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Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Western Isles Hospital

NHS Western Isles

13 – 14 October 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. Taking account of the changing risk considerations and sustained service pressures the methodology was adapted to minimise the impact of our inspections on staff delivering care to women, birthing people and families. Our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records.

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 acute hospital 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

Western Isles Hospital is a small, rural general hospital located in Stornoway. NHS Western Isles provides maternity services to approximately 200 women per year, including on the Isles of Uist and Barra, supporting approximately 150 births. Western Isles Hospital is the largest of the three hospital services within NHS Western Isles, with a total capacity of 98 beds (of which 16 are contingency beds). Western Isles

Hospital opened in 1992 with a range of acute hospital specialties such as general surgery, paediatrics, maternity and psychiatry. The hospital also includes diagnostic facilities, day hospital (ambulatory care unit), laboratory, allied health professionals and other services.

About this inspection

We carried out an unannounced maternity services inspection in conjunction with a hospital safe delivery of care inspection to Western Isles Hospital, NHS Western Isles on Monday 13 to Tuesday 14 October 2025 using our safe delivery of care inspection methodology. We inspected the following areas during the maternity inspection:

- Combined antenatal, postnatal ward and labour suite.

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 women's health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Western Isles 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 Tuesday 18 November 2025, we held a virtual discussion session with key members of NHS Western Isles 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 Western Isles and in particular all staff at Western Isles Hospital 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 our inspection we observed staff providing compassionate and responsive care to women and their families. Senior midwifery managers and senior obstetricians were visible and clinically active, working with the multidisciplinary team to provide care to women and their families across a remote and rural service.

Good teamwork was evident throughout the inspection between obstetricians, midwives and the health care support team. Visible senior midwifery and senior obstetric leadership with respectful, friendly and supportive interactions between the team was observed. Staff described being supported by senior managers and felt able to raise concerns.

During inspection we identified areas for improvement. These included the lack of a person specific risk assessment or guideline to identify women or babies who require transfer off of the island for ongoing care. We also identified the need for improved hospital oversight of activity within the maternity unit during site huddles to support the safe delivery of care when senior midwifery leaders are unavailable. Improvement in the completion of the electronic staffing tools was identified to ensure the service is safe to start and that mitigations to ensure patient safety are consistently recorded.

During the acute hospital inspection in September 2024, concerns were raised with NHS Western Isles regarding the governance and review of policies and procedures. Although we found all acute policies and procedures to be in date and updated, we found that within maternity services a number of policies and procedures were out of date, in draft form with no target publication date or dates for review. The improved oversight and governance of the review of policies, guidelines and procedures was identified and discussed with senior managers during inspection.

Staff were actively engaged with their own learning and development however some aspects of mandatory training were identified as requiring improvement.

Other areas of improvement include fire safety requirements within maternity services and completion of patient documentation. Fire safety requirements were also identified during the acute hospital inspection.

Women and families we spoke with were complimentary of the care they received and would be happy to recommend NHS Western Isles maternity services to family and friends.

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

This inspection resulted in nine areas of good practice, one recommendation and 11 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 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 Western Isles 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.org

Areas of good practice

The unannounced inspection to Western Isles Hospital resulted in nine areas of good practice.

Domain 1	
1	Staff were observed providing prompt, person-centred care (see page 13).
2	The ward inspected was calm with good visibility of staff and senior managers (see page 13).

Domain 2	
3	We observed senior managers and senior obstetricians being approachable and engaging with all team members (see page 17).
4	Staff reported feeling well supported and able to escalate concerns to senior managers (see page 17).
5	A trigger list was available to all staff to aid and encourage the submission of incident report forms following an adverse event (see page 17).

Domain 4.1	
6	We observed positive and caring interactions between staff and patients (see page 20).
7	Women were supported during their antenatal, labour and postnatal period to support their feeding choices (see page 20).

Domain 4.3	
8	NHS Western Isles has been proactive in arranging training with subject matter experts to provide in-house training to support staff development (see page 24).

Domain 6	
9	We observed a service which is flexible and staff working hard to provide care to women and families within the island community (see page 26).

Recommendations

The unannounced inspection to Western Isles Hospital resulted in one recommendation.

Domain 1	
1	NHS Western Isles should improve bereavement training compliance rates for all staff providing bereavement care to families (see page 13)**.**

Requirements

The unannounced inspection to Western Isles Hospital resulted in 11 requirements.

Domain 1	
1	NHS Western Isles must ensure a system is in place to support the clinical risk assessment of women and babies when transfer to a mainland health board is required (see page 13). This will support compliance with: Quality Assurance Framework (2022) Criteria 2.6.

Domain 2	
2	NHS Western Isles must ensure timescales of significant adverse event reviews are achieved, including action plans, to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland National Framework (see page 17). 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) Criteria 2.5.
3	NHS Western Isles must ensure that all patient documentation is accurately and consistently completed with actions recorded. This includes risk assessment tools such as the maternity early warning system (MEWS) (see page 17). 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.

