Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Victoria Hospital

NHS Fife

02 – 03 December 2025

Published March 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. 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

Victoria Hospital in Kirkcaldy is the main acute hospital within NHS Fife. The hospital has 534 staffed beds. The hospital provides a range of outpatient, inpatient and day services such as emergency care, renal services, critical care, haematology and women

and children's services. The maternity services provided support for approximately 2700 births in 2024/25.

About this inspection

We carried out an unannounced inspection to Victoria Hospital, NHS Fife on Tuesday 2 December and Wednesday 3 December 2025 using our safe delivery of care inspection methodology. We inspected the following areas:

- Consultant led delivery unit
- Maternity triage, and
- Maternity ward – combined antenatal and postnatal.

During our inspection, we:

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

As part of our inspection, we also asked NHS Fife 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 26 January 2026, we held a virtual discussion session with key members of NHS Fife 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 Fife, and in particular all staff at the Victoria 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.'

We observed staff providing compassionate and responsive care to women and their families. Women and families whom we spoke with were complimentary of the care

they received and would recommend NHS Fife maternity services to family and friends.

Senior obstetricians and senior midwifery managers were visible and clinically active, working with the multidisciplinary team to provide person-centred care to women and their families. Good teamwork between obstetricians, midwives and the health care support team was evident throughout the inspection. Visible senior obstetrics and midwifery leadership with respectful and supportive interactions between the teams were observed.

Staff, newly qualified practitioners, and students described respectful working relationships with senior managers and the multidisciplinary team, feeling well supported and able to raise concerns.

During inspection we identified some areas for improvement. These include improvement to the maternity triage department to support the continued improvement of patient safety and communication as well as a dedicated midwife for telephone triage. We also identified maternity and site wide huddles require improved oversight of how maternity services safe staffing oversight is achieved and how these feed into the wider site huddle.

Staff were actively engaged with their own learning and development. However, staff require time to complete their mandatory training, and clinical leaders require protected time to lead to fulfil their leadership roles.

Further improvements are required to ensure timescales of incident reviews and significant adverse event reviews are achieved. This includes feedback to staff and completion of action plans to support and improve the safe delivery of care.

Other areas for improvement include assurance of fire safety requirements.

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

This inspection resulted in ten areas of good practice, two recommendations and 13 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 Fife 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 Victoria Hospital resulted in ten areas of good practice.

Domain 1	
1	NHS Fife has implemented a dedicated 'red phone' system within maternity triage to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff (see page 15).
2	We observed a family-centred approach recognising the importance of, and encouraging, fathers, co-parents, partners and family members to be partners in care (see page 15).
3	Staff were observed providing responsive, person-centred care (see page 15).

Domain 2	
4	Student midwives reported positive practice and learning environments and support from the multidisciplinary team within clinical areas (see page 19).
5	We observed an open and transparent culture with respectful, multidisciplinary team communication (see page 19).

Domain 4.1	
6	We observed implementation of system to raise awareness of newborn babies who require increased observations (see page 23).

Domain 4.3	
7	Staff reported the leadership team are supportive and responsive when staff required to raise concerns (see page 26).

Domain 6	
8	In all areas inspected, we observed staff working hard to provide compassionate, responsive and person-centred care (see page 29).
9	Women, families and visitors that we spoke with were highly complementary of the multidisciplinary team and the care provided (see page 29).
10	Women and families were supported by staff to build confidence in their infant feeding choice (see page 29).

Recommendations

The unannounced inspection to Victoria Hospital resulted in two recommendations.

Domain 1	
1	NHS Fife should consider improving bereavement training compliance rates for all staff providing bereavement care to families (see page 15).

Domain 6	
2	NHS Fife should consider improving trauma informed training compliance rates for all staff (see page 29).

Requirements

The unannounced inspection to Vicotria Hospital resulted in 13 requirements.

Domain 1	
1	NHS Fife must ensure the ongoing oversight and governance in maternity triage to support the safe delivery of care (see page 15). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) criteria 2.5 and 2.6.

Domain 2	
2	NHS Fife must ensure timescales of incident reviews and significant adverse event reviews are achieved. This includes feedback to staff and action plans to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland's National Framework (see page 19). 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 and 2.6.
3	NHS Fife must ensure they facilitate a consistent supporting structure for staff following adverse events (see page 19). 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.

4	NHS Fife must ensure ongoing oversight of care assurance data; this includes but is not limited to: (i) Apgar specific data (see page 19). 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 and 2.6.
5	NHS Fife must ensure that improvement points from patient feedback are utilised to guide structured learning and improvements (see page 19). 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.

Domain 4.1	
6	NHS Fife must ensure that employees receive time and resources to undertake training which is essential to their role (see page 23). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
7	NHS Fife must ensure staff carry out mandatory fire safety training and that all fire exits are free of obstructions (see page 23). 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).
8	NHS Fife must ensure that equipment used is safe and suitable for its purpose, including when placing baby mats and scales on appropriate equipment to ensure patient safety (see page 23). This will support compliance with: Health and Social Care Standards 2018.
9	NHS Fife must ensure that all staff comply with hand hygiene in line with the National Infection and Prevention control manual (see page 24). This will support compliance with: National Infection and Prevention Manual.
10	NHS Fife must ensure all hazardous cleaning products are securely stored (see page 24). This will support compliance with: Control of Substances Hazardous to Health (COSHH) Regulations 2002.

