Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Ayrshire Maternity Unit, University Hospital Crosshouse

NHS Ayrshire & Arran

08 - 09 October 2025

Published February 2026

www.healthcareimprovementscotland.scot

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

Ayrshire Maternity Unit is a purpose-built unit linked to University Hospital Crosshouse and provides maternity services for the whole of Ayrshire, supporting approximately 2,800 births a year.

About this inspection

We carried out an unannounced maternity services inspection to Ayrshire Maternity Unit, University Hospital Crosshouse, NHS Ayrshire & Arran on Wednesday 08 to Thursday 09 October 2025 using our safe delivery of care inspection methodology. We inspected the following areas during the maternity inspection:

- inpatient ward
- labour ward
- maternity triage

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 Ayrshire & Arran 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 Monday 27 October 2025, we carried out an unannounced return visit to Ayrshire Maternity Unit to ensure concerns we raised during our initial onsite inspection had been addressed.

On Tuesday 18 November 2025, we held a virtual discussion session with key members of NHS Ayrshire & Arran 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 Ayrshire & Arran and in particular all staff at Ayrshire Maternity Unit, University Hospital Crosshouse 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.'

We observed, cohesive multidisciplinary team working in all areas inspected. Maternity staff we spoke with described positive working relations between midwifery, obstetric, anaesthetic and the health care support team.

We observed positive leadership across multidisciplinary teams, with senior charge midwives visible and engaged across all wards. Staff described feeling supported to escalate staffing issues and concerns to their senior charge midwife. We received varied feedback from clinical staff regarding visibility of senior managers impacting on their ability to ask for support at times of high acuity.

Despite the pressures on maternity services at the time of inspection, women and their babies were receiving a good standard of care and families consistently expressed positive views regarding the care provided.

Women we spoke with told us they felt listened to and supported in making decisions about their care. All women described positive experiences of communication and compassionate interactions with staff. Women and their families told us they would be happy to recommend NHS Ayrshire & Arran maternity services to their family and friends.

However, as a result of concerns raised during our inspection and in line with our inspection methodology, we returned to carry out a return visit on Monday the 27 October 2025 to assess progress made against concerns raised during our initial onsite inspection. Our concerns included potential delays to care for women accessing maternity triage and potential gaps in incident reporting, which may impact on the learning from adverse events, reducing opportunities to improve safety.

Throughout the inspection we also raised concerns regarding fire safety and compliance with NHS Scotland Fire code SHTM 86: Fire Risk Assessment. NHS Ayrshire & Arran provided an update on improvement actions to address this. Improvement actions identified throughout this report will be monitored by NHS Ayrshire & Arran through their safe delivery of care improvement action plan. NHS Ayrshire & Arran are responsible for the necessary improvements to meet the requirements. Other areas for improvement identified include flushing of infrequently used water outlets and some improvements required in the cleanliness of patient equipment.

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

This inspection resulted in 10 areas of good practice, two recommendations and 16 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 Ayrshire & Arran 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 NHS Ayrshire & Arran resulted in 10 areas of good practice.

Domain 1	
1	NHS Ayrshire & Arran have progressed work to implement a dedicated 'red phone' system within maternity triage in an aim to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff (see page 14).
2	Within the transitional care areas, there are two family rooms for parents whose babies require care within the neonatal unit which helps to support keeping the family unit together (see page 14).
3	Good multidisciplinary team working with maternity care assistants trained and working within the transitional care area (see page 14).

Domain 2	
4	Student midwives reported positive practice and learning environments and support from staff within clinical areas (see page 19).

Domain 4.1	
5	Families were being supported by staff and wider staff groups to build confidence in their chosen feeding method of their baby (see page 22).

Domain 4.3	
6	We observed proactive succession planning (see page 25).

Domain 6	
7	All interactions we observed between women, babies and families were positive and respectful (see page 27).
8	We observed a dedicated family room for bereaved families (see page 27).
9	Parents had the option to stay overnight, supporting the family unit (see page 27).
10	We observed that maternity staff were proactive in discussing contraception with postnatal women (see page 27).

Recommendations

The unannounced inspection to Ayrshire Maternity Unit, University Hospital Crosshouse resulted in two recommendations.

Domain 2	
1	NHS Ayrshire & Arran should consider current guidance around Shared Language for Pregnancy, Labour and Birth (see page 19).

Domain 6	
2	NHS Ayrshire & Arran should improve bereavement training compliance rates for all staff providing bereavement care to families (see page 27).

Requirements

The unannounced inspection to Ayrshire Maternity Unit, University Hospital Crosshouse resulted in 16 requirements.

Domain 1	
1	NHS Ayrshire & Arran must ensure a process is in place to ensure women receive timely access to midwifery telephone assessment (see page 14). This will support compliance with: Health and Social Care Standards (2017) 3.21.
2	NHS Ayrshire & Arran must ensure effective governance and oversight of activity within the maternity service to support safe delivery of care for women, including, but not limited to maternity triage (see page 14). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) criteria 2.5 and 2.6.
3	NHS Ayrshire & Arran must ensure that patients are provided with the right care, in the right place, at the right time (see page 14). This is to comply with Health & Social Care Standards (2017) Standard 1, criteria 1.19, 1.20, and Standard 3, criteria 3.14-3.19, and Standard 4, criteria 4.11,4.14,4.27.
4	NHS Ayrshire & Arran must ensure an effective system is in place to ensure patient documentation is accurately completed to support the safe delivery of care (see page 14). This is to comply with Nursing and Midwifery Council (NMC) The code (2018) and NHS Scotland and Healthcare Improvement Scotland Quality Assurance Framework (2022) criteria 2.6.

