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Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Royal Infirmary of Edinburgh

NHS Lothian

23–24 June 2025

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About our inspection

Background

In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. In response to Healthcare Improvement Scotland's Neonatal Mortality review in 2024, Healthcare Improvement Scotland made a commitment to expanding our safe delivery of care inspection approach to include inpatient maternity services. The methodology was adapted to minimise the impact of our inspections on staff delivering care to women, birthing people and families. Our inspection teams carry out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers.

From April 2023 our inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland [Quality Assurance Framework](#). Further information about the methodology for maternity services safe delivery of care inspections can be found on our [website](#).

Our Focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

Whilst this report uses the term 'women' the inspection team acknowledge the importance of including all people who give birth.

About the hospital we inspected

The Royal Infirmary of Edinburgh is a major acute teaching hospital located on the Edinburgh BioQuarter. With a 24-hour accident and emergency department, it provides a full range of acute medical, surgical and specialist services including maternity services, which supports 5,000 births annually for families from across Lothian.

About this inspection

We carried out an unannounced maternity services inspection to the Royal Infirmary of Edinburgh, NHS Lothian on Monday 23 and Tuesday 24 June 2025 using our safe delivery of care inspection methodology. We inspected the following areas:

- labour ward
- maternity triage
- ward 119 combined antenatal and postnatal care
- ward 211 postnatal care

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with women such as during mealtimes
- spoke with women, visitors and ward staff, and
- accessed womens health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Lothian to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On 22 July 2025, we held a virtual discussion session with key members of NHS Lothian staff to discuss the evidence provided and the findings of the inspection.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Lothian and in particular all staff at the Royal Infirmary of Edinburgh for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection'.

Throughout the inspection we observed staff working hard to provide compassionate and responsive care in very challenging circumstances. The multidisciplinary team within maternity services spoke highly of the clinical working relationship. We observed good teamwork and innovation within the maternity triage department, this

included extended members of the multidisciplinary team including obstetricians, midwives and the healthcare support team.

In some areas staff were complimentary and described their line manager as supportive. However, the majority of the multidisciplinary team we spoke with expressed feeling frustrated at staffing levels which they believe left areas short staffed and staff unsupported. Staff told us this presented a safety risk for women, babies and families within their care which they raised on multiple occasions with managers.

The majority of the staff we spoke with shared their concerns and feelings of being overwhelmed, described feeling unsupported and believed they were not being listened to. Staff informed inspectors this has impacted staff confidence to escalate staffing concerns due to lack of feedback and resolution when concerns are raised.

We observed delays to the induction of labour process of up to 29 hours and other delays to women who required ongoing care within the labour ward due to lack of staff availability, capacity and increased acuity.

Staff we spoke with described suboptimal skill mix, low staffing levels and high acuity resulting in challenges in providing and maintaining one-to-one care for women within the labour ward. Staff also described staffing impacting on timely care such as delays in undertaking maternity early warning score (MEWS) observations or escalation of clinical concerns.

Women told us of mixed experiences within Royal Infirmary of Edinburgh maternity services. In some areas women were highly complimentary of the care they experienced, describing it as exceptional; however, other women described their experience leaving them feeling alone and vulnerable. Whilst some women were complimentary of their care, they also informed inspectors of poor communication, leaving them feeling uninformed and with no 'voice' in their care.

Our inspection has highlighted gaps in incident reporting and what appears to be a reluctance to submit incident reports with staff describing a culture of mistrust. These are concerning issues that may have significant impact on the learning from adverse events within the system, reducing opportunities to improve safety.

During the course of this inspection, Healthcare Improvement Scotland escalated serious concerns with NHS Lothian through the Healthcare Improvement Scotland and Scottish Government Operating Framework. These concerns related to culture, oversight of patient safety and staff wellbeing within Royal Infirmary of Edinburgh maternity services. The findings from our inspection are aligned with Healthcare Improvement Scotland's Responding to Concerns process and outcome.

Other areas for improvement have been identified within maternity services within Royal Infirmary of Edinburgh. These include fire safety requirements, safe storage of cleaning products and required improvements to the environment.

What action we expect the NHS board to take after our inspection

This inspection resulted in five areas of good practice, two recommendations and 26 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on women, birthing people and families using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Lothian to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: <http://www.healthcareimprovementscotland.scot>

Areas of good practice

The unannounced inspection to the Royal Infirmary of Edinburgh resulted in five areas of good practice.

Domain 1

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| 1 | Maternity triage is carried out by a dedicated midwife utilising a standardised telephone triage template and maintaining oversight of women attending the unit through this process (see page 20). |
| 2 | Maternity triage have a system in place to capture women attending the department for care which provides system oversight and situational awareness within the department (see page 20). |
| 3 | NHS Lothian support an equity, diversity and inclusion working group to improve the multiprofessional care, experience and outcomes for women and their babies (see page 20). |

Domain 6

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| 4 | NHS Lothian have an established maternity voices partnership to support the co-production of maternity services (see page 38). |
| 5 | NHS Lothian support parents to stay overnight supporting the family unit (see page 38). |

Recommendations

The unannounced inspection to the Royal Infirmary of Edinburgh resulted in two recommendations.

Domain 1

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| 1 | NHS Lothian should improve bereavement training compliance rates for all staff providing bereavement care to families (see page 20). |
| 2 | NHS Lothian should adopt a process to support staff to identify bereaved families when returning for ongoing care (see page 20). |

Requirements

The unannounced inspection to the Royal Infirmary of Edinburgh resulted in 26 requirements.

Domain 1

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|----------|--|
| 1 | <p>NHS Lothian must ensure effective processes are in place to ensure the safe management and care for women including but not limited to:</p> <ul style="list-style-type: none">(i) when delays to ongoing care occur(ii) women require diverted or redirected to other maternity units for ongoing care (see page 20). <p>This will support compliance with: Health and Social Care Standards (2017) Criteria 1.13, 1.14 and 1.19.</p> |
| 2 | <p>NHS Lothian must ensure that all women have access to a call bell within maternity triage rooms (see page 20).</p> <p>This will support compliance with: Health and Social Care Standards (2017) Criterion 3.17.</p> |
| 3 | <p>NHS Lothian must improve communication with women, this includes but is not limited to when delays to the induction of labour process (see page 21).</p> <p>This will support compliance with: Healthcare Improvement Scotland Quality Assurance Framework (2022) criterion 2.5. and Health and Social Care Standards (2017) Criteria 2.1, 2.3, 2.6 and 2.8.</p> |
| 4 | <p>NHS Lothian must ensure systems and processes are in place to monitor and support a consistent approach to the provision of transitional care within the postnatal ward (see page 21).</p> <p>This will support compliance with: Best start: A five year forward plan for Maternity and Neonatal care in Scotland, Healthcare Improvement Scotland Quality Assurance Framework (2022) Criterion 1.5 and Health and Social Care Standards (2017) Criteria 1.19, 1.20 and 4.11.</p> |

5	NHS Lothian must ensure improvement in ethnicity completeness data for all women and birthing people booking for perinatal care (see page 21). This will support compliance with: Healthcare Improvement Scotland Quality Assurance Framework (2022) Criteria 2.4 and 2.6.
6	NHS Lothian must ensure access to interpretation services for all women and families accessing care (see page 21). This will support compliance with: Health and Social Care Standards (2017) Criteria 2.8, 2.9 and 2.10.

Domain 2

7	NHS Lothian must ensure the development of a positive culture where staff feel safe and supported to highlight risks and concerns in relation to staff and patient safety (see page 26). This will support compliance with: Healthcare Improvement Scotland Quality Assurance Framework (2022) Criterion 2.1.
8	NHS Lothian must take steps to improve wellbeing initiatives available to staff by promoting a workplace environment which offers support to both the mental and physical health of staff (see page 26). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) Criterion 2.1. and Health and Care (Staffing) (Scotland) Act 2019.
9	NHS Lothian must ensure timescales of significant adverse events reviews are achieved, to support and improve the quality and safety of care. This should be aligned with the timeframes suggested in guidance (see page 26). This will support compliance with: Healthcare Improvement Scotland A national framework for reviewing and learning from adverse events in NHS Scotland and Healthcare Improvement Scotland Quality Framework (2018) Criterion 2.5.
10	NHS Lothian must take steps to improve governance and oversight to ensure all adverse events are reliably reported; and improve feedback to staff on incidents raised through the incident reporting system (see page 26). This will support compliance with: Healthcare Improvement Scotland A national framework for reviewing and learning from adverse events in NHS Scotland and Healthcare Improvement Scotland Quality Framework (2018) Criterion 2.5.

