address this, a focused Complaints Improvement Sprint was launched, supported by additional temporary resource and enhanced governance arrangements, including monthly oversight meetings chaired by the Executive Medical Director and Executive Nurse Director. Phase 1 commenced on 25 May 2026 with the aim of reducing the complaints backlog and improving complaint flow. The initial targets were to:

- Close 129 complaints that were at draft or approval stage; and
- Progress 64 older complaints from investigation into the drafting stage by mid-June 2026.

The sprint exceeded both objectives. By 16 June 2026, 130 complaints in total had been closed and 80 complaints had progressed from investigation into drafting, demonstrating a significant improvement in complaint throughput and backlog reduction.

By the end of phase 1 there remained 134 open complaints within acute services, 101 of which were out of time. The majority of these remained predominantly at the investigation stage, with surgical accounting for the largest proportion. Progress was evident with complaints moving through draft and approval stages, several cases have been identified as potential Adverse Event Reviews (AERs).

Chart 24 Phase 1 – Stage of Open Complaint



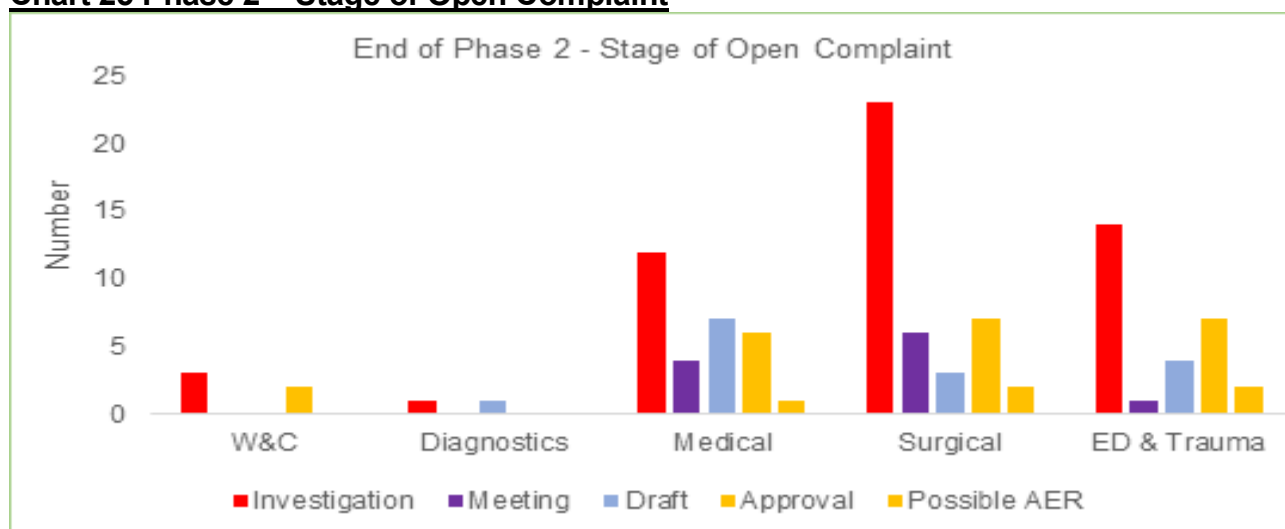
Complaints Improvement Sprint Phase 2

Phase 2 commenced on 22 June 2026, at that time Acute Services had 134 acute complaints, including 101 that were out of time. Phase 2 Sprint overall aims were to:

- Close 116 complaints at drafting or approval stage
- Progress 42 complaints from investigation to drafting stage

Phase 2 of the Complaints Sprint ran for an additional 4 weeks concluding on 17th July. 120 complaints in total have been closed and 43 complaints had progressed from investigation, surpassing both targets and contributing to a significant reduction in the overall complaints backlog. Within Acute services the most significant reduction was seen within Surgical, where investigation-stage complaints fell from 33 to 23. Medical also showed reductions across investigation, draft and approval stages. Investigation-stage complaints remain the largest proportion of the open complaints workload.

Chart 25 Phase 2 – Stage of Open Complaint



At the end of phase 2 there remained 106 open complaints within acute services, of which 66 are out of time.

Next Steps

Phase 3 of the Complaints Improvement Sprint will commence on 27 July 2026 and run for a further four weeks. The focus of the next phase will be on reducing the remaining backlog, progressing investigations to completion and embedding sustainable processes to support long-term improvement in complaints management and performance. Additional resource will continue, with the proposal that staff allocate 40% of their time to complaint improvement activity and 60% to their substantive roles.

9. Significant Adverse Events

Significant Adverse Events within Acute Services is shown in table 2 (Local Management Team Reviews) and table 3 (Significant Adverse Event Reviews)

Table 2 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	3	0	77
19/20	68	0	0	16	0	52
20/21	50	0	0	17	0	33
21/22	183	2	0	56	3	122
22/23	112	3	0	42	2	65
23/24	129	7	0	58	7	57
24/25	88	10	0	37	13	28
25/26	112	47	0	21	30	14
26/27	21	13	6	0	1	1
Total	843	82	6	250	56	449

* On Target - within timescales as defined by HIS Framework

Table 3 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	2	0	20
21/22	19	0	0	5	0	14
22/23	18	1	0	10	0	7
23/24	29	1	0	15	1	12
24/25	33	8	0	17	2	6
25/26	51	35	5	8	2	1
26/27	16	0	16	0	0	0
Total	224	45	21	57	5	96

* 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/services until completion. The themes identified from SAERs approved in recent months are:

- Recognition and escalation of clinical risk
- Communication, documentation and information systems
- Standardised safe practice and clinical governance
- Environmental and infection prevention safety
- Workforce capability, capacity and team working
- Learning, assurance and continuous improvement