Domain 2	
5	NHS Ayrshire & Arran must ensure ongoing engagement with staff to ensure an open and transparent culture (see page 20). This will support compliance with: Healthcare Improvement Scotland Quality Assurance Framework (2022) Criterion 2.1.
6	NHS Ayrshire & Arran 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 within national guidance (see page 20) 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 Assurance Framework (2022) Criterion 2.5.
7	NHS Ayrshire & Arran must ensure staff receive time and resources to undertake training essential to their role. This includes protected learning time, monitoring of training completion and consideration of skills and experience (see page 20) This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
8	NHS Ayrshire & Arran must ensure governance and oversight of incident reporting and improve feedback to staff who have submitted incident reports through the incident reporting system (see page 20) 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 Assurance Framework (2022) Criterion 2.5.

Domain 4.1	
9	NHS Ayrshire & Arran must ensure governance and oversight to ensure venous thromboembolism risk assessment compliance (see page 22). This will support compliance with Quality Assurance Framework (2022) criteria 2.6.
10	NHS Ayrshire & Arran must ensure that patient equipment is clean and ready for use (see page 22). This will support compliance with: National Infection Prevention and Control Standards (2022).
11	NHS Ayrshire & Arran must ensure infrequently used water outlets are flushed in line with current national guidance (see page 22). This will support with compliance with National Infection Prevention and Control Manual (2023) and Scottish Health Technical Memorandum SHTM 04-

	01 part B (2014) 'Water Safety for healthcare premises Part B:Operational management.'
12	NHS Ayrshire & Arran must ensure fire risk assessments are up to date and fire actions and improvements identified within fire safety risk assessments are addressed (see page 22). This will support compliance with: Fire Safety (Scotland) Regulations (2006).

Domain 4.3	
13	NHS Ayrshire & Arran must ensure oversight of potential risks within maternity services are consistently captured within the wider hospital safety huddle (see page 25). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
14	NHS Ayrshire & Arran 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 (see page 25). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
15	NHS Ayrshire & Arran must ensure that there are processes in place to support consistent annual application of the common staffing method, demonstrating triangulation of all relevant service specific quality, safety and workforce data (see page 25). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
16	NHS Ayrshire & Arran must ensure clinical leaders within maternity services have appropriate protected leadership time to fulfil their leadership and management responsibilities. This will include consistent monitoring and recording of when and why this is sacrificed as part mitigation for staffing shortfalls (see page 25). 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 cohesive multidisciplinary team working. This included obstetricians, midwives and the healthcare support team. However, we observed delays to care for women requiring assessment and ongoing care within maternity triage which we raised as a concern with senior managers.

At the time of inspection, maternity services within Ayrshire Maternity Unit 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 from 12 weeks of pregnancy until birth and from birth to six weeks postnatal. There is currently no national standardisation of maternity triage system available. However, the Royal College of Obstetricians and Gynaecologists good practice paper 17 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.

NHS Ayrshire & Arran's triage service is accessed following a telephone assessment carried out by midwives, allowing maternity staff oversight of women attending for assessment. The department has access to six single rooms for review of any attendees. At the time of inspection, the area was busy but calm with the senior charge midwife visible.

NHS Ayrshire & Arran have a bespoke midwifery training package designed to support midwives undertaking calls and to support the continuity of telephone assessment. This is in line with best practice described by the Royal College of Obstetricians and Gynaecologists.

However, during our inspection, we identified several areas for improvement within NHS Ayrshire & Arran's Triage service. As a result of concerns during our inspection and in line with our inspection methodology we returned to carry out a return visit, to assess progress with concerns we had raised during our initial onsite inspection.

Due to capacity and acuity within the department, we observed delays to telephone triage. This resulted in women having to wait up to 30 minutes for a return call from a midwife trained in telephone assessment. Staff described occasional incidences of women self-presenting in the department due to delays in a return call from a midwife. Inspectors also observed unregistered staff, who had not undertaken the bespoke training carrying out telephone assessment, recording details of women who were calling for advice. We raised this immediately as a patient safety concern with the midwife in charge who responded promptly by returning a woman's call. The delay in triage assessment by a trained midwife could result in delays in recognising an

emergency. This may also impact negatively on women's experience if attendance could be more appropriately directed to another service. During our return inspection, we were provided assurance that the process had changed, and only trained midwifery staff would carry out telephone assessment. A requirement has been given to support continuous improvement in this area.

Inspectors observed the department had a "triage board" to support system oversight and situational awareness for midwifery, obstetric and clinical support staff. However, the board was not being used by staff. Loss of situational awareness of women currently in the department can result in adverse clinical outcomes. Additionally, there were gaps in the process of capturing any women who failed to attend the unit following advice to do so during a telephone assessment. This could prevent welfare checks being undertaken where necessary. A requirement has been given to support improvement in this area.