Domain 4.1

- 11** NHS Lothian must ensure effective senior management oversight and support, to ensure the fundamentals of care are provided and reduce the risks for women, their babies and staff at times of extreme pressure within maternity services (see page 31).

This will support compliance with: Health and Social Care Standards (2017) criterion 4.23 and Healthcare Improvement Scotland Quality Assurance Framework (2022) criteria 2.3, 2.6 and 5.5.

- 12** NHS Lothian must ensure the development of a culture which promotes and supports staff psychological safety (see page 31).

This will support compliance with: Healthcare Improvement Scotland Quality Assurance Framework (2022) Criteria 2.1.

- 13** NHS Lothian must ensure venous thromboembolism guidance and risk assessments in place are aligned to support staff during the risk assessment of venous thromboembolism (see page 31).

This will support compliance with Quality Assurance Framework (2022) Criteria 2.6.

- 14** NHS Lothian must ensure that all patient documentation is accurately and consistently completed with actions recorded. This includes risk assessments such as the maternity early warning system (MEWS) (see page 31).

This will support compliance with: Social Care Standards (2017) criteria 1.2, 1.3, 2.12, 4.1, 4.11 and 4.14 and Healthcare Improvement Scotland Quality Assurance Framework (2022) and relevant codes of practice of regulated healthcare practice of regulated healthcare professions.

- 15** NHS Lothian must ensure systems and processes are in place to support the choices made by women. This includes but is not limited to women's feeding intention (see page 31).

This will support compliance with: Health and Social Care Standards (2017) criteria 1.19, 1.20, 2.1, 2.2 3.15 and 3.17.

- 16** NHS Lothian must ensure the healthcare-built environment is effectively maintained to allow decontamination and ensure potential risks to patients and staff safety are effectively identified and mitigated (see page 31).

This will support compliance with: National Infection Prevention and Control Standards (2022) and Infection Prevention and Control Standards.

17	NHS Lothian must ensure the appropriate management and monitoring is in place to ensure the safe storage of medicines (see page 31). This will support with compliance with Royal Pharmaceutical Society on the Administration and storage of Medicines in Healthcare Settings (2019) and Nursing and Midwifery Council (NMC) The code (2018).
18	NHS Lothian must ensure compliance with SICPS this includes but is not limited to: a. hand hygiene b. linen management c. sharps management (see page 32). This will support compliance with National Infection Prevention and Control Standards (2022).
19	NHS Lothian must ensure all fire actions and improvements identified within fire safety risk assessments are addressed (see page 32). This will support compliance with: Fire Safety (Scotland) Regulations (2006).

Domain 4.3

20	NHS Lothian must ensure that clear and robust systems and processes are in place, including guidance and support for staff, to allow consistent assessment and capture of real-time staffing risk across all professional clinical groups. Assessments should consider skill mix of available staff, dependency and complexity of patients to support staff to confidently apply and record professional judgement in relation to required staffing when declaring “safe to start.” (see page 36). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
21	NHS Lothian must ensure that maternity and obstetric services are appropriately and effectively staffed in order to reduce delays to care, preserve patient safety and support staff wellbeing (see page 36). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
22	NHS Lothian must ensure the necessary governance, leadership and oversight is in place to ensure international midwifery and medical graduates are supported to achieve the necessary competencies to assure the safe delivery of care. (see page 36). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Health and Social Care Standards (2017) criteria 3.14, and 3.19.

23	NHS Lothian must ensure that there are clear, consistent systems and processes in place to support management of any identified staffing risks within maternity services. This includes accurate recording of any escalation, mitigation/inability to mitigate, communication of outcomes with all relevant clinical teams and any disagreements with decisions made (see page 36). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
24	NHS Lothian must ensure a supportive and inclusive working environment for staff which supports staff to raise concern with systems and processes in place to ensure that these concerns are responded to and appropriately addressed (see page 36). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019, guiding principles 12IA.
25	NHS Lothian must have robust systems and processes in place to ensure that all staff are appropriately trained to carry out their role. This includes protected learning time, monitoring of training completion and consideration of skills and experience when redeploying staff (see page 36). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Health and Social Care Standards (2017) criteria 3.14, 3.15 and 3.19.
26	NHS Lothian must ensure that there are systems and processes in place to safeguard all clinical leaders within maternity services being able to access appropriate protected leadership time in order to fulfil their leadership and management responsibilities such as oversight of quality of care and provision of support for staff. This will include consistent monitoring and recording of when and why this is sacrificed as part mitigation for staffing shortfalls and/or increased service demand (see page 36). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Health and Social Care Standards (2017) criteria 3.14, 3.15 and 3.19.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We observed good teamwork and innovation within the maternity triage department. This included extended members of the multidisciplinary team including obstetricians, midwives and the healthcare support team. However, we observed delays to the induction of labour process and other delays to women who

required ongoing care within the labour ward due to staff availability and increased acuity.

The vision for maternity services in Scotland was set out in 2017 by Scottish Government within The Best Start: A five-year forward plan for maternity and neonatal care in Scotland. Further information can be read [here](#).

At the time of inspection maternity services within Royal Infirmary of Edinburgh were experiencing pressures, like many of NHS Scotland services, such as reduced staff availability and increased patient acuity.

Maternity triage is a specialised assessment area which provides 24 hours a day, seven days a week unscheduled (emergency) care to women during pregnancy and within the postnatal period. Maternity triage within Royal Infirmary of Edinburgh provides care to pregnant women from 12 weeks of pregnancy until birth and from birth to six weeks postnatal. The department has access to 10 beds with six single rooms available for review of any attendees.

Obstetric emergencies and concerns over the wellbeing of the unborn baby are time sensitive, requiring a systematic approach which identifies women of the highest clinical priority to improve outcomes. There is currently no national standardisation of maternity triage system available. However, the Royal College of Obstetricians and Gynaecologists good practice paper on maternity triage, and the National Institute for Health and Care guidance recommend each board develops their own guidance based on an evaluated system. Further information can be found [here](#). The Birmingham Symptom Specific Obstetric Triage System (BSOTS) is an evaluated system that assesses and prioritises pregnant and recently postnatal women with unexpected problems or concerns. The aim of the system is to improve safety, efficiency and communication. Maternity triage within Royal Infirmary of Edinburgh adopted Birmingham Symptom Specific Obstetric Triage System in August 2021.

Maternity triage within Royal Infirmary of Edinburgh is accessed following a telephone assessment carried out by midwives, allowing maternity staff oversight of women attending the service. Best practice described by the Royal College of Obstetricians and Gynaecologists recommends telephone triage is undertaken by a midwife dedicated to and experienced in triaging calls for all or part of their shift. During inspection inspectors observed telephone triage being undertaken by an allocated midwife within a private area utilising a standardised telephone triage template. Outcomes of telephone triage can include signposting of women to other available care such as their community midwife, general practitioner, telephone advice or admission to the maternity unit for review. The Royal College of Obstetricians and Gynaecologists recommends recording details of all women who have been asked to attend maternity triage departments and that the urgency and timeframe for attendance is explained to the woman during the telephone triage. During inspection when women were asked to attend the triage department, inspectors observed an

area for staff to document expected attendees. This enabled staff to maintain oversight of the women expected to attend the department and allowing welfare checks to be undertaken where necessary.

The triage service is located on the ground floor of the Simpsons Centre for Reproductive Health and during inspection we observed good use of signage to direct the public and staff to the area. On admission to a maternity triage unit best practice guidance from the Royal College of Obstetricians and Gynaecologists recommends a prompt and brief assessment is carried out to assess the clinical urgency by which women should be reviewed. Inspectors observed the use of a “triage board” which captured women attending the department for care and was observed in use providing system oversight and situational awareness for midwifery, obstetric and clinical support staff. This included location of women, time of arrival, time of initial triage, outcome of initial assessment and an ongoing care summary.

Within maternity triage there is a requirement for all staff working in the department to be trained within the use of the triage system. There is a desire within the midwifery team to complete this training although staff described limitations to this such as current staffing issues preventing attendance at training and substantive members of the triage team being prioritized for the training. However, at times of staffing pressures staff are sent to work within the area regardless of training, which staff describe as challenging. Senior managers informed us where staff have not completed training, they will only be redeployed on a temporary basis to provide ongoing midwifery care and will not be involved in the initial triage of women.