Domain 4.1	
4	NHS Western Isles must ensure effective and appropriate governance approval and oversight of policies and procedures are in place (see page 20). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.24 and Quality Assurance Framework (2022) Indicator 2.6.
5	NHS Western Isles must ensure staff carry out mandatory fire safety training and that fire planning is carried out in line with fire safety officer recommendations (see page 20). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).

Domain 4.3	
6	NHS Western Isles must ensure safe, person-centred service provision is maintained by having the right staffing in place including the provision of development roles to support succession planning (see page 24). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019
7	NHS Western Isles must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and management responsibilities (see page 24). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
8	NHS Western Isles must ensure clear real-time staffing data is consistently recorded and communicated and clear escalation processes and any mitigations/inability to mitigate are recorded clearly and accurately (see page 24). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
9	NHS Western Isles should ensure daily oversight of maternity services within wider safety huddles to maintain senior managers oversight of the service (see page 24). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

10	NHS Western Isles must ensure that there are processes in place to support the consistent application of the common staffing method, demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement. This includes that the principles of the common staffing method are applied, including having a robust mechanism for feedback to be provided to staff about the use of the common staffing method, and staffing decisions made as a result (see page 2). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
11	NHS Western Isles 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 24). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We observed staff working hard as a multidisciplinary team to deliver person-centred care. Staff were observed working together to maintain good communication and were accessible to women and their families. The maternity unit was clean and the environment was well maintained.

NHS Western Isles provides maternity services to women and their families across the Outer Hebrides. Whilst the maternity unit is situated within the Western Isles Hospital in Stornoway, maternity care is also provided in the community setting. The services support the continuity of care model described within Scottish Governments 2017 vision for maternity services; The Best Start: A five-year forward plan for maternity and neonatal care in Scotland. Further information can be read here. We observed a flexible maternity service provision which ensures women living on the Isles of Uist and Barra have access to consultant care which is based within the Western Isles Hospital. NHS Western Isles provides maternity services to approximately 200 women per year supporting approximately 150 births.

The maternity unit is located on the first floor of the hospital and is accessed through the main entrance. The unit is equipped to provide antenatal, postnatal and labour care. There is also an area within the unit equipped and utilised for the treatment and stabilisation of any unwell or unexpected premature baby. During the onsite inspection, staff from the multidisciplinary team were observed providing prompt and

person-centred care. The maternity unit was calm, tidy, clean and maintained to a high standard.

Women can contact the service 24 hours a day, seven days a week. Maternity triage is provided by midwives who are available to take their call and undertake a triage assessment. If any women require emergency unscheduled care during pregnancy or within six weeks of birth they will be invited to attend the unit for assessment upon their first call with the midwife. This was introduced as a safety measure to reduce the time it would take to present at the maternity unit for assessment due to the distances women may require to travel, sometimes in difficult road or weather conditions. On arriving at the unit they will be reviewed immediately. This is consistently achievable due to low patient acuity within the department. Electronic patient records and risk assessments are reviewed and a plan of care documented.

Both scheduled and unscheduled care are provided within the maternity unit where staff are available to support this. During discussions with senior managers they did not describe any delays in prioritising triage calls or care. Whilst on site, inspectors were able to observe triage calls being taken by midwives with no delays observed. We asked NHS Western Isles to provide any incident reports submitted by staff for the six months prior to our inspection in relation to patient safety. From review of submitted reports we observed no incidents related to delays to prioritising triage.

During our onsite inspection and within evidence provided we did not observe any delays to care. Senior managers informed us that although delays to care were occasional, they did occur and as a mitigation, in particular in the out of hours period, where only one midwife was on duty within the unit, they operated an on-call model to ensure the availability of a second midwife when the need arose. NHS Western Isles were able to provide a policy which supports the escalation of staffing risk concerns to support the safe delivery of patient care. Data relating to any delays to care including if medical staff were unavailable to attend a patient would be captured through the incident reporting system. Through review of evidence submitted by the board there were no incidents of delays to one-to-one care or induction of labour observed in the six months prior to inspection.

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. The appropriate equipment to manage these situations should be readily available. Within the maternity unit, emergency trolleys were placed appropriately within the ward and accessible to all staff for prompt use. An emergency trolley provides immediate access to critical equipment and medications during an obstetric emergency. Essential medications which would be used during obstetric emergencies were noted to be stored safely and appropriately.

When concerns are identified due to complications affecting the wellbeing of the mother or unborn baby staff will arrange, if appropriate, to have the woman

transferred to a mainland health board. As part of our inspection, staff told us that transfer would be arranged as promptly as possible. Senior managers highlighted that transfer may not always be possible due to an emerging risk to the mother or baby or due to advancing stages of labour. However, due to the geographical challenges of remote and rural living, there is limited access to emergency assistance on the Western Isles therefore requiring a collaborative approach from NHS Western Isles and supporting mainland boards. Any urgent transfer from the Western Isles relies on air transport therefore how quickly this can occur will depend on the availability of aircraft, crew and weather conditions. Any changing clinical circumstance can also determine the urgency of the transfer.