Obstetric emergencies and concerns over the wellbeing of the unborn baby are time sensitive requiring a systematic approach to improve outcomes. The Royal College of Obstetricians and Gynaecologists good practice paper states that clinical priority should not be assigned during telephone assessment and an appointment system should not be used as part of admission criteria. During our inspection and within evidence provided, we observed both telephone assigned clinical prioritisation and the use of an appointment system were being practised. This was utilised at times of high acuity and reduced staffing to support patient flow. This could result in further delays to women presenting for and accessing emergency care. During the inspection although staff endeavoured to ensure women attending the unit were triaged within 30 minutes, this was not always possible. Within evidence received we observed waits of over one hour for the initial clinical assessment to be undertaken. Staff within the department told us they would escalate to the senior on-call manager if acuity or capacity prevented timely triage and review.

Staff explained there was no formal guidance in place and professional judgement and experience was used to prioritise the care of women. The absence of formal evidence-based guidance can lead to the potential for variation in practice and care. Following our initial onsite visit, NHS Ayrshire & Arran provided draft guidance on clinical prioritisation and timescales for assessment. During our return visit staff informed us that since the initial inspection the draft guidance document had been implemented to support clinical prioritisation. However, on review the guidance provided did not align with current Royal College of Obstetrics and Gynaecologists and National institute for Health and Care guidance. We discussed this with senior managers who explained that following the inspection feedback the outdated guidance was removed from practice whilst a draft standard operating procedure that aligns with current national evidence is being produced.

Obstetric care provision is shared within maternity triage and the labour ward area. During weekdays a second on-call consultant is available to support in times of high acuity. We asked for evidence of any assurance systems or processes in place to

monitor the effectiveness of the triage system. NHS Ayrshire & Arran provided an audit carried out to "analyse patient flow and delays within the maternity unit" for women attending the department in July 2025. This demonstrated 85% of attendees, were seen within 15 minutes for their initial assessment by midwifery staff. When an obstetric review was required, we observed potential delays to care occurred as a result of medical staff availability, staff shift changes and acuity within the service. However, the audit lacked key data, for example lack of detail on clinical prioritisation which would be required to assess if timely care had been achieved. A requirement has been given to support improvement.

We reviewed patient safety incident reports submitted by staff for the six months prior to the inspection. There had been no reports submitted that related to delays in care within the maternity triage area. However, areas for improvement with incident reporting, governance and oversight will be discussed further within domain 2.

The Royal College of Obstetricians and Gynaecologists recommend only women requiring unscheduled care are seen within maternity triage, to prevent competing priorities and allow for the provision of focused unscheduled emergency care. We observed scheduled care was provided in the triage area. Staff told inspectors at times this impacted on their ability to prioritise unscheduled care. A requirement has been given to support improvement.

NHS Ayrshire & Arran have progressed work to implement a dedicated 'red phone' system within maternity triage in an aim to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff. The availability of a 'red phone' was also raised as a recommendation following a recent Fatal Accident Inquiry within another NHS board. This system facilitates timely, clear and prioritised communication during critical information sharing, supporting safer and more effective coordination of patient care.

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. NHS Ayrshire & Arran utilise a hybrid approach to documentation where electronic patient care records and paper-based documentation are both used. This was due to ongoing IT issues. This hybrid approach to documentation presents potential risks to patient safety, including duplication of records, loss of information, non-standard approach and inconsistency in escalation parameters across different documentation formats. We observed incomplete data was captured between the electronic and paper documents and staff described significant time spent working between systems to locate and record relevant information. NHS Ayrshire & Arran provided their audit tool utilised to assess the quality of documentation within the service. However, the audit tool did not assess specific aspects of care such as completeness of risk assessments limiting information gained to support improvement work. A requirement has been given to support improvement in this area.

The labour ward is situated on the ground floor and is well signposted from the main hospital entrances. There are seven birth rooms available within the obstetric led unit which also supports bereavement care and an area for the provision of high dependency care and theatre recovery beds. During inspection although labour ward had increased activity, the ward was calm with good visibility of staff and clinical leadership.

A recent publication from the Nursing and Midwifery Council (NMC) in collaboration with the General Medical Council (GMC) highlighted the positive impact of effective communication within the multidisciplinary team on the safe delivery of maternity care. More information can be found here. We were able to attend the labour ward multidisciplinary team morning huddle where the obstetric, midwifery and anaesthetic team were represented. During discussion there was a comprehensive overview of women within maternity services led by the consultant team. The discussion promoted oversight and situational awareness of systems pressures and potential impact on patient experience and outcome. The induction of labour process is a procedure performed to artificially start labour. At the time of our inspection and during our return visit there were no delays to the induction of labour process and we observed evidence of oversight of the induction of labour process being monitored and escalated through the on-call managers documentation and safety huddles.

Antenatal, postnatal and transitional care provision within Ayrshire Maternity Unit is based in one ward situated on the first floor. 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. The area supports babies born above 34 weeks gestation with a birth weight over 1.8 kg to remain within the postnatal ward with oversight from the neonatal unit. NHS Ayrshire & Arran have guidance in place outlining admission criteria to the transitional care area, which was aligned with the British Association of Perinatal Medicine (BAPM) Transition Care Guidance.