At the time of inspection, we observed the time from admission to initial triage assessment varied between five to 15 minutes. During periods of high acuity, we observed systems and teamwork utilised to ensure all women admitted met the recommended good practice of initial triage within 15 minutes of arriving in the department. On inspection we observed a quality improvement board displayed within the department which detailed compliance with triage within 15 minutes of arrival in the department as occurring for 84% of women over the last four weeks. However, feedback from both staff and women experiencing care within the department described a delay when obstetric review was required. The department currently has dedicated medical staff between the hours of 10:30 and 18:00. Out with these hours, obstetric review is provided by the obstetric registrar covering labour ward and staff discussed how the competing demands for the obstetric registrar could result in long waits for obstetric review within the triage department. Feedback from women during inspection described delays of between seven and 15 hours for obstetric review within the triage department following initial triage assessment.

We asked NHS Lothian to provide us with any incident reports submitted by staff for the six months prior to this inspection in relation to patient safety. From incident reports submitted from maternity triage we note some staff have completed incident reports when delay in first triage, delay in medical review and delay in transfer to

labour ward occur. This is to allow oversight and improvement work to be undertaken. Review of the incident reports highlights that delays to care was within the top five reasons for staff to submit a patient incident form. Within data submitted we observed from November 2024 to May 2025 that delays to care occurred for the majority of women attending maternity triage within Royal Infirmary of Edinburgh. During discussions with senior managers, they told us that the unit coordinator has oversight of these delays, to maintain situational awareness and escalation at staffing and safety huddles for senior managers. A requirement has been given to support improvement in this area.

Staff informed inspectors in an aim to maintain situational awareness and support staff during periods of high capacity and acuity, the team had introduced safety huddles within the department every two hours, which involved the multidisciplinary team including the maternity unit coordinator.

At the time of inspection, the neonatal unit was closed to further admissions due to capacity within the department. When this happens, transfer of women may be required to another maternity unit to ensure the safe delivery of care to both women and unborn babies. We observed areas of good practice where the multidisciplinary team requested oversight and discussion of any women attending triage with suspected preterm labour in an aim to maintain situational awareness and to plan for transfer of care where required. We observed initial triage of women who were attending the maternity triage department for suspected preterm labour occurring within 15 minutes however, senior obstetric review had not been undertaken despite some women being in the department for up to six hours.

On discussion with staff, they described the process of diverting women to other maternity units as very stressful and at times a challenging process. Staff described an escalation pathway which involves the maternity unit coordinator for oversight to highlight women who may require diversion to another unit. We observed discussion and oversight of the care of these women at safety huddles during inspection. However, at the time of inspection NHS Lothian did not have a divert policy in place. Lack of an approved process to support staff decision making when assessing the suitability of women for transfer to another maternity unit may result in an inconsistent approach which could result in adverse outcomes for both women and their babies. Senior managers told us work is underway to produce guidance to support staff to maintain the safe delivery of care for women requiring transfer to another maternity unit. A requirement has been given to support improvement in this area.

The nurse call system should be available within all bed spaces to allow occupants the opportunity to request support or call for help when required. During inspection it was observed that five single rooms within maternity triage had no call bell system available, however an emergency call system was in place for staff to summon assistance during an emergency. These rooms are utilised to undertake clinical

assessment and whilst most women are ambulant and self-caring, there are times during clinical assessments, such as during fetal monitoring or ill health, which may reduce the opportunity to summon assistance independently. During inspection some women described being left alone in a triage room for long periods of time following their initial assessment and they were unable to call for help due to the lack of call bells available. One woman described being in pain with no call system available which resulted in her not being able to request analgesia. Another woman described her experience as isolating as she was in the department on her own with no way to access help if required.

Due to the potential impact on the safe delivery of care, we asked NHS Lothian for any risk assessments undertaken in this area however, at the time of inspection no risk assessment had been completed. Senior managers responded promptly by providing evidence of a risk assessment carried out following onsite inspection. The risk assessment detailed mitigations being put in place to limit risk such as regular staff walk arounds of the rooms and advising the person accompanying women to call for assistance when required. However, although this may mitigate some risk, at times of high acuity or limited staffing, the impact on the safe delivery of care remains. A requirement has previously been given to NHS Lothian within safe delivery of care inspections regarding the availability of nurse call bells within the emergency department of Royal Infirmary of Edinburgh. A requirement has been given to support improvement in this area.

The labour ward within Royal Infirmary of Edinburgh is situated on the first floor and is signposted from the main hospital entrances and through the entrance at Simpson Centre for Reproductive Health. There are 13 birth rooms and a three bedded high dependency area with two labour ward recovery beds and two theatre beds available within the ward. During inspection the ward was calm with good visibility of staff and clinical leadership, however, at the time of inspection, we observed delays to the induction of labour process of up to 29 hours.

Induction of labour is a practice that is undertaken to artificially induce labour; this can be in response to concerns with the mothers or unborn baby's health. Delays to the induction of labour process are associated with increased risk of adverse maternal and perinatal outcomes. NHS Lothian offer an induction of labour leaflet and video which informs women that delays to the procedure may occur and the process for women to follow if they have any concerns. We observed delays to induction being escalated by senior charge midwives at the service and site safety huddle for senior management oversight. NHS Lothian have an established induction of labour safety tool in place to risk assess and escalate delays to senior hospital managers. We observed mitigations to reduce the risks associated with an extended delay including assessment of maternal and fetal wellbeing with a full antenatal assessment of women, and electronic fetal monitoring (cardiotocography) for the unborn baby. However, staff training compliance with cardiotocography training may reduce the reliability of this mitigation. Review of cardiotocography training demonstrated compliance rates of

38.5% for consultant obstetricians, 33.3% for obstetric trainees and 16.8% compliance rate for midwives for the one year training element. Compliance for fetal monitoring training for the two-year element demonstrated 46.2% for consultant obstetricians, 63% for obstetric trainees and 51.6% for midwives.

Within information requested as part of the inspection, we observed delays to care, such as delays to the induction of labour, resulting in women being transferred between Royal Infirmary of Edinburgh and St John's Hospital. This occurred in times of high capacity and reduced staffing and was described as being offered to women attending for a planned caesarean section, induction of labour and women presenting in spontaneous labour within the triage department. We requested guidance and risk assessments which support staff to ensure the safe delivery of care is achieved for these women and their unborn babies and any information given to women when this may occur. However, in addition to the absence of any divert policy or guidance we were informed there were no risk assessments carried out or in place to support redirection for care between Royal Infirmary of Edinburgh and St John's Hospital. Oversight of redirection of care is currently being monitored through audit work to understand the reasons for the redirection of women. We observed the induction of labour leaflet highlights redirection of care may be offered to women during the process. In review of incident reports, no adverse events highlighted redirection of care resulting in an adverse event. A requirement has been given to support improvement in this area.

Women we spoke with undergoing the induction of labour process described a lack of communication resulted in them feeling they did not know what was happening with their ongoing care. We discussed this with senior managers who told us of an induction of labour coordinator role, which was recently introduced in July 2025. This is being trialled in an aim to improve oversight, patient experience and patient safety.

Senior managers explained in the event of delays in admission to the labour ward, women were either admitted to the antenatal ward for continued monitoring and care oversight or remained within the triage department until care could be transferred. However, women we spoke with told us delays were poorly communicated resulting in them feeling anxious. From evidence received, we observed the number one reason for complaints within Royal Infirmary of Edinburgh maternity service were attributed to lack of communication and extended waiting times. A requirement has been given to support improvement in this area.

Antenatal and postnatal care provision within Royal Infirmary of Edinburgh is based over two wards. During inspection we did not have the opportunity to observe the provision of transitional care within the postnatal area. Transitional care units offer additional support to babies above normal neonatal care with the aim to prevent separation of mum and baby and unnecessary admissions to the neonatal unit. The vision for maternity services across Scotland set within The Best Start: A five-year forward plan for maternity and neonatal care in Scotland, is one in which parents and

babies are offered truly family centred and compassionate care. We raised this with senior managers who provided information on neonatal transitional care within the postnatal ward which was introduced in January 2018 and supports babies born above 35 weeks gestation with a birth weight over 1.8 kg to remain within the postnatal ward with oversight from the neonatal unit. However, senior managers reported, at times, it can be challenging to secure necessary support from medical staff for transitional care babies on the postnatal ward, as their workload may limit availability. A requirement has been given to support improvement in this area.