We requested evidence of any risk assessment undertaken when transfer of women or neonates (newborn babies) to another NHS board was required to ensure the continued safe delivery of care. NHS Western Isles provided evidence of guidance aimed to support staff in communication with other agencies such as mainland health boards and ScotSTAR (Scottish Specialist Transport & Retrieval). However, from the evidence received it was unclear if guidance for clinical risk assessment was in place to support a standardised approach to establish the suitability for transfer of a patient. Risk assessments form an important part of care planning to ensure that timely intervention and treatment is consistently applied using a standardised approach. At our virtual discussion session, senior managers advised risk assessment would occur on a case by case basis. However, available guidance would ensure a standardised assessment was undertaken by staff to reduce variation in practice. A requirement has been given to support improvement in this area.

In an event where a baby is born prematurely or requiring increased support at birth, it is essential that the staff have the emergency skills and training to be able to respond. Stabilisation of the newborn is a process where midwives, neonatologists and paediatricians are involved in providing care to a baby who requires increased support whilst awaiting the attendance of a neonatal transport team. This is carried out with the support of ScotSTAR. ScotSTAR is a national service for safe and effective transport and retrieval of newborn babies (neonates) and critically ill children throughout Scotland. Senior managers informed us that collaborative working with ScotSTAR has provided support, education and guidance to staff to ensure that immediate neonatal care can be initiated to provide the safe delivery of care. Training evidence supplied by NHS Western Isles shows that 95% of midwifery staff are trained in stabilisation of the newborn. The board were also able to provide the operational guideline which is available to staff to support clinical decision making when arranging transfer for newborn babies who require additional neonatal care. It was possible for inspectors to speak with families who had experienced the transfer process off of the island with their babies, who spoke highly of the care during the transfer and repatriation process. The care, compassion and professionalism that had been evident throughout was commended by the families.

Each birth room has ample space to enhance mobility and movement around the room but would also make access easy in an emergency situation. Birthing aids were observed during inspection including a birthing pool, ceiling slings to encourage upright birth, birthing balls and ensuite toilet and shower facilities. Within the birthing room resuscitaires were in place to ensure any immediate resuscitation needs for the baby are initiated promptly. This reduces the impact of separating mother and baby and prevents unnecessary separation in the immediate period after birth. Staff described being able to support partners and families to stay overnight with facilities available on the ward. Family members inspectors spoke with described staying together as being actively encouraged in line with The Best Start: A five-year forward plan for maternity and neonatal care in Scotland, where a truly family-centred and compassionate care approach is offered. This was offered to support bonding, monitor newborn feeding patterns and encourage the development of parenting skills with support on hand from midwives and maternity care support workers.

Women and families we spoke with told inspectors that communication was always clear with important information being given in a balanced and proportional way, allowing time for care planning and to make decisions.

The impact of inequalities within maternity services has been highlighted through national reports such as MBRRACE: Saving Lives, Improving Mothers' Care (2024). All women deserve safe, kind and accessible care throughout their pregnancy journey. NHS Western Isles were observed to be working in partnership with independent agencies across the islands and mainland to improve access to care for women in the community. Senior managers were able to describe this as an integral part of how services to women and families can be provided with support from health and social care partners and also within local industry such as ferry operators, accommodation providers and volunteer organisations. To reduce the financial and logistical impact of travel on women, routine pregnancy scans and screening has been made available on the Isle of Uist. NHS Scotland Birthplace Decisions information describes the importance of the choice of where to labour and give birth. NHS Western Isles provides a flexible service to enable women to make use of the homebirth service which ensures all women are able to access their choice of birth place. Midwifery staff will relocate to the Isles of Uist and Barra to ensure this choice is supported. Senior managers recognised the commitment this requires from staff and spoke highly of staff involvement. We were informed of the use of online interpretation services to support care for women if a language barrier is identified. Due to the location of the maternity unit, it would not always be possible to access face to face interpretation however staff did not raise concerns around this during inspection. Data relating to inequalities which women experience is captured within the Perinatal Mortality Review Tool.

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 room used to provide bereavement care which encompassed an area to allow the full in-hospital bereavement journey to be undertaken. This provided a private area to discuss care options, birth and spend family time following the death of a baby. Senior managers described opportunities for families to make memories including taking photographs and using memory making boxes. Within the maternity unit the role of the bereavement lead is undertaken by a midwife. Evidence supplied by NHS Western Isles highlighted bereavement training opportunities for staff at both local and national level. Following a recent self-assessment audit and collaboration with the National Bereavement Care Pathway Scotland partners, NHS Western Isles has demonstrated developments within their bereavement service. This includes having the right information available for families and staff, training all staff in having difficult conversations and how to support families when a pregnancy loss or neonatal death occurs off of the island. However, only 14% of midwives and no other staff groups have undertaken bereavement care training. Staff bereavement training is a recognised standard recommended by the National Bereavement Care Pathway. Whilst we recognise the ongoing improvement work in this area, a recommendation has been given to ensure continued improvement in this area.