Within the transitional care areas there are two family rooms for parents whose babies require care within the neonatal unit which helps to support keeping the family unit together. We observed the availability of reclining chairs and facilities to support partners staying overnight. Siblings were encouraged to visit during visiting time. We observed good utilisation of skill within the multidisciplinary team with maternity care assistants trained and working within the transitional care 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. 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 Ayrshire & Arrans latest perinatal mortality

review report demonstrated compliance of 100% data completeness in relation to maternal ethnicity with the national average for completeness at 97% within the report. The staff described using Language Line to help with translation of women whose first language is not English or using an online translator who could join the appointment online. Maternity staff spoke positively of the use of these translation services to aid communication. Leaflets in multiple languages were available and used appropriately.

Areas of good practice

Domain 1	
1	NHS Ayrshire & Arran have progressed work to implement a dedicated 'red phone' system within maternity triage in an aim to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff.
2	Within the transitional care areas, there are two family rooms for parents whose babies require care within the neonatal unit which helps to support keeping the family unit together.
3	Good multidisciplinary team working with maternity care assistants trained and working within the transitional care area.

Requirements

Domain 1	
1	NHS Ayrshire & Arran must ensure a process is in place to ensure women receive timely access to midwifery telephone assessment.
2	NHS Ayrshire & Arran must ensure effective governance and oversight of activity within the maternity service to support safe delivery of care for women, including, but not limited to maternity triage.
3	NHS Ayrshire & Arran must ensure that patients are provided with the right care, in the right place, at the right time.
4	NHS Ayrshire & Arran must ensure an effective system is in place to ensure patient documentation is accurately completed to support the safe delivery of care.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

Throughout the inspection staff described positive working relationships. Student midwives described a friendly and supportive learning environment. However, some staff described the lack of visibility of senior managers impacted their ability to ask for support at times of high acuity. Staff described support following adverse events as variable and raised time constraints and a lack of feedback following adverse events as barriers to submitting incident reports.

We observed effective multidisciplinary team working in all areas inspected. Staff described positive working relations between midwifery, obstetric, anaesthetic and the health care support team. Inspectors had the opportunity to speak to student midwives who described a friendly and supportive learning environment. Once qualified, they were hopeful of achieving a midwifery post within NHS Ayrshire & Arran maternity services. Student midwives described a relationship of psychological safety with their mentors expressing the ability to raise concerns and questions. Within evidence reviewed we observed consistent positive feedback submitted to NHS Education for Scotland (NES) following medical student placement which resulted in the service being highlighted for excellence by the University of Glasgow.

Trauma can significantly affect a person's emotional and psychological wellbeing and it is therefore essential for services to be sensitive to the experiences of trauma survivors. This was demonstrated during huddles; we observed a proactive approach to trauma-informed practice within the multidisciplinary team morning huddle within labour ward. Individualised care plans were highlighted, discussed and collaboratively accommodated across departments to best meet the needs of each woman. These discussions reflected a compassionate, empathetic and sensitive understanding of individual needs. Inspectors observed evidence of positive staff information and learning opportunities in relation to supporting trauma-informed practice. NHS Ayrshire & Arran have a planned programme of trauma-informed education sessions scheduled for staff to commence in November 2025.

A positive working culture is essential to the safe delivery of care. This has been highlighted through national reports into reviews of maternity care such as Kirkup (2015) and Ockenden (2022). Most staff described an open and supportive culture and a good working environment. Staff reported feeling well supported by their peers with mutual psychological support within the team, describing a commitment to deliver person-centred care. However, staff did not always feel this was possible due to the continuous high workload. In some areas inspected, staff described a disconnect with the senior management team, explaining that the lack of visibility of senior leaders whilst on shift impacted the ability to ask for support at times of high acuity in the absence of the senior charge midwife. From information reviewed, we observed a scoping exercise that was undertaken by senior managers to assess clinical staffs' perception of senior roles and responsibilities in an aim to foster a positive working culture. Anonymous feedback was gathered in the form of a questionnaire which was

open to all nursing, midwifery, medical, health care support and administrative roles. Results provided by NHS Ayrshire & Arran demonstrated up to 39% of staff surveyed were not aware of the roles and responsibilities of the senior management team with qualitative findings showing that staff were concerned regarding lack of visibility and disconnect with the senior management team. In discussion with senior managers, they described ongoing work to strengthen culture within the service. An example of this included shadowing opportunities for staff to experience senior leadership roles. Whilst we acknowledge the positive steps to support a positive working culture, a requirement has been given to support continued improvement.

Current national guidance, including The Royal College of Midwives Re:Birth 'Shared Language for Pregnancy, Labour and Birth' recommendations, highlights the importance of language that is respectful, inclusive, person-centred and supports informed choice. Inconsistent application of this recommended language can undermine patient confidence, create barriers to effective communication and has the potential to impact the quality and safety of care. During the inspection, we observed that staff communicated clearly with women, however terminology used between staff during our inspection was not aligned with current professional language guidance. For example, for the use of the term 'emergency caesarean section,' if applying Re:Birth principles, staff would use terms such as 'unplanned caesarean birth' or 'birthed' as opposed to 'delivered.' A recommendation has been given to support improvement in this area.