The National Bereavement Care Pathway Scotland is a project funded and developed by Scottish Government in partnership with Sands, the stillbirth and neonatal death charity, with the aim of standardising and improving the quality of bereavement care for the families of Scotland. Further information can be found [here](#). During our inspection we observed a dedicated family room for bereaved families within the antenatal ward. NHS Lothian have an assigned bereavement lead who also undertakes the role of the perinatal mental health lead. NHS Lothian have carried out a self-assessment on their alignment with the nine bereavement care pathway standards; from this assessment NHS Lothian report they are achieving seven of the nine standards recommended. Evidence supplied by the board highlighted bereavement training opportunities for staff at both local and national level. However, staff compliance rates supplied demonstrated only 9% of midwives and 6% of obstetricians have completed bereavement training. NHS Lothian have attributed this to current staffing resource and have a recommendation within their self-assessment plan to attempt to improve compliance. Staff bereavement training is a recognised standard recommended by the National Bereavement Care Pathway. A recommendation has been given to support improvement in this area.

Staff we spoke with told us there was no system in place to support staff to identify and signpost families returning to the maternity service for care following a bereavement, resulting in difficult and upsetting conversations. We observed evidence of staff reporting this through incident reports received as part of the inspection. We raised this with senior managers who informed us of the current process to highlight bereaved families to professionals in the antenatal and inpatient setting. A recommendation has been given to support improvement in this area.

The impact of inequalities within maternity services has been highlighted through national reports such as saving mother's lives, improving care ([MBRRACE-UK 2024](#)). All women and their families deserve safe, kind and accessible care throughout their pregnancy journey. NHS Lothian support an equity, diversity and inclusion working group to improve the multiprofessional care, experience and outcomes for women and their babies. Within evidence we observed the group facilitates collaboration of professionals, service users and members of relevant charities such as [KWISA](#). We observed recent collaboration has resulted in the publication of the [Nothing About Us Without Us Report 2024](#), an "initiative which aims to end inequalities in maternal health outcomes and experience for ethnic minority women of African Caribbean

heritage living in Scotland”. Within evidence provided we observed several incident reports highlighted barriers to communication due to the lack of available access of interpreters for women where English was not their first language. A requirement has been given to support improvement in this area.

Ethnicity data is vital information in pregnancy as it helps to identify and address inequalities in maternal and perinatal adverse outcomes. Ethnicity data reviewed through NHS Lothians latest perinatal mortality review report demonstrated compliance of 85.2% data completeness in relation to maternal ethnicity with the national average for completeness at 97% within the report. Senior managers described challenges within the electronic patient record impacting data completeness and explained NHS Lothian’s information technology team are working to address and improve ethnicity data collection. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 1	
1	Maternity triage is carried out by a dedicated midwife utilising a standardised telephone triage template and maintaining oversight of women attending the unit through this process.
2	Maternity triage have a system in place to capture women attending the department for care which provides system oversight and situational awareness within the department.
3	NHS Lothian support an equity, diversity and inclusion working group to improve the multiprofessional care, experience and outcomes for women and their babies.

Recommendations

Domain 1	
1	NHS Lothian should improve bereavement training compliance rates for all staff providing bereavement care to families.
2	NHS Lothian should adopt a process to support staff to identify bereaved families when returning for ongoing care.

Requirements

Domain 1	
1	NHS Lothian must ensure effective processes are in place to ensure the safe management and care for women including but not limited to: (i) when delays to ongoing care occur (ii) women require diverted or redirected to other maternity units for ongoing care.
2	NHS Lothian must ensure that all women have access to a call bell within maternity triage rooms.

3	NHS Lothian must improve communication with women, this includes but is not limited to when delays to the induction of labour process.
4	NHS Lothian must ensure systems and processes are in place to monitor and support a consistent approach to the provision of transitional care within the postnatal ward.
5	NHS Lothian must ensure improvement in ethnicity completeness data for all women and birthing people booking for perinatal care.
6	NHS Lothian must ensure access to interpretation services for all women and families accessing care.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

During inspection we observed positive working relationships within the clinical teams however, many staff described challenges in the wider team dynamics. The majority of staff we spoke with described a negative culture, with lack of visible senior management, and expressed concern regarding patient and staff safety within maternity services.

Psychological safety and organisational culture have been highlighted as a key factor impacting the safe delivery of care within maternity services and have been evidenced through recent national reports into reviews of maternity care including Kirkup ([2015](#)) and Ockenden ([2022](#)). Psychological safety is the ability of all staff groups to feel free to speak up, ask questions, report errors, raise concerns and ask for feedback without fear of the consequences and being judged.

Within maternity triage we observed a positive culture where staff told us they have observed improvements regarding leadership, culture and improved oversight within the department with escalation pathways available and activated as required. To support the safe delivery of care within maternity services, full system working and oversight is essential. We did observe positive working relationships within the clinical teams however, many staff described challenges in the wider team dynamics. This included different teams and wards operating independently with limited communication and collaboration, with staff describing a lack of mutual respect between teams. We highlighted this in feedback to senior managers during inspection who acknowledged our findings were also raised through a recent culture survey undertaken within the service. In review of incident reports, we observed delays and errors in care delivery because of poor communication between different care areas resulting in omissions of care such as missed medication and care observations.

Many staff we spoke with were very emotional and tearful and described being constantly understaffed and feeling undervalued. Staff highlighted a disconnect and lack of trust between maternity staff and the senior leadership team but reported positive working relationships between midwifery, obstetric and anaesthetic

colleagues. Many midwives we spoke with described a punitive culture where they experienced a lack of professionalism by some members of the senior midwifery leadership team. When errors did occur, many midwives described a culture where mistakes were met with criticism rather than constructive feedback or support which they believed contributed to a poor culture within the service. Staff also described a lack of response from senior managers when escalation of staffing and patient safety concerns occurred.

Newly qualified midwives reported little to no support within their preceptorship depending on the department they work in. Staff we spoke with told us that the new cohort of newly qualified midwives received two weeks supernumerary shifts (up to six clinical shifts) and once they completed this supernumerary period, they would then be expected to provide supervision and preceptorship to other newly qualified midwives during their supernumerary period. Staff told us they felt they did not have the necessary experience to provide this level of supervision so soon after completing their own supernumerary period. In discussion with senior managers, they informed us of the use of a preceptorship programme to support newly qualified midwives. The programme includes a named preceptor and the use of a “clinical skills passport” which encourages individual learning and progress. In the current cohort of 57 newly qualified midwives employed from 2023 to 2024, a compliance rate of 87% attendance rate at the prescribed study days was demonstrated.

Some student midwives we spoke with expressed concerns about a lack of adequate support during their training, particularly in clinical placements, describing little or no support. They reported feeling isolated and at times under prepared, often having to make decisions they felt they did not yet have the experience to make about women and babies due to limited supervision and available support from qualified staff. They spoke about the practice of “see one, do one” and described feeling pressure to ‘just get on with it’. In the review of incident reports, we observed evidence of medication errors occurring involving student midwives where skill mix and acuity in the ward or care areas were described as being suboptimal at the time of the incident.

In contrast, foundation year doctors we spoke with described being supported in their role and whilst they acknowledged short staffing impacted delivery of care such as delays to medical reviews, they advised they could escalate concerns with confidence, however, described their seniors as being under a great deal of pressure due to staffing shortages. We raised serious concerns regarding culture within Royal Infirmary of Edinburgh maternity services with NHS Lothian Executive team.

Following concerns regarding the safe delivery of care raised through multiple sources including a whistleblowing investigation, NHS Lothian told us that they commissioned an external cultural review as part of a focused improvement plan. The improvement plan launched in September 2024 focusing on culture, leadership and managerial governance. The culture survey report was produced in April 2025. Many of the cultural concerns identified within the report were evident at the time of the onsite

inspection. An example of this is the fractured team working observed whilst onsite and within incident reports which the culture report describes as “pockets of good teamwork” and “fragmented working”.

We were provided with information regarding work being undertaken around improving culture within the maternity services. This included staff engagement sessions described as “townhall events” in an aim to begin the journey to improve culture. We observed the planned introduction of culture ambassadors who are employees and managers trained to promote culture initiatives and improvement. Senior managers provided information aimed to improve leadership and engagement and create a culture of psychological safety over the next year. This included the creation of a new culture charter which will be co-created by senior managers and clinical staff.

Whilst we acknowledge a change in culture will take significant time before a true improvement is felt by staff, engagement of staff and visibility and commitment of senior leaders is essential to support meaningful improvement. A requirement has been given to support improvement in this area.