Areas of good practice

Domain 1	
1	Staff were observed providing prompt, person-centred care.
2	The ward inspected was calm with good visibility of staff and senior managers.

Recommendations

Domain 1	
1	NHS Western Isles should improve bereavement training compliance rates for all staff providing bereavement care to families.

Requirements

Domain 1	
1	NHS Western Isles must ensure a system is in place to support the clinical risk assessment of women and babies when transfer to a mainland health board is required.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

We observed an open and transparent culture where maternity senior managers were visible, aiding support and care provision throughout our visit. Staff described respectful working relationships with senior managers and the obstetric team, feeling well supported and were able to raise concerns.

A positive working culture is essential to the safe delivery of care and has been evidenced within the reviews into maternity services by Kirkup (2015) and Ockenden (2022). During inspection staff described a positive and supportive workplace and described NHS Western Isles as a good place to work. Staff told inspectors that they felt well supported when they escalate issues such as understaffing and increased acuity. Within evidence received NHS Western Isles were able to provide the escalation policy which supports staff in and out of hours to escalate any staffing concerns to senior managers.

Inspectors observed respectful, multidisciplinary team communication during inspection. The Nursing and Midwifery Council and General Medical Council emphasise the importance of effective team working and communication to provide good and safe patient care within their 'Good teamwork means better maternity care' document. Further information can be found here. Communication and effective multidisciplinary working is key in all clinical areas where there may be multiple issues which require prioritisation and planning. Midwives and obstetric consultants were noted to be visible and working well together within the maternity unit with a good oversight of how they would contact other teams including anaesthetists, theatre teams and senior managers if the need should arise during an emergency situation.

Midwives within NHS Western Isles have taken on or adopted additional roles to support the service. Additional roles including sonographer training to enable more pregnancy scans to be performed, quality improvement and data collection to enhance learning within the service, infant feeding support, instructors for emergency scenario training and a lead midwife for bereavement services were described. Staff spoke of their roles as being "more than a job but a way of life on the islands." The head of midwifery described these additional duties as invaluable as these roles enhance the person-centred, safe and effective care that women receive.

Senior midwifery and senior obstetric staff were visible and engaged with the whole maternity team during times of staff handover and ward round safety huddles. The purpose of a safety huddle is to provide situational awareness, understand patient flow and raise issues such as patient safety concerns, review staffing and identify wards or areas at risk due to reduced staffing levels. The timings of these huddles with the obstetric and midwifery team varied on a day-to-day basis to ensure the multidisciplinary team were represented.

Staff described a supportive working culture where wellbeing was promoted in their daily work and following an adverse event which may occur within the service. Inspectors observed evidence of a "trigger list" to promote guidance to staff of which events should be reported through the electronic incident reporting system. The trigger list was readily available for staff to access and inspectors were not informed of any barriers to submitting incident reports. The learning from adverse events national framework indicates that 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. Further information on the national framework can be found here. A significant adverse event is an event which caused or could have caused significant harm. Significant adverse event reviews are essential to ensure key learning and reduce the risk of future harm. Thematic review of incident reports in correlation with available national data demonstrated senior management oversight.

Staff described the use of the hot debrief technique to support and promote psychological safety following an adverse event. As described within Healthcare Improvement Scotland National Framework for reviewing and learning from adverse events, NHS boards should ensure immediate access to support for staff involved in adverse events. A hot debrief or discussion that takes place immediately following the event is an important element of staff support. This is an opportunity to ensure there are no immediate patient safety risks, acknowledge what has happened and support staff wellbeing. The use of peer support and confidential contacts within the hospital were also highlighted to inspectors to ensure staff wellbeing, where they could raise concerns if required. Members of the multidisciplinary team described close working relationships which fostered a culture of open conversation and feeling able to raise areas of concerns. From evidence received, the action plan from the most recent serious adverse event was shown to involve wide communication of the learning points which were generated by the review. This action plan involved communication with staff, supporting wellbeing and improving systems for the safe delivery of care.

We discussed the adverse events process with senior managers who described the governance in the management of adverse events and reviews. They described participating in the national standardisation of recognition, escalation and commissioning of significant adverse events review (SAER) using the learning from adverse events national framework. The review process of incidents is supported by staff from other health boards due to the limited number of staff able to participate in case review in an aim to support openness and transparency. Inspectors requested evidence of how maternity services report to the hospital board to assure oversight and governance of any risks that are identified or any adverse events that occur. NHS Western Isles provided evidence demonstrating an oversight report which is discussed at governance meetings. Within this report there is an overview of all current serious adverse event reviews and their progress. This includes action plans and learning to be shared to support staff awareness, service improvement and patient safety. However, actions generated from serious adverse event reviews, for example the updating of

hypertension management and fetal monitoring guidance for staff, remain incomplete over a year from the original event. Ockenden (2022) recommends that any actions to change clinical practice or learning identified from a serious adverse event review should be implemented within six months. A requirement has been given to support this.