The national perinatal mortality review tool is a national tool designed to standardise review and learning following the death of a baby. NHS Ayrshire & Arran utilise the tool for review of all stillbirths and neonatal deaths. We observed families are engaged 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. Within the most recent report supplied in evidence we observed data completeness was demonstrated at 100% and all notifiable deaths were reported within seven days of death. In discussion with the consultant obstetric team, we were informed of an established multidisciplinary governance meeting within the service. This meeting is embedded in practice to ensure multidisciplinary team availability and commitment occurring every Friday morning incorporating risk management, quality improvement and perinatal mortality review. We reviewed evidence that demonstrated board level oversight, with output from these sessions feeding into the overarching NHS Ayrshire & Arran governance meetings.

We were provided with an incident trigger list which aims to encourage submission of an incident form following an adverse event to ensure review and learning is undertaken. Feedback to staff following an adverse event is vital to support learning, improve patient safety and to ensure emotional support of staff is provided. Staff described the use of hot debrief within the service. This is an opportunity to ensure there are no immediate patient safety risks and assuring staff wellbeing. We also observed the use of "focus of the month" and learning summaries to direct specific

learning from reviews. However, staff described support following adverse events as variable and raised time constraints and a lack of feedback following adverse events as barriers to submitting incident reports.

Within the trigger list we noted submission of a patient incident report is requested when a fourth-degree tear is sustained by a woman during childbirth. Obstetric anal sphincter injury defined as a third or fourth degree perineal tear sustained during childbirth 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. Senior managers advised us that oversight of third-degree tears is captured through the service dashboard and implementation of the obstetric anal sphincter injury care bundle which supports oversight and improvement work in this area.

At the time of inspection, Public Health Scotland data reports the instance of an obstetric anal sphincter injury occurs for 3.7% of women who birth in NHS Ayrshire & Arran, which is below the Scottish national average of 3.9% for the same reporting period.

The consistent reporting and learning from adverse events are essential in assuring systematic learning, quality improvement and patient safety within a service. The Healthcare Improvement Scotland: A National Framework for reviewing and learning from Adverse Events National Framework emphasises that all adverse incidents must be reviewed. The extent of each review is determined by the event category and the level of harm caused, with the most serious incidents requiring Significant Adverse Event Review (SAER). Reviews into maternity services such as Ockenden 2022 states incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner. This report further recommends that change in practice arising from an incident investigation should be implemented within six months after the incident occurred. The adverse events framework recommends significant adverse event reviews are completed within 140 working days. Within evidence we observed of the three significant adverse event reviews currently in progress within NHS Ayrshire & Arran maternity services, all exceeded 140 working days. With the longest review currently over 300 working days. These delays can impact significantly on the family involved and delays systematic learning and improvement within the service. A requirement has been given to support improvement in this area.

Shoulder dystocia is within the top two reasons for an incident report to be submitted by staff in the six months prior to inspection. Shoulder dystocia is an obstetric emergency where, after delivery of the fetal head, the shoulders fail to deliver due to impaction behind the maternal pelvis. Emergency scenario training, for example PROMPT (Practical Obstetric Multi-Professional Training) is vital in the maternity setting to ensure staff can respond promptly and effectively to obstetric emergencies, promoting teamwork, preparedness and the delivery of safe, high-quality care. Regular, scenario-based training in the management of shoulder dystocia is essential to ensure that maternity staff can recognise, respond to and resolve this time-critical

obstetric emergency effectively. Overall compliance of this training varied between 80-100% for midwifery staff and 62-67% for medical staff.

Cardiotocograph training is critical to safeguarding fetal wellbeing, supporting consistent interpretation of fetal monitoring and ensuring adherence to clinical governance standard. NHS Ayrshire & Arran provided information of their clinical governance oversight group which highlights core mandatory training such as cardiotocography (CTG) training as an area for improvement. NHS Ayrshire & Arran deliver CTG training over two 'face to face' days. Compliance rates with this training varied between areas inspected and ranged from 40-90% for midwifery staff and between 67-85% for medical staff. The online training package that is expected to be completed by all staff assessing cardiotocographs has a compliance of 69-91% for midwifery staff and 44-69% for medical staff.

Regular and up to date neonatal resuscitation training is essential to ensure staff are competent and confident in responding effectively to neonatal emergencies, thereby supporting safe outcomes for newborns and maintaining high standards of clinical care within the maternity setting. Within evidence reviewed there was variation of compliance rates for Scottish Neonatal Resuscitation Course (SNRC) of between 34-82%. NHS Ayrshire & Arran also deliver an Annual Neonatal Resuscitation course and compliance is currently 75-95%.

Support for learning and development was a concern raised by some staff who described being booked on courses but unable to attend as they were unable to leave the ward as it would compromise patient care and safety. As a result, many staff highlighted that they had not managed to do their mandatory learning and development. Staff described a perceived expectation that they would undertake training in their own time with the hours either paid or could be taken back. Staff told us that they often felt too tired to attend in their own time after finishing their contracted hours. Senior Managers provided up to date compliance rates for training, which showed variable compliance of mandatory training rates including violence and aggression training of between 48-100%.

The inspection has identified several areas where compliance with essential and mandatory training is variable across midwifery and medical staff groups. A requirement has been given to support improvement in training compliance.

Some staff we spoke with described incidents of verbal abuse and aggression from women and families in their care. However, they described a reluctance to report this due to a lack of feedback, support and action from managers. Some staff described feeling burnt out and overwhelmed due to these incidents on top of a very high workload. They explained that they relied heavily on their peers for wellbeing support after these incidences. Some staff reported this resulted in time off work.