Staff we spoke with were aware of aspects of the culture and quality improvement actions being undertaken within the service. However, many described not being included in the improvement journey therefore reporting little hope for true improvement. Staff described an overwhelming feeling of helplessness, frustration and worry for not only patient, but staff safety. In discussion with senior managers, we were advised of the use of a wellbeing facilitator within women’s services. The wellbeing facilitator champions access to health and wellbeing tools such as yoga, hydration advice and menopause management and has an option for online access to staff. However, during inspection, staff were unaware of any initiatives to support their wellbeing and unable to describe how they would access wellbeing support with some staff believing it would be seen as them ‘being difficult’ if they were to ask. Following review of evidence and discussion with senior managers, we are not assured the NHS Lothian staff health and wellbeing measures in place are sufficient to support individual staff and ensure that their concerns are able to be raised, responded to and appropriately addressed. A requirement has been given to support improvement in this area.

Senior midwifery and senior obstetric leadership are fundamental to the delivery of safe care. During the onsite inspection senior managers informed us of current changes within the senior midwifery team. This can impact on effective leadership and oversight of service delivery and support for staff. Staff described recent changes to management structures has reduced the availability of senior staff, resulting in staff describing being unaware of their line for escalation when concerns arise. At the time of onsite inspection we raised this with senior managers and during our virtual discussion we were informed of a senior interim midwifery manager role put in place following inspection to provide continuity and guidance to staff. Within evidence we

observed a staff bulletin utilised to inform staff of changes to the management structure. The obstetric team advised us there was no current vacancies within their senior management team at the time of inspection.

The national perinatal mortality review tool is a national tool designed to standardise review and learning following the death of a baby. NHS Lothian utilise the tool for review of all stillbirths and neonatal deaths. NHS Lothian engage families in the significant adverse events and perinatal mortality review process by assigning a key contact to the family. Where appropriate, this role is undertaken by the community midwife known to the family to ensure the families experience forms part of the review process and learning. However, in evidence we observed there are often delays in reviews when adverse events occurred. An example of this was observed within the perinatal mortality reviews where the reviews of the death of a baby were delayed by up to one year. This delay can impact significantly on the mental health and grieving journey of the family involved and delays systematic learning and improvement within the service. Current guidance within Healthcare Improvement Scotland is that significant adverse event reviews should be complete within 140 working days. Senior managers acknowledged the current delays with significant adverse event reviews and described immediate actions which includes a rapid review of any significant adverse events. This ensures any immediate patient safety concerns are identified and mitigations can be put in place. NHS Lothian maintain communication with families affected by adverse events using “keeping in touch letters” which they described were sent to families impacted by adverse events every three months until the review is completed. A requirement has been given to support improvement in this area.

The consistent reporting and learning from adverse events are essential in assuring systematic learning, quality improvement and patient safety within a service. The learning from adverse events national framework highlights all adverse incidents should be reviewed. The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. Staff we spoke with described perceived barriers to submitting incident reports when patient safety incidents or adverse events occurred such as systems pressures including lack of staffing and punitive culture within the service. Staff also described a lack of feedback and support following adverse events. Due to a lack of positive change or learning when things go wrong, there is a loss of trust among staff, resulting in a reluctance to submit incident reports.

Within the incident reports reviewed, we observed an inconsistency between available national data which did not correlate with incident reports submitted by staff. An example of this is NHS Lothian’s instance of obstetric anal sphincter injury which has been above national average since September 2024. Obstetric anal sphincter injury can significantly impact a woman’s physical and emotional wellbeing and can lead to long term complications such as faecal incontinence, pain and psychological distress.

In response to this NHS Lothian introduced a care bundle of interventions in an aim to improve outcomes related to obstetric anal sphincter injury which demonstrated improvement, however incidents of the injury sustained within NHS Lothian remains above national average. From incident reports submitted we observed obstetric anal sphincter injury reports submitted are significantly lower than expected in comparison to national data available which is supplied by NHS Lothian. This would suggest that not all instances of this injury are being reported within the incident reporting system to support senior managers oversight, local learning and improvements in patient safety.

We discussed this with senior managers who told us they were aware of staff perception that they required permission to submit incident reports when adverse events occurred. To support improvement, senior managers described actions underway to improve this such as staff engagement sessions with senior leaders to promote a standardised approach to the submission of incident reports when adverse events occurred.

We were also provided with copies of staff newsletters to support staff learning. This included written information on when and how to submit incident forms following an adverse event, topics to “demystify adverse events reviews” and sharing learning from adverse event reviews including “focus of the month”. The newsletter also included dates of up-and-coming care review meetings encouraging staff to attend and participate in local reviews of care following an adverse event. NHS Lothian have an incident trigger list of adverse events which require staff to submit an incident report. However, from this trigger list we also observed further missed opportunities for oversight and improvement. An example of this can be observed in the reporting and oversight of post-partum haemorrhage within NHS Lothian. Major obstetric haemorrhage is a critical condition defined as significant blood loss in the antenatal, intrapartum and postnatal period and is generally defined as blood loss exceeding 1.5 litres. However, NHS Lothian trigger list requests an incident form is completed when major obstetric haemorrhage exceeds 2.5 litres which impacts on the potential learning and improvement which may be achieved prior to severe major obstetric haemorrhage occurring. The Scottish Patient Safety Programme (SPSP) Perinatal Programme recommend oversight of all postpartum haemorrhage which occurs from 1.5 litres and above in an aim to reduce morbidity and mortality related to maternal haemorrhage following childbirth.

We also observed submission of retrospective incident reports following a number of stillbirths of babies occurring up to 11 days after death was diagnosed. Our inspection has highlighted gaps in incident reporting with staff describing a reluctance to submit incident reports due to perceived repercussions and a culture of mistrust. These are concerning issues that may have significant impact on the learning from adverse events within the system, reducing opportunities to improve safety. NHS Lothian have previously received a requirement relating to incident reporting in the Royal Infirmary

of Edinburgh Acute inspection report 2023. A requirement has been given to support improvement in this area.

Requirements

Domain 2	
7	NHS Lothian must ensure the development of a positive culture where staff feel safe and supported to highlight risks and concerns in relation to staff and patient safety.
8	NHS Lothian must take steps to improve wellbeing initiatives available to staff by promoting a workplace environment which offers support to both the mental and physical health of staff.
9	NHS Lothian must ensure timescales of significant adverse events reviews are achieved, to support and improve the quality and safety of care. This should be aligned with the timeframes suggested in guidance
10	NHS Lothian must take steps to improve governance and oversight to ensure all adverse events are reliably reported; and improve feedback to staff on incidents raised through the incident reporting system.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

All areas inspected were calm and well organised with staff working hard to support the safe delivery of care. However, staff raised concerns in relation to delays in escalation of clinical concern due to the lack of available staff and skill mix.

Quality improvement aims to make a difference to women by improving safety, effectiveness and experience of care. We asked for evidence of data oversight and quality improvement initiatives to improve patient safety and experiences within the maternity services. In discussion with inspectors some staff described being aware of ongoing quality improvement projects within maternity services however, many staff described poor communication with the teams leading these initiatives with regard to the aims and goals of the improvement work. We highlighted this to senior managers who described a variety of methods they had utilised to communicate the current improvement work being undertaken to staff. This includes quality improvement huddles, emails to staff and newsletters highlighting improvement work in progress.

The Scottish maternity early warning score (MEWS) is a bedside screening tool which supports observation of physiological parameters such as blood pressure and heart rate. The aim of this is to improve the recognition of pregnant and postnatal women at risk of clinical deterioration, facilitating early intervention to improve outcomes.

During inspection we observed only 13% of the MEWS charts reviewed by inspectors had all the essential observations completed. There were also significant delays in

repeat observations being carried out despite the frequency of repeated observation required being clearly defined. Inspectors also observed instances where actions had not been taken in line with the NHS Lothian MEWS chart escalation pathway. In one instance an inspector raised concerns with staff members in relation to delayed escalation of a woman's care where the MEWS score indicated a potential deterioration in the woman's clinical condition. The concern was raised immediately with the midwife in charge of the area, who ensured this was rectified.

Within evidence reviewed, we observed that NHS Lothian maternity service has undertaken audits of their MEWS chart compliance. This demonstrated areas for improvements, such as frequency of MEWS recordings, escalation and communication. NHS Lothian has taken some steps to address their low compliance rates, with the introduction of focused improvement work, incorporating audit, quality improvement huddles, staff feedback and training. However, the audit highlighted that only 55% of women had received the appropriate escalation based on their MEWS scores. In review of the last six months incident reports, we observed that delays in escalation of care have resulted in significant adverse outcomes for women. A requirement has been given to support improvement in this area.