NHS Western Isles use the national Perinatal Mortality Review Tool which is designed to standardise the review and identify learning to review all stillbirths and neonatal deaths. This tool is designed to include the experience of and questions of the families involved. During virtual discussion, NHS Western Isles described a support system in place for families who experience an adverse event. Families will be provided with a key contact who can support them throughout the review of the event and gather their thoughts and questions.

Quality improvement aims to make a difference to women by improving safety, effectiveness and experience of care. We asked for evidence of quality improvement initiatives to improve patient safety and experiences within maternity services. NHS Western Isles provided evidence of learning achieved from significant adverse events reviews and an ongoing quality improvement project. Learning from the adverse event and the improvement project aims to support the improvement in completion of maternity early warning score (MEWS) charts.

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 in an aim to improve the recognition of pregnant and postnatal women at risk of clinical deterioration. This facilitates early intervention to improve outcomes. NHS Western Isles shared the outcome of MEWS observation audits carried out over the past six months. These audits showed varying compliance between 55.6% and 100% of the full completion of MEWS. The improvement project is part of the Scottish Patient Safety Programme to improve recognition of the deteriorating patient as part of the national approach. The Scottish Patient Safety Programme is a national quality improvement programme which aims to improve the safety and reliability of care and reduce harm. Senior managers described an improvement focus to ensure completion of MEWS. Maternity clinical governance papers highlighted MEWS completion as an area for improvement. From evidence we received from NHS Western Isles training sessions, staff communication at ward meetings and visual aids have been utilised in an aim to improve staff compliance with MEWS documentation. It was noted within further evidence that the ability to carry out quality improvement work has been impacted by staff absence. Whilst we acknowledge the ongoing improvement work currently being undertaken within the service, a requirement has been given to support improvement in this area.

Areas of good practice

Domain 2	
3	We observed senior managers and senior obstetricians being approachable and engaging with all team members.
4	Staff reported feeling well supported and able to escalate concerns to senior managers.
5	A trigger list was available to all staff to aid and encourage the submission of incident report forms following an adverse event.

Requirements

Domain 2	
2	NHS Western Isles must ensure timescales of significant adverse event reviews are achieved, including action plans, to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland National Framework.
3	NHS Western Isles must ensure that all patient documentation is accurately and consistently completed with actions recorded. This includes risk assessment tools such as the maternity early warning system (MEWS).

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

Women and their babies appeared well cared for with families speaking highly of the care they had received. However, during inspection we observed that the majority of clinical policies and guidelines were out of date.

Evidence-based clinical guidelines, policies and procedures are used to assist clinicians in decision making regarding treatment and care in specific circumstances. Guidelines are a resource within clinical practice to improve communication between patients and health professionals and help patients make informed decisions. Ensuring clinical guidelines are consistent with evidenced based practice requires oversight and a system of review to ensure they remain relevant.

In September 2024 Healthcare Improvement Scotland undertook an unannounced safe delivery of care inspection of Western Isles acute hospital. During that inspection several guidelines and standard operating procedures which were in draft form or had no approval or review date were provided by the board. Governance and oversight processes were raised as a concern in a letter of serious concern sent to NHS Western Isles at that time. During this inspection we observed clinical guidelines within maternity to support and guide staff in clinical practice were out of date. Additionally, we observed guidelines and policies in draft form or with no review date. We raised this with senior managers who were aware of the need to review and renew these guidelines. It was discussed that the timely review process of these guidelines has been

hindered due to limited senior staffing availability. 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. Through the review of evidence provided, we observed that 73% of antenatal and 57% of postnatal risk assessments were completed. Further review of incident reports did not highlight any submissions relating to thromboprophylaxis being omitted. Following inspection, we explored this with senior managers who were able to describe the risk assessment tool which is supported by the electronic documentation system. However, we could not gain assurance that up to date guidance was available for staff to support clinical assessment and decision making. A requirement has been given to support improvement in this area.

Inspectors had the opportunity to hear from women who described support when establishing the feeding of their babies. Women described feeling well supported in their chosen feeding method and felt less anxious due to the care and attention provided by midwives and maternity care support workers during this time. We requested NHS Western Isles most recent United Nations International Children's Emergency Fund (UNICEF) baby friendly reassessment report. This report commended the work across the professions within the maternity unit, with women noting the positive interactions they had within the antenatal period, during and following birth to support feeding choices.

During the inspection, patient care equipment was clean and ready for use. Storerooms, including the medication preparation room, were tidy and well organised.