Senior managers explained that the Women and Children's page holder is present for any concerns related to violence and aggression and that this is monitored within the page holder's documentation. As detailed within the incident reporting trigger list this

should be a reportable incident. However, within the incident reports submitted six months prior to inspection no forms were submitted in relation to violence and aggression experienced by staff despite staff raising this as a concern with inspectors. As described earlier in domain 1, only two incident reports were reported in the same time frame relating to maternity triage. This appears to be a low number of incident report submissions and may reflect the concerns staff raised with inspectors regarding their reluctance to submit incident reports. We raised management oversight of incident reporting with senior managers at our return visit, through email and as part of our virtual discussion. However, we could not gain assurance of the systems and processes in place to ensure appropriate governance and oversight of the incident reporting system which may have an impact on the learning from adverse events, reducing opportunities to improve safety.

NHS Ayrshire & Arran have previously been given recommendations to improve governance and oversight of adverse events reporting, review and staff training within the 2017 review of Ayrshire Maternity Unit adverse events. A requirement has been given to support improvement in this area.

Through evidence, NHS Ayrshire & Arran provided information describing wellbeing initiatives and how to escalate non-clinical concerns, highlighting access to staff support via their occupational health service and the availability of spiritual care. NES created the national clinical supervision nursing and midwifery frameworks which supports a 'Once for Scotland' approach to implementation, practice and governance of clinical supervision. Clinical supervision is a proactive process to support staff's development and professional growth by offering dedicated time, feedback and guidance in a psychologically safe space to critically reflect practice. The aim is to enable and empower staff to provide high-quality, safe, person-centred care. Through evidence, we observed NHS Ayrshire & Arran provide regular opportunities for staff to attend clinical supervision and that their overall compliance was currently 82%. Medical staff informed us of medical peer support which can result in signposting onto specialised care as required.

Areas of good practice

Domain 2	
4	Student midwives reported positive practice and learning environments and support from staff within clinical areas.

Recommendations

Domain 2	
1	NHS Ayrshire & Arran should consider current guidance around Shared Language for Pregnancy, Labour and Birth.

Requirements

Domain 2	
5	NHS Ayrshire & Arran must ensure ongoing engagement with staff to ensure an open and transparent culture.
6	NHS Ayrshire & Arran 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 within national guidance.
7	NHS Ayrshire & Arran must ensure staff receive time and resources to undertake training essential to their role. This includes protected learning time, monitoring of training completion and consideration of skills and experience.
8	NHS Ayrshire & Arran must ensure governance and oversight of incident reporting and improve feedback to staff who have submitted incident reports through the incident reporting system.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

We observed women and their babies receiving a good standard of care and families consistently expressed positive views regarding the care provided. We observed areas of good practice, with families being supported by staff and wider staff groups to build confidence in their chosen feeding method of their baby.

Quality improvement aims to improve safety, effectiveness and experience of care. Inspectors observed the use of quality improvement and quality assurance boards to communicate current work with staff. We observed quality improvement information boards within the labour ward containing information on the Scottish Patient Safety Programme Quality Indicators and 'focus of the month' to share learning and ongoing quality improvement work within the department. The 'focus of the month' board highlights ongoing work to educate and inform practice. At the time of inspection, this was related to risk assessing for post-partum haemorrhage (PPH) and the management of increasing blood loss. However, most staff described varying levels of awareness of, and involvement in ongoing quality improvement projects.

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. We were provided with audits which maintained oversight of areas for improvement within MEWS score charts which demonstrated a sustained compliance rate of above 85%. During inspection, we observed 94% of the MEWS charts, reviewed by inspectors, had all essential observations complete.

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 (VTE). Learning from the report highlighted a need for continuous evidence-based risk assessment throughout pregnancy and following birth. We asked for evidence of assurance processes in place to monitor compliance with venous thromboembolism risk assessment. We were advised the quality of venous thromboembolism risk assessments are reviewed by the clinical risk management group, during significant adverse event and perinatal mortality reviews. However, senior managers advised there is currently no formal audit process to gain oversight of venous thromboembolism risk assessment compliance. A requirement has been given to support improvement in this area.

We observed food and fluid available to women within all areas of maternity services. The provision of patient lounges in each area creates a non-clinical space that offers women and their families a comfortable space to relax and socialise away from the clinical setting. We observed areas of good practice, with families being supported by staff and wider staff groups to build confidence in their chosen feeding method of their baby.

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 hand hygiene practice with alcohol based hand rub was available throughout Ayrshire Maternity Unit. Personal protective equipment such as gloves and aprons were readily available at the point of care with staff using the personal protective equipment appropriately.

We observed good compliance with safe medication storage throughout the hospital, with all medication trollies and storage cupboards locked in all the areas inspected. Safe medication storage reduces the risk of medication being taken in error by a patient or a member of the public.

Care equipment can be easily contaminated and a source of transferring infection if equipment has not been effectively cleaned. It is essential that patient care equipment is free of damage and cleaned following use and stored safely. In some areas the equipment was dusty and cleaning schedules and daily checks were not fully completed. This was fed back to the midwife in charge at the time of inspection who responded appropriately with the checks completed by the second day of inspection. A requirement has been given to support continuous improvement in this area.