Delays in escalation of deteriorating clinical condition were raised by most staff in most clinical areas during inspection. Staff described delays to escalating clinical concerns were multifactorial and included staff availability, staff skill mix and the experience and availability of multiprofessional training in the management of deteriorating women. Staff described an environment where staffing numbers varied vastly on a shift-to-shift basis, impacting on clinical care. At times there was no staff to undertake care needs and limited availability of midwifery and obstetric staff resulted in delays in response to the escalation of clinical care and concerns. We highlighted these concerns to senior managers at the time of inspection.

As part of evidence, we requested the NHS Lothian escalation policy to be followed at times of staffing concern and patient safety concern. However, the escalation guidance provided was directed at senior charge midwife and unit coordinator level of escalation. It is not clear what guidance is available to clinical staff providing care within the unit. Communication is key in all clinical areas where there may be multiple handovers of care in short periods of time or during emergency situations as this helps to maintain situational awareness. During inspection we observed initiatives to share learning and improve communication. Within triage, a fact of the week board within the staff base was utilised to communicate new information with staff reporting this was updated regularly. Inspectors were invited to attend newly introduced quality improvement huddles in triage and labour ward. They observed written summaries of the information presented at the huddle displayed on the quality improvement board for staff who were unable to attend.

Situation, Background, Assessment, Recommendation and Decisions (SBAR-D) handover tools have been recognised as an effective way to optimise communication

of critical information in the aim to reduce the risk of an adverse event and improve safety. Within NHS Lothian the situation, background, assessment, recommendation and decision tool is utilised during escalation and transition of care. However, staff described the inconsistent use of the standardised communication tools with communication being highlighted as an area for improvement through several serious adverse events reviews. NHS Lothian's reducing avoidable harm and quality improvement programme has highlighted nine areas of priority for improvement which include both MEWS and communication improvement work. In summer this year senior managers focused resources to improve the units compliance with MEWS. A requirement has been given to support improvement in this area.

Mother and babies: reducing risk through audits and confidential enquiries across the UK ([MBRRACE-UK](#)) aim to improve outcomes for women and babies through learning from national audit. The 2024 report demonstrated the leading cause for maternal death in the UK being attributed to venous thromboembolism. Learning from the report highlighted a need for continuous evidence-based risk assessment throughout pregnancy and following birth. Within incident reports provided by NHS Lothian we observed that errors regarding venous thromboembolism risk assessments and medication was the second leading cause for a patient safety incident report to be submitted by staff in the six months prior to our inspection. Through the review of evidence, we observed an issue in interpretation of guidance and electronic risk assessment tool which resulted in delays to medication, incorrect prophylactic treatment or some women receiving venous thromboembolism prophylaxis when it was not indicated. NHS Lothian provided us with their 'Thromboprophylaxis during pregnancy and puerperium' guideline which utilises national guidance to support risk assessment of women. At the time of inspection, we observed senior staff raising awareness of thromboembolism risk assessment at staff handovers and safety huddles. A requirement has been given to support improvement in this area.

Electronic care records are designed to enhance accessibility and information sharing, supporting the safe delivery of care. Part of the 2017 best start vision for maternity care recommended a Scottish electronic maternity record was developed. Whilst NHS Lothian utilise electronic patient care records for documentation through the maternity care journey, this does not align with the electronic record used predominantly across NHS Scotland. Senior staff described this as challenging and as a barrier to information sharing, particularly as NHS Lothian is one of three neonatal intensive care units for Scotland, therefore many women and babies transfer in and out the unit during times of complex care needs. In discussion with senior managers we were advised that a review of the electronic system used in NHS Lothian was currently being undertaken. During our onsite inspection we did not have the opportunity to review the electronic patient records. We asked NHS Lothian to provide evidence of processes in place to audit documentation and discussed with senior managers current oversight for improvement. Senior managers described an improvement focus to streamline all documentation audits currently underway within the service to ensure all learning identified through audit is applied to practice. Within

evidence reviewed clinical governance papers highlighted documentation as an area for improvement. A requirement has been given to support improvement in this area.

During inspection we observed mealtimes were well organised, and staff were aware of women's dietary requirements. However, women and families we spoke with described a lack of feeding support for their newborn baby, describing that this left them feeling anxious, alone and worried for their baby's wellbeing. Some women told us their experience of lack of support may result in them changing their chosen feeding method. Within incident reports provided, we observed a few staff reporting a lack of feeding support. We requested NHS Lothians most recent UNICEF baby friendly reassessment report which detailed accreditation with the condition of further audit work being undertaken. In discussion with senior managers, they explained that infant feeding support had been impacted as they are no longer able to use volunteers within the organisation. Senior managers told us midwives are available to support families with their feeding intention. However, this approach does not appear to consider staffing pressures or skill mix within the midwifery team as described throughout this report. A requirement has been given to support improvement in this area.

Evidence of wear and tear throughout the hospital environment was observed during inspection including flooring with gaps where seals had come loose and holes in the floor. Domestic staff reported the current condition of the flooring impacted on the cleaning process for these areas. The senior charge midwife for the area was aware of concerns relating to the condition of the environment and was able to describe the system for reporting environmental issues. In evidence reviewed, we observed plans from the beginning of 2025 identified improvement was required to increase maternity services infection prevention and control oversight and assurance. Senior managers also explained that due to the nature of the labour ward and the challenges in relocating this area has resulted in difficulty maintaining the environment. A requirement has been given to support improvement in this area.

Care equipment can be easily contaminated and a source of transferring infection if equipment has not been effectively cleaned. During inspection the majority of patient care equipment was clean and ready for use. Storage issues within clinical areas resulted in equipment being stored in corridors within wards, however this did not appear to cause any obstruction or impact on the safe delivery of care.

We observed medication cupboards were unlocked in some areas and could have been accessed by women, children or members of the public. This is not in line with the Royal Pharmaceutical Society Professional guidance on the safe and secure handling of medicines (updated 2024) and The Code by the Nursing and Midwifery Council. Inspectors raised this with the senior charge midwife for the area who rectified this immediately. A requirement has been given to support improvement in this area.

Hand hygiene is an important part of standard infection control precautions to minimise the risk of infection. Other standard infection prevention and control precautions include patient placement, the use of personal protective equipment (such as gloves and aprons), management of the care environment, safe management of blood and fluid spillages, linen and waste management and prevention and exposure management (such as sharps injuries).

Hand hygiene involves '5 moments' when hand hygiene should be performed. These are prior to touching a patient, prior to performing a procedure, after a procedure or body fluid exposure risk, after touching a patient or after touching a patient's surroundings. During inspection we observed that there were occasions where staff missed opportunities to clean their hands including before and after contact with patients. A requirement has been given to support improvement in this area.

Personal protective equipment includes items such as disposable aprons and gloves. During our inspection we observed that staff used this appropriately and that there were sufficient supplies of personal protective equipment available throughout the clinical areas inspected.

Clean linen should be stored in a linen cupboard with the door closed or an appropriate identified covered trolley to minimise the risk of contamination. Inspectors observed that in some areas the covers on clean linen storage trollies were not always in place. This is not in line with the national infection prevention and control manual. A requirement has been given to support improvement in this area.

Inspectors observed that in most areas chlorine-based cleaning products were not stored securely, resulting in a risk that it may be accessed by women, children and members of the public. This is not in line with The Control of Substances Hazardous to Health (COSHH) Regulations 2002 which stipulate that these products must be kept in a secure area such as a locked cupboard. We raised this with senior managers at the time of inspection; a requirement has been given to support improvement in this area.

The national infection prevention and control manual recommends cleaning products should be freshly made and discarded after 24 hours. However, inspectors observed that bottles were not marked with the date and time of when chlorine-based cleaning products were reconstituted. This would make it difficult for staff to know when the cleaning solution should be discarded.

We observed poor compliance with sharps management in all areas, such as sharps containers not having temporary closures in place and incorrect labelling of sharps boxes. The use of the temporary closure prevents needles or other sharp objects protruding from the boxes or falling out of the container if it is dropped. A requirement has been given to support improvement in this area.

During inspection we spoke with staff regarding water flushing regimes. Water flushing regimes support the prevention of the build-up of bacteria within the water system. On discussion with staff, inspectors were informed water flushing within Royal

Infirmery of Edinburgh was undertaken by domestic staff. Evidence provided demonstrated that water flushing was being carried out in line with guidance.