Call bells were available at each bed space which allowed women to call for assistance without delay.

Medication fridges were secure and only accessible to appropriate staff within the maternity unit. The hospital environment appeared clean and although the hospital estate is 32 years old, we did not observe evidence of excessive wear and tear. Damage to the healthcare environment can impact effective cleaning. En suite shower and toilet facilities were maintained to a high standard. Ward corridors were unobstructed due to the appropriate placement of equipment.

Hand hygiene is an important part of standard infection control precautions to minimise the risk of infection. Other standard infection 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). We observed good compliance with hand hygiene and no opportunities to perform hand hygiene were missed.

Personal protective equipment such as gloves and aprons were readily available at the point of care. Inspectors observed appropriate use of personal protective equipment.

Linen trolleys were placed and stored appropriately with the correct covering. This is in line with the national infection prevention control manual. Used linen, which was potentially contaminated with blood or suspected to be infectious, was also noted to be handled and disposed of correctly.

Inspectors observed safe sharps management compliance with sharps boxes labelled as per guidelines and having temporary closures in use. The use of the temporary closure prevents needles or other sharp objects protruding from the boxes or falling out of the container if they are dropped. Inspectors also observed sharps boxes being stored appropriately when not in use.

We observed that chlorine-based cleaning products were stored securely 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. Where chlorine releasing agents are not stored securely this may result in a risk that it may be accessed by patients or members of the public. We observed chlorine-based cleaning products stored in locked access domestic storerooms which were situated behind pass-controlled doors leading into the maternity unit.

We observed fire risk assessments were completed in December 2024. 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. A fire risk assessment within the maternity unit was noted. All staff should be aware of fire evacuation processes, maintain up to date fire safety training modules and fire safety assessments should be maintained accurately with all recommendations and actions noted. All fire escape routes and exits were clear, well signposted and unobstructed. Within the assessments, we were able to identify that the report had highlighted that there was an obstruction observed in front of the fire extinguisher points in the maternity unit. This had subsequently been resolved, and there was no evidence of obstruction during inspection. Staff e-learning training compliance for fire safety was 71%. There were no reported fire safety concerns contained within incident submissions. We were also provided with the fire risk assessment action tracker which identifies any jobs outstanding from the fire risk assessments. The majority of the highlighted work for maternity has been completed, however, fire planning for the area continues to require to be updated. To support continued improvement, a requirement has been given to support ongoing work in this area.

Areas of good practice

Domain 4.1	
6	We observed positive and caring interactions between staff and patients.
7	Women were supported during their antenatal, labour and postnatal period to support their feeding choices.

Requirements

Domain 4.1	
4	NHS Western Isles must ensure effective and appropriate governance approval and oversight of policies and procedures are in place.
5	NHS Western Isles must ensure staff carry out mandatory fire safety training and that fire planning is carried out in line with fire safety officer recommendations.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Staff we spoke with described supportive senior leadership who were accessible, with the ability to escalate any staffing or clinical concerns as required.

Workforce pressures including recruitment and retention of staff continue to be experienced throughout NHS Scotland. Senior managers were able to discuss the ongoing challenge of recruitment within midwifery and obstetrics in NHS Western Isles. This is contributed to by the fact that island communities are more remote and the nature of service provision requires staff to be willing to work in roles within the hospital and community setting rather than in one setting only. This would include a requirement to work on-call across day and night. For example, within NHS Western Isles the consultant obstetric team currently work a 1 in 2 on-call rota pattern which requires the obstetrician to be on call for 24 hours every other day. There is also a requirement to cover extended on call periods during sickness or annual leave. In discussion with obstetric consultants, they highlighted the difficulty in recruiting experienced obstetric staff to the Western Isles. Senior obstetric trainees are not currently rotated to NHS Western Isles which limits their experience and exposure to remote and rural working and results in the obstetric consultants providing all cover for daytime and overnight on call for the maternity unit, including any emergency cases which may arise.

The senior obstetric team described opportunities for middle grade obstetric training within the unit. This could be undertaken as an opportunity to support succession planning, service development and attracting new medical staff to the unit as highlighted within the review of Moray maternity services report in 2021. Whilst the senior obstetric team highlighted limitations to middle grade obstetric training within the service with regard to the number of service users and potential exposure to

learning, they acknowledged its' essential nature to support recruitment and retention.