Water flushing regimes support the prevention of the build-up of bacteria within the water system. Evidence provided demonstrated inconsistent water flushing that is not in line with guidance. A requirement has been given to support improvement in this area.

During our onsite inspection we observed that the safe storage of medical gases was not being adhered to. We observed gases being stored on the floor and in rooms that had no signage to indicate that medical gases are stored in the area. We raised this at the time of inspection with the midwives in charge for each area.

Through review of evidence, we became aware that the maternity unit was scheduled for three yearly fire risk assessments. However, this is not in line with NHS Scotland Fire code SHTM 86: Fire Risk Assessment which states that hospitals and other healthcare premises with sleeping accommodation should have a yearly fire safety review. The last fire risk assessment carried out within the maternity unit was in September 2022, with outstanding improvement actions yet to be completed. This included storage of combustible items in plant rooms, staff unable to attend training and fire damper testing had not been subject to regular specified testing and maintenance. We raised this as a serious concern with senior managers who responded by providing confirmation that improvement work was underway on the safe storage of medical gases and other outstanding actions were now completed or due to be completed by March 2026. Senior managers confirmed as a result of the inspection findings, yearly fire risk assessments would now be completed, in line with NHS Scotland Fire code SHTM 86: Fire Risk Assessment and confirmed this had been carried out in December 2025. Staff compliance with online fire safety training was 56-87%. A requirement has been given to support ongoing improvement in this area.

Areas of good practice

Domain 4.1	
5	Families were being supported by staff and wider staff groups to build confidence in their chosen feeding method of their baby.

Requirements

Domain 4.1	
9	NHS Ayrshire & Arran must ensure governance and oversight to ensure venous thromboembolism risk assessment compliance.
10	NHS Ayrshire & Arran must ensure that patient equipment is clean and ready for use.
11	NHS Ayrshire & Arran must ensure infrequently used water outlets are flushed in line with current national guidance.
12	NHS Ayrshire & Arran must ensure fire risk assessments are up to date and fire actions and improvements identified within fire safety risk assessments are addressed.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

We observed evidence of positive clinical leadership across multidisciplinary teams, with senior charge midwives visible and engaged across all wards. Staff described feeling supported to escalate staffing issues and concerns to their senior charge midwife.

We were able to attend the midday safety huddle attended by senior maternity managers, Consultant Neonatologist, Consultant Obstetrician, midwifery and nursing staff. We observed open and honest discussions to support and maintain situational awareness within the service. The huddle included oversight of patient flow, acuity, any emerging patient safety concerns and aligned current and ongoing staffing levels which was inclusive of the full multidisciplinary team. However, the meeting did not include oversight of maternity community services. 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 neonatal unit was closed to admissions of babies external to NHS Ayrshire & Arran due to acuity and staffing within the obstetric unit. We observed detailed conversations between departments to achieve an agreed status for the neonatal unit with planned ongoing discussion to monitor the continued status of the area. Information from the discussions was captured within the maternity units staff huddle document. As part of evidence NHS Ayrshire & Arran provided guidance to support staff with risk assessment and the process for accepting and transferring women between NHS Ayrshire & Arran and other NHS boards.

We had the opportunity to attend the biweekly workforce planning meeting. The meeting aimed to have multi-area oversight and included managers representing all women and children's services. We observed discussion of workforce forecasting which included oversight for bank and supplementary staffing requirements to support and address emerging staffing concerns. Staff described an openness to raise staffing concerns with their clinical management team who would assist and would be supportive with patient care or staff break relief. As discussed within domain 1 of this report we observed delays within the maternity triage department. National institute for Health and Care guidance refers to a 'Delay of 30 minutes or more between presentation and triage' being a red flag event. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. We discussed how staffing concerns are captured and monitored in an aim to provide assurance of safe staffing with senior managers. NHS Ayrshire & Arran captured this within the page holder's documentation. The page holder escalates any concerns and this assurance is reviewed by the Duty Manager daily.

In discussion with senior managers, we were advised that staffing skill mix is assessed as part of staff rostering and reviewed daily to ensure appropriate skill mix is

maintained and mitigated when required. Senior managers also described how this would be captured through the daily staffing huddle documentation and monitored through staffing governance groups.

We discussed with senior managers how oversight of real-time staffing, acuity and safety concern of maternity services feed into the wider hospital safety huddle within NHS Ayrshire & Arran. However, we were informed this is not attended by the service unless period of extremis and at this point the manager of the day would liaise with the wider hospital where required. This approach limits senior managers within the wider hospital oversight of potential risks within maternity services; a requirement has been given to support improvement in this area.

The Health and Care (Staffing) (Scotland) Act 2019 stipulates that NHS boards have a duty to follow the Common Staffing Method (CSM), which includes a staffing level tool run. This is a multifaceted, triangulated approach to analysis of service specific quality, safety and workforce data which includes, but is not limited to, the completion of a specialty specific staffing level tool. The mandated annual application of the CSM and staffing level tools enables NHS boards to better understand and plan the appropriate workforce required to support safe, effective care and the wellbeing of staff in the longer term. NHS Ayrshire & Arran provided staffing level tool runs which were incomplete due to missing data regarding professional judgement. Senior managers were unable to provide assurance in relation to the full and consistent application of the CSM within maternity services. The consistent and complete application of the CSM would support senior managers to better understand and inform appropriate staffing requirements at all Agenda for Change bands within the midwifery team. A requirement has been given to support improvement in this area.