Senior managers informed us staff compliance with fire safety training was 84%. During our onsite inspection we observed that some fire doors were not fully functioning, and the safe storage of medical gases was not being adhered to. We raised this at the time of inspection with the senior charge midwife for the area and observed within evidence this has been highlighted as high risk within previous risk assessments and no mitigations have been put in place. NHS Scotland Fire code SHTM 86: 'Fire Risk Assessment' states that hospitals and other healthcare premises with sleeping accommodation should have a yearly fire safety review. We observed fire risk assessments which were a year out of date. We raised this with senior managers who undertook an updated fire risk assessment following our onsite inspection. However, we observed within evidence further fire risk assessments which were up to three years out of date and contained outstanding action plans. We discussed this with senior managers who told us maternity services collaborate with NHS Lothians fire safety advisor to ensure the environment is maintained in line with fire regulations. A requirement has been given to support improvement in this area.

Requirements

Domain 4.1	
11	NHS Lothian must ensure effective senior management oversight and support, to ensure the fundamentals of care are provided and reduce the risks for women, their babies and staff at times of extreme pressure within maternity services.
12	NHS Lothian must ensure the development of a culture which promotes and supports staff psychological safety.
13	NHS Lothian must ensure venous thromboembolism guidance and risk assessments in place are aligned to support staff during the risk assessment of venous thromboembolism.
14	NHS Lothian must ensure that all patient documentation is accurately and consistently completed with actions recorded. This includes risk assessments such as the maternity early warning system (MEWS).
15	NHS Lothian must ensure systems and processes are in place to support the choices made by women. This includes but is not limited to women's feeding intention.
16	NHS Lothian must ensure the healthcare-built environment is effectively maintained to allow decontamination and ensure potential risks to patients and staff safety are effectively identified and mitigated.
17	NHS Lothian must ensure the appropriate management and monitoring is in place to ensure the safe storage of medicines.

18	NHS Lothian must ensure compliance with SICPS this includes but is not limited to: a. hand hygiene b. linen management c. sharps management.
19	NHS Lothian must ensure all fire actions and improvements identified within fire safety risk assessments are addressed.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Staff raised concerns with inspectors regarding the fluctuation of staffing levels and staffing skill mix impacting on the ability to provide safe maternity care and maintain patient safety. Staff told us the culture within the service has impacted confidence to escalate staffing concerns due to lack of feedback and resolution when staffing concerns do arise.

During inspection we had the opportunity to attend the staffing oversight and acuity safety huddle. The safety huddle included the senior management team such as service managers, director of midwifery, women’s services associate medical director, clinical midwifery manager for community midwifery and senior charge midwives and included a cross-site approach, however the opportunity was not taken to discuss the community midwifery service safe to start position. This may impact on the awareness and oversight across the system as inpatient and community services can have a direct impact on each other, such as the transfer of women between both services, particularly in emergency situations. The safety huddles occur twice daily with supplementary huddles organised at times of high acuity.

From January 2025 women’s services within NHS Lothian introduced an electronic staffing system which monitors real-time staffing levels in relation to care needs and service capacity. This utilises a colour system of green, amber, red and purple, with purple areas having the highest shortfall of staff and increased system pressures impacting on the safe delivery of care for both women and babies. This staffing system enables informed decisions to be made when deploying staff to help mitigate risk and considers the acuity of the women and babies versus available staffing numbers allowing for professional judgement to be made in terms of required staffing. However, we were concerned NHS Lothian did not appear to take account of all potential safety risks. For example, there was no discussion around midwifery skill mix and whilst other clinical groups were present at the staffing and safety huddle there was no oversight of obstetric or anaesthetic staffing within the safety tool utilised to determine the safe to start position of the service. We observed what appeared to be a lack of psychological safety within the safety huddle discussions. We also observed one area within the service which declared purple status however, there was lack of communication and mitigation of the risks for the clinical area affected or the impact

on the safe delivery of care. We raised this at the time of inspection with senior managers. A requirement has been given to support improvement in this area.

We were able to observe how maternity services fed into the wider hospital safety huddle. The hospital safety huddles occur twice a day and were attended by members of the multidisciplinary team including nursing, midwifery, allied health professionals, hospital discharge team and facilities colleagues. The wider hospital safety huddle supports site wide situational awareness, including patient flow, patient safety concerns, review of staffing and identifying wards or areas at risk due to reduced staffing levels. We observed evidence of maternity services staffing, acuity, capacity and safety concerns raised.

During safety huddles we observed attendance of the staff bank team in an aim to support and address emerging staffing concerns with submission of requests for staff for areas highlighted as a priority for supplementary staffing. We were also advised of the proactive engagement of the staff bank team during roster planning which ensures shortfalls of staffing are advertised to supplementary staffing up to six weeks prior to the staffing shortfall.

Maternity services are high risk environments with unpredictable transition between low and high acuity. Maternity services within NHS Lothian introduced the role of the maternity unit coordinator in May 2024 to improve situational awareness and staff described this as a positive introduction in the aim to improve patient safety. However, introduction of the role resulted in the reduction of available band 7 midwives within the labour ward. Prior to the unit coordinator role, two band 7 midwives were available within the labour ward, one to support clinical practice and the other to maintain situational awareness for the area. Staff described this reduction in senior clinical midwifery leadership as impacting on the ability to escalate concerns due to competing demands placed on the band 7 midwife. From incident reports reviewed, we observed at times of reduced available staffing the role of unit coordinator may be impacted on, resulting in one band 7 midwife to facilitate both the charge midwife for labour ward and the unit coordinator role. This resulted in challenges maintaining situational awareness and the ability to provide support for staff across the unit. Within incident reports reviewed we observed this impacted on delays to reviews when women demonstrated deterioration in clinical observations, oversight of appropriate staffing throughout maternity services and staff breaks.

Furthermore, staff described the current fluctuations in staffing and skill mix prevented them providing the standard of care women and families deserved and professionally supporting members of the team when challenges arose. We observed in evidence fluctuations in staffing resulting in reduced availability of midwives by up to 50% on some shifts. We observed delays to one-to-one care provision were in the top five reasons for staff to submit incident reports within Royal Infirmary of Edinburgh maternity services with staffing concerns highlighted as the main or

contributing factor. A requirement has been given to support improvement in this area.

Although there were no staffing incident reports submitted which related directly to staffing issues regarding obstetric or anaesthetic staff, during inspection the obstetric team informed us of current gaps in the middle grade obstetric registrar rota. This resulted in consultant obstetricians backfilling these gaps whilst also maintaining their own work capacity. On discussion with senior managers and within the provision of evidence we were made aware NHS Lothian have a workforce paper highlighting staffing pressures in the obstetric team. This is moving through NHS Lothian governance processes to seek executive support for additional resource to support resident doctor rotas, out of hours obstetric cover and increase senior decision makers presence in key areas of the service. Senior managers informed us of a recent investment in staffing with an additional 25 whole time equivalent staff. This includes frontline midwifery, predominantly newly qualified band 5 midwives and healthcare support staff. The investment has also resulted in successful employment of international midwifery and medical graduates within maternity services.

Internationally graduated professionals play a significant and valued role in supporting NHS Scotland. However, transition into a role within an NHS board requires senior professional leadership and structured oversight to facilitate opportunity to align with the necessary professional body requirements such as the Nursing and Midwifery Council and the General Medical Council.

At the time of inspection, staff told us of concerns they had raised following assessment through preceptorship frameworks and necessary transition supports relating to international midwifery graduates. These concerns relate to practical skills, risk assessments, and familiarity of escalation processes and different local and national guidelines.

We asked senior managers for evidence of training provided for international midwifery graduates and how they have been supported to transition into NHS Lothian. However, senior managers explained there has been no provision of a bespoke programme of induction, orientation or pastoral care for international midwifery graduates. Instead they are supported through the preceptorship programme for newly qualified midwives.

Within evidence we observed the induction programme undertaken to support integration of international medical graduates within NHS Lothian. However, it appears there is a gap within NHS Lothian's systems and processes as to how to consistently implement, monitor and evaluate the support and wellbeing offered to these staff groups. NHS Lothian need to be able to demonstrate the arrangements, with necessary governance, leadership and oversight, which assure international midwifery and medical graduates within maternity services they are supported to

achieve the necessary competencies and standard of care. A requirement has been given to support improvement in this area.