A plan to develop a robust system of workforce support, nurturing leadership to prepare staff to take on senior leadership roles including a focus on succession planning is outlined within the National Workforce Strategy for Health and Social Care in Scotland. More information can be found here. During onsite inspection we discussed with senior managers there was uncertainty regarding the current strategy to develop and maintain senior leadership roles within maternity services in NHS Western Isles to facilitate succession planning and assure the availability of the service was protected. The Health and Care (Staffing) (Scotland) Act 2019 states that health boards have a duty to ensure safe, high quality, person-centred service provisions through having the right staffing in place. We discussed this further with senior managers at our virtual discussion. NHS Western Isles is undertaking a review of the service requirements to support recruitment for senior posts to ensure continuity in the management of the service remains. It was also highlighted that there is ongoing work with a mainland health board to support the obstetric staff in view of potential staff retirement. Senior managers discussed maximising development opportunities for existing midwifery staff within the maternity unit. Whilst recognising the challenges that are presented due to recruitment within this rural and remote location, succession planning is essential to ensure the maintained provision of maternity care is available to the families of the Western Isles. A requirement has been given to support this.

Midwives within NHS Western Isles work within a day, night and back shift pattern which incorporates the on-call model of care out of hours. Inspectors were able to explore this with staff and senior managers to identify that this is to ensure that there is always an on-call midwife available during the day and night to support the safe provision of care to women during labour. During a night shift one midwife and care assistant will be present on the unit. Staff spoke of a low threshold to call in the on-call midwife or escalate any clinical care concerns to the senior midwifery and obstetric team. Staff spoke positively of the support they would receive from the multidisciplinary team when concerns arose or when advice was sought. Within evidence provided by the board it was noted that a concern covering midwifery on-call had occurred. We asked how shortfall within the on-call rota would be managed. Senior managers were able to describe that covering on-call had been challenging due to the number of staff on maternity leave but this had now resolved as staff had returned to work. Shortfall within the on-call rota would be supported by staff and senior managers taking extra on-call duties and was never unable to be covered.

In evidence received we observed that there is a staffing gap in the band 6 midwife role of 19.6%. A shortfall of 10% vacancy is considered high. This was discussed during virtual discussion where senior managers described a stable workforce whilst recognising the challenges of recruiting staff to remote and rural boards. Supplementary staffing is used to support the delivery of safe care. Supplementary

staffing includes substantive staff working additional hours, staff from the NHS board's staff bank or staff from an external agency. A high use of supplementary staff can have an impact on continuity of care, however within NHS Western Isles there are limited numbers of supplementary staffing available with those who do undertake these roles being familiar with the unit and the local community. During discussion with senior managers, it was noted that supplementary staff were used during periods of annual leave, sickness or to cover vacancy.

Inspectors observed that maternity health care support workers have undergone further training to become maternity care assistants within the maternity unit. Maternity care assistants provide support, assisting the midwife and wider multidisciplinary team to deliver safe care. Maternity care assistants are non-registered health care staff working under the guidance of the midwife within a hospital or community setting. They provide important support to staff and women across the maternity journey. Maternity care assistants who inspectors spoke with felt they had good opportunities to carry out their role with women and families and understood how to escalate their concerns to midwifery staff. Respectful and engaging relationships were noted between support staff and families.

The head of midwifery and consultant obstetricians were observed to be clinically active and highly respected members of the team. Due to the limited senior management in place to support the head of midwifery it was highlighted to inspectors, senior midwifery management may be required to take a clinical caseload due to staffing shortages and to support the multidisciplinary teams. Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This is to enable clinical leaders to ensure they have protected time and resource to ensure appropriate staffing alongside other professional duties to lead the delivery of safe, high quality and person-centred healthcare. However, in evidence received we observed only 12% of midwifery staff had received an appraisal in the last 12 months. Staff appraisals are essential to assessing and supporting staff performance resulting in a positive work culture. 100% of obstetric staff appraisals were complete. A requirement has been given to support improvement in this area.

NHS Western Isles introduced an electronic staffing system which reports real-time staffing requirements based on professional judgement in relation to patient care needs. This provides a traffic light system with red areas having the highest shortfall of staff available to meet patients' needs. This enables informed decisions to be made when reorganising staff to help mitigate risk. This system considers the acuity of the patients versus available staffing numbers. It also allows for professional judgement to be made in terms of required staffing. The electronic staffing system informs discussions and decisions in relation to staffing and is utilised at their safety huddles where any mitigations or actions are recorded. The head of midwifery maintains oversight of the activity and capacity within the maternity unit to assess any unplanned short and long term absences which may impact on the safe delivery of care within the maternity unit. The use of the electronic system and tools available

reduce the risks associated with a person dependant system of oversight. Paper records of daily staffing and activity were provided to demonstrate oversight of unit activity. However, we observed risk status was not applied to these records limiting senior managers oversight. A requirement has been given to support improvement in this area.

During inspection we had the opportunity to observe the wider hospital safety huddle. This was attended by members of the multidisciplinary team including nursing, 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. However, we observed maternity services did not form part of this huddle limiting NHS Western Isles senior managers oversight of real-time staffing, acuity and safety concerns within maternity services. A requirement has been made to support improvement with this.