Workforce data reviewed demonstrates a significant number of staff 51.41(%) are over the age of 55 and are preparing for retirement. NHS Ayrshire & Arran evidenced clear forecasting of this experience shift within the workforce and have made plans to actively recruit student midwives as part of a wider succession plan. Proactively planning succession for an ageing maternity workforce ensures continuity of specialist skills, protects the quality and safety of patient care and supports stable service delivery during staffing transitions.

To support the safe delivery of care within maternity service during staff shortfalls, staff described frequently being moved to different wards to work part of, or all of their shift. Staff having the right skills and knowledge within their area of practice is essential in the safe delivery of care. 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. Within the midwifery workforce we observed compliance with appraisal varied from 33% to 50% within the departments inspected over the last 12 months. NHS Ayrshire & Arran recognise appraisals as an area for improvement and have and improvement plan in place to

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

Areas of good practice

Domain 4.3	
6	We observed proactive succession planning.

Requirements

Domain 4.3	
13	NHS Ayrshire & Arran must ensure oversight of potential risks within maternity services are consistently captured within the wider hospital safety huddle.
14	NHS Ayrshire & Arran 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.
15	NHS Ayrshire & Arran must ensure that there are processes in place to support consistent annual application of the common staffing method, demonstrating triangulation of all relevant service specific quality, safety and workforce data.
16	NHS Ayrshire & Arran must ensure clinical leaders within maternity services have appropriate protected leadership time to fulfil their leadership and management responsibilities. This will include consistent monitoring and recording of when and why this is sacrificed as part mitigation for staffing shortfalls.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

The women we spoke with told us they felt listened to and supported in making decisions about their care. All women described positive experiences of communication and compassionate interactions with staff. Women and their families told us they would be happy to recommend NHS Ayrshire & Arran maternity services to their family and friends. We observed good practice and oversight of the contraception service delivery.

All interactions we observed between women, babies and families were positive and respectful. Women we spoke with described staff as being responsive to their needs and spoke highly of the staff and the care provided. Women described receiving good communication from the multidisciplinary team, receiving assistance when required and access to analgesia when needed.

We observed staff working hard to provide compassionate, responsive and respectful care. Women, families and visitors that we spoke with were complimentary about staff and the care provided. Inspectors observed staff taking time to answer any questions

and allowing the women and families time to ask further questions and drawing curtains as required. Each room had access to a patient and emergency call system.

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, provided within a bespoke, sound proofed room. Almost all the care can be provided here unless there is a clinical need to move the woman for increased care such as increased analgesia or high dependency level care. Within the room there are elements of information to support ongoing care, gain feedback and allow staff to spend time with the family in a comfortable, less clinical setting. Staff work closely with Ayrshire Baby Loss who work alongside Sands. We observed the service had a system in place to signal to the multidisciplinary team a current or previous bereavement had occurred. We were informed of a team of midwives with enhanced bereavement training who can specifically support families and staff who are caring for them, and we observed discussion to ensure a midwife with bereavement training was available on each clinical shift to ensure bereaved families and staff had access to a specialised midwife. Staff conveyed a sense of pride in the bereavement service, reflecting strong ownership in this essential component of the maternity service. However, bereavement training compliance rates for staff groups could not be provided. 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.

We observed evidence of family-centred care throughout maternity services including the labour and postnatal ward where parents had the option to stay overnight, supporting the family unit. It was evident that staff were aware of how positively this impacts the family's experience.

The Faculty of Sexual and Reproductive Health (FSRH) states that ‘effective contraception should be commenced as soon as possible after birth.’ Due to the rapid return of fertility, The FSRH, in collaboration with The Royal College of Midwives (RCM) and The Royal College of Gynaecologists (RCOG), produce guidance for healthcare professionals to recommend that effective contraception should be discussed and offered prior to discharge from maternity services. This enables women to plan any subsequent pregnancies and avoid short interpregnancy intervals which are associated with poorer pregnancy outcomes. The provision and ease of access to effective contraception within maternity services offers an opportunity to reduce health inequalities. We observed that maternity staff were proactive in discussing contraception with postnatal women. Within the staffing huddle we observed discussion to ensure midwives trained in being able to provide contraception to women, were highlighted and available to provide the service.

Areas of good practice

Domain 6	
7	All interactions we observed between women, babies and families were positive and respectful.
8	We observed a dedicated family room for bereaved families.
9	Parents had the option to stay overnight, supporting the family unit.
10	We observed that maternity staff were proactive in discussing contraception with postnatal women.

Recommendations

Domain 6	
2	NHS Ayrshire & Arran should improve bereavement training compliance rates for all staff providing bereavement care to families

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, May 2022)
- Intrapartum care (NICE guideline, June 2025)
- 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, July 2009)
- Operating Framework: Healthcare Improvement Scotland and Scottish Government: (Healthcare Improvement Scotland, July 2023)
- 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)

Published February 2026

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email contactpublicinvolvement.his@nhs.scot

Healthcare Improvement Scotland

Edinburgh Office	Glasgow Office
Gyle Square	Delta House
1 South Gyle Crescent	50 West Nile Street
Edinburgh	Glasgow
EH12 9EB	G1 2NP
0131 623 4300	0141 225 6999

www.healthcareimprovementscotland.scot