To support safe delivery of care within maternity service during staff shortfalls, staff described frequently being moved to different wards to work part or all their shift. Staff having the right skills and knowledge within their area of practice is essential in the safe delivery of care. On inspection and discussion with senior managers, we asked how staff are supported to maintain skills and knowledge to enable transition safely between areas of maternity services. Staff appraisals are essential to assessing and supporting staff performance, resulting in a positive work culture. In evidence received we observed obstetric staff could demonstrate 100% compliance rate with appraisals. However, evidence submitted demonstrated variation in compliance of midwifery staff appraisals of between 19-50% compliance rate. A requirement has been given to support improvement in this area.

In 2018 the Scottish Government published the core mandatory training requirements for midwives and obstetricians. This required each NHS board to establish training around fetal heart monitoring, obstetric emergencies and neonatal resuscitation. During inspection, staff told us about mandatory training being cancelled due to staffing levels and acuity within the service. Evidence received demonstrated a compliance rate of 69.2% of consultants, 66.7% of obstetric trainees and 37.2% of midwives had undertaken practical obstetric multiprofessional training (PROMPT). Cardiotocography training compliance rates were highlighted and discussed in domain one of this report. Within evidence reviewed, neonatal resuscitation compliance rates for midwives were 49.6% within the yearly requirement and only 49.6% compliance rate for the four yearly neonatal resuscitation requirement. Staff also informed inspectors they did not have protected work time to complete online education resulting in this being carried out mostly in their own time. The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives ([Nursing and Midwifery Council 2018](#)) and the Good medical practice document ([General Medical Council 2024](#)) state the importance of undertaking and maintaining continuous professional development to preserve patient safety and to practice effectively. Wider national reports on the provision of safe maternity care over the last decade such as Ockenden ([2022](#)), Each baby counts ([RCOG 2019](#)) and Kirkup ([2015](#)) have highlighted the essential safety features of teams working and training together to improve outcomes for families. A requirement has been given to support improvement in this area.

Each senior charge midwife is responsible for a midwifery team. This includes quality and performance management, HR requirements, roster management, ensuring training is up to date and wellbeing support for their team. Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This is to enable clinical leaders to provide and oversee the delivery of safe, high quality and person-centred healthcare. We were told that senior charge midwives have allocated managerial and supervisory roles, which would potentially help support improvements in staff wellbeing as well as the implementation of improvement initiatives. However,

we were told they are often required to take a clinical caseload as mitigation for staffing shortfalls. This impacts on their capacity to complete their leadership and management responsibilities. A requirement has been given to support improvement in this area.

Requirements

Domain 4.3	
20	NHS Lothian must ensure that clear and robust systems and processes are in place, including guidance and support for staff, to allow consistent assessment and capture of real-time staffing risk across all professional clinical groups. Assessments should consider skill mix of available staff, dependency and complexity of patients to support staff to confidently apply and record professional judgement in relation to required staffing when declaring “safe to start.”
21	NHS Lothian must ensure that maternity and obstetric services are appropriately and effectively staffed in order to reduce delays to care, preserve patient safety and support staff wellbeing.
22	NHS Lothian must ensure the necessary governance, leadership and oversight is in place to ensure international midwifery and medical graduates are supported to achieve the necessary competencies to assure the safe delivery of care.
23	NHS Lothian must ensure that there are clear, consistent systems and processes in place to support management of any identified staffing risks within maternity services. This includes accurate recording of any escalation, mitigation/inability to mitigate, communication of outcomes with all relevant clinical teams and any disagreements with decisions made.
24	NHS Lothian must ensure a supportive and inclusive working environment for staff which supports staff to raise concern with systems and processes in place to ensure that these concerns are responded to and appropriately addressed.
25	NHS Lothian must have robust systems and processes in place to ensure that all staff are appropriately trained to carry out their role. This includes protected learning time, monitoring of training completion and consideration of skills and experience when redeploying staff.
26	NHS Lothian must ensure that there are systems and processes in place to safeguard all clinical leaders within maternity services being able to access appropriate protected leadership time in order to fulfil their leadership and management responsibilities such as oversight of quality of care and provision of support for staff. This will include consistent monitoring and recording of when and why this is sacrificed as part mitigation for staffing shortfalls and/or increased service demand.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

We observed women and their families being treated with dignity, compassion and kindness. However, feedback from women during onsite inspection was mixed.

All interactions observed during inspection between women, babies and families were positive and respectful. We observed staff working hard to provide respectful and compassionate care. However, during onsite inspection women told us of mixed experiences within Royal Infirmary of Edinburgh maternity services. In some areas women were highly complimentary of the care they experienced describing it as exceptional; however, other women described their experience leaving them feeling alone and vulnerable. Whilst some women were complimentary of their care, they also informed inspectors of poor communication leaving them feeling uninformed with no 'voice' in their care.

NHS Lothian have a long-standing commitment to maternity services liaison which was established in 1984, this transitioned into the maternity voice partnership which was established in 2021. The national maternity voices partnership supports the co-production of maternity services ensuring the "voices of all women including those from diverse backgrounds" are heard and utilised to plan, design and improve maternity services. The partnership meets every two months where parents and representatives of parent's support groups meet with midwifery, obstetric and service managers in an aim to improve maternity services. Recent work undertaken by the maternity voice partnership in NHS Lothian includes a survey to improve informed consent for women and birthing people through their maternity journey. In collaboration with the maternity voice partnership a maternity care survey has been designed to actively request feedback from families who have recently experienced maternity care within NHS Lothian. This aims to improve the experience of others.

We observed evidence of family centred care within the postnatal ward where parents had the option to stay overnight, supporting the family unit. However, the availability of resources such as beds and chairs limited this option.

We observed an initiative within maternity triage where all women attending were given a QR code on discharge requesting feedback from their visit. In response to the feedback received, a wordle was created to inform staff with a "you said we did" poster displayed within triage to communicate to women improvements made following their feedback.

Areas of good practice

Domain 6	
4	NHS Lothian have an established maternity voices partnership to support the co-production of maternity services.
5	NHS Lothian support parents to stay overnight supporting the family unit.

Appendix 1 - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- [Allied Health Professions \(AHP\) Standards](#) (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- [Antenatal care](#) (NICE, August 2021)
- [CMO\(2018\)18 - Core mandatory update training for midwives and obstetricians](#) (Scottish Government, December 2018)
- [Delivering Together for a Stronger Nursing & Midwifery Workforce](#) (Scottish Government, March 2025)
- [Fire \(Scotland\) Act 2005](#) (Fire Scotland Act, Acts of the Scottish Parliament, 2005)
- [Food Fluid and Nutritional Care Standards](#) (Healthcare Improvement Scotland, November 2014)
- [Generic Medical Records Keeping Standards](#) (Royal College of Physicians, October 2015)
- [Guidance — NHS Scotland Staff Governance](#) (NHS Scotland, June 2024)
- [Health and Care \(Staffing\) \(Scotland\) Act](#) (Acts of the Scottish Parliament, 2019)
- [Health and Social Care Standards](#) (Scottish Government, June 2017)
- [Infection prevention and control standards](#) (Healthcare Improvement Scotland, 2022)
- [Intrapartum care](#) (NICE guideline, September 2023)
- [Maternity Triage](#) (RCOG Maternity Triage good practice paper, December 2023)
- [MBRRACE-UK](#) (Maternal, Newborn and Infant Clinical Outcome Review Programme, 2024)
- [National Infection Prevention and Control Manual](#) (NHS National Services Scotland, June 2023)
- [NMC Record keeping: Guidance for nurses and midwives](#) (NMC, August 2012)
- [Operating Framework: Healthcare Improvement Scotland and Scottish Government:](#) (Healthcare Improvement Scotland, November 2022)
- [Person-centred care - NMC](#) (The Nursing and Midwifery Council, December 2020)
- [Prevention and management of pressure ulcers standards](#) (Healthcare Improvement Scotland, October 2020)

- [Professional Guidance on the Administration of Medicines in Healthcare Settings](#) (Royal Pharmaceutical Society and Royal College of Nursing, January 2024)
- [Recommendations | Postnatal care | Guidance | NICE](#) (NICE, April 2021)
- [Scottish Patient Safety Programme \(SPSP\)](#) (Healthcare Improvement Scotland)
- [The best start: five-year plan for maternity and neonatal care - gov.scot](#) (Scottish Government, January 2017)
- [The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives](#) (Nursing & Midwifery Council, October 2018)
- [The UNCRC Act - UNCRC \(Incorporation\) \(Scotland\) Act 2024](#) (Scottish Government, September 2024)
- [The Quality Assurance System \(healthcareimprovementscotland.scot\)](#) (Healthcare Improvement Scotland, September 2022)

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