The Health and Care (Staffing) (Scotland) Act 2019 stipulates that health boards have a duty to follow the common staffing method. This is a multifaceted triangulated approach which includes the completion of a staffing level tool run to support boards to ensure appropriate staffing. The application of the common staffing method and staffing level tools enables NHS boards to ensure appropriate staffing levels, the health, wellbeing and safety of patients and the provision of safe and high quality care. From evidence received we could not gain assurance of the consistent application of the common staffing method within maternity services. A requirement has been given to support improvement.

Staff we spoke with told us they are actively encouraged and supported to undertake regular training including mandatory training. Core mandatory training requirements for midwives and obstetricians in Scotland were published by Scottish Government in 2018. This required each NHS board to establish training around fetal (unborn baby) heart monitoring, obstetric emergencies and neonatal resuscitation. 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 feature of teams working and training together to improve outcomes for families. Evidence received from NHS Western Isles demonstrated that 100% of the midwifery and obstetric team had undertaken the practical Scottish core obstetric teaching and training in emergencies (SCOTTIE) course. This course is designed to train the multidisciplinary team in the management of obstetric emergencies. Cardiotocography and intermittent auscultation is used to record and interpret the fetal heart rate in the antenatal and labour period. It is an important tool used in conjunction with clinical assessment to be able to determine fetal wellbeing. NHS Western Isles provided evidence that showed 42% of midwives had completed the yearly fetal heart monitoring training and 59% the two-yearly requirement. 50% of obstetric staff had undertaken the two-yearly training. Neonatal resuscitation compliance rates for midwives were 80% within the yearly requirement and 95%

compliance rate for the four yearly neonatal resuscitation requirement. The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives emphasises the importance of maintaining knowledge and skills by taking part in the appropriate learning and professional development activities. A requirement has been given to support improvement in this area.

NHS Western Isles has been proactive in bringing subject matter experts to the islands to undertake in-house training with staff members to maximise the possibility of staff being able to benefit from bespoke training including trauma informed practice and bereavement care. It was discussed that any supplementary training may have to be undertaken in personal time, with no expectation of attendance, but that staff were actively engaged in their own learning and development. Paid working time to support this learning experience would be provided where possible.

Areas of good practice

Domain 4.3	
8.	NHS Western Isles has been proactive in arranging training with subject matter experts to provide in-house training to support staff development.

Requirements

Domain 4.3	
6	NHS Western Isles must ensure safe, person-centred service provision is maintained by having the right staffing in place including the provision of development roles to support succession planning.
7	NHS Western Isles must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and management responsibilities.
8	NHS Western Isles must ensure clear real-time staffing data is consistently recorded and communicated and clear escalation processes and any mitigations/inability to mitigate are recorded clearly and accurately.
9	NHS Western Isles should ensure daily oversight of maternity services within wider safety huddles to maintain senior managers oversight of the service.
10	NHS Western Isles must ensure that there are processes in place to support the consistent application of the common staffing method, demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement. This includes that the principles of the common staffing method are applied, including having a robust mechanism for feedback to be provided to staff about the use of the common staffing method, and staffing decisions made as a result.
11	NHS Western Isles 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.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

We observed respectful and caring interactions between women, their families and members of the multidisciplinary team. Services were designed to support women and families within the island community. Families we spoke with told us they would be happy to recommend NHS Western Isles maternity services to family and friends.

Inspectors observed a maternity service which was able to be flexible and accommodating to the needs of women and their families living on the islands. All families that we spoke with described their care with the highest regard. They described a truly individualised support system which would respond to and accommodate their needs. Women described benefitting from the understanding and time that the midwives and obstetricians provided during the antenatal, labour and postnatal period. Women described receiving assistance when required and access to analgesia when needed.

During inspection it was highlighted that temporarily relocating to the mainland is a reality for a quarter of the women receiving maternity care within NHS Western Isles. Relocation can be through choice or through necessity if pregnancy complications develop. Women who live on the Isles of Uist and Barra will relocate to either Stornoway or the mainland by 38 weeks of their pregnancy. Staff discussed the logistical requirements and financial implications for families having to relocate. Relocating to another area can be a complicated circumstance, adding extra pressure during a vulnerable period where family and community support is essential.

We observed staff working hard to maintain privacy and dignity, utilising side rooms and privacy screens when necessary. Meals were supplied for women and their birth partners with drinks also available. Women discussed how this was supportive to them and their family during their admission to the maternity unit as it reduced the amount of time the family would spend apart.

Parenting classes which support families during the preparation for labour, birth and bringing baby home are held within the maternity unit. These classes introduce families to different members of staff as well as helping them become familiar with the maternity unit.

We observed the provision of care discussed respectfully by the multidisciplinary team, taking a holistic overview of the individual situation. Inspectors observed a flexible workforce who took time and consideration to ensure women received the right care in the right place at the right time by the right team.

Areas of good practice

Domain 6	
9.	We observed a service which is flexible and staff working hard to provide care to women and families within the island community.

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 for Staff and Managers on Coronavirus— 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.org) (Healthcare Improvement Scotland, September 2022)

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