Domain 4.3	
11	NHS Fife must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real-time staffing risk across all clinical professional groups within maternity services. This is to support consistent management of any identified staffing risks and must include: • recording any escalation, mitigation and or inability to mitigate, and communication of outcomes to all relevant teams • a record of any disagreements with decisions made (see page 27). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
12	NHS Fife must ensure that there are processes in place to support the consistent application of the common staffing method. This should include but not limited to: • the correct application of running the mandated staffing level and professional judgement tools • a reporting template demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement (see page 27). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
13	NHS Fife 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. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls (see page 27). 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 good multidisciplinary team working to deliver person-centred care. However, improvement in oversight and governance of maternity triage is required.

Maternity triage within Victoria Hospital is located on the first floor and was well signposted from the maternity entrance to direct the public. Triage is a specialised assessment area which provides 24 hours a day, seven days a week unscheduled (emergency) care to women during pregnancy and within the postnatal period. The department provides care to pregnant women from 14 weeks of pregnancy until birth and from birth to six weeks postnatal. The service has access to one assessment room; one four bedded bay and three single rooms, which are available for review of any attendees. There is currently no national standardisation of maternity triage system available. However, the Royal College of Obstetricians and Gynaecologists good practice paper and the National institute for Health and Care guidance recommend each board develops their own guidance based on an evaluated system. Further information can be found here.

The service is accessed following a telephone assessment carried out by midwives, allowing maternity staff oversight of women attending. However, the dedicated service is only available between the hours of 07:00 – 01:00. Outwith this time calls are transferred to the midwifery led labour ward where calls are answered by a midwife. The Royal College of Obstetricians and Gynaecologists recommends that telephone triage is undertaken by a midwife dedicated to and experienced in triaging calls. During onsite inspection staff advised us that the lack of a dedicated midwife to carry out the telephone assessment at times of high acuity and outwith the dedicated opening times can lead to missed calls or an engaged tone, requiring women to call back. In an aim to understand the impact this has on women accessing the service, senior managers have undertaken an audit of missed calls. As a result of the audit findings, work is ongoing towards improving the phone service. This will ensure women who contact maternity triage and previously have received an engaged tone, will hear an options message, for example to press 1 for the maternity led unit and to press 2 for the consultant led unit. The need for a dedicated maternity triage system 24 hours a day, seven days a week has been acknowledged by the senior management team who are currently scoping the implementation of an evaluated triage system within NHS Fife. A requirement has been given to support improvement in this area.

The service utilises a standard maternity electronic patient record communication log to record telephone conversations. The senior charge midwife undertakes several audits, such as telephone advice audits, to monitor the quality and accuracy of advice provided. In evidence submitted, audit results demonstrate the advice provided by midwives complies with the board's policies, guidelines and that staff have an average

documentation compliance rate of 90% in the six months prior to the inspection. Where any learning needs are identified through audit these are actioned by the senior midwife supporting continuous learning and development.

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. On admission to maternity triage, best practice guidance from the Royal College of Obstetricians and Gynaecologists and the National Institute for Health and Care Excellence (NICE) recommends a prompt and brief assessment is carried out on arrival to assess the clinical urgency by which women should be reviewed. Within NHS Fife the service aims for women to be seen within 20 minutes of arrival by a midwife. This triaging process is often supported by a healthcare support worker who completes vital observations on admission. Through review of evidence submitted by the board, audit results from June to November 2025 demonstrate that more than 80% of women are seen within this time. We observed this audit data was also displayed within the patient waiting area to allow patients and staff oversight of the aims and outcomes of their care.

Inspectors observed staff utilising a white board in the staff duty room which captured expected attendees as well as women attending the department. The board is intended to provide situational awareness for midwifery, obstetric and clinical support staff of the women expected to attend the department whilst also allowing welfare checks to be undertaken where necessary. However, although there was a system in place to identify women requiring medical review, there was no consistent approach to prioritisation of clinical urgency assigned to each woman. At the time of inspection we did not observe delays to medical reviews. Evidence provided by NHS Fife demonstrated the regular use of quality assurance audits to assess delays women may face within the department. The audits have identified instances of delays of medical review during June to November 2025. However, the lack of consistent approach to prioritisation of clinical urgency means potential medical delays cannot be effectively and consistently identified within the audit process and therefore audit outputs can provide only limited assurance.

A quality-of-care review was undertaken by NHS Fife in September 2025. This outlined required improvements to maternity triage to ensure effective oversight and governance within the area. As part of this, NHS Fife has taken steps to introduce The Birmingham Symptom Specific Obstetric Triage System. This is an evaluated system that assesses and prioritises pregnant and recently postnatal women with unexpected problems or concerns. The aim of this standardised system is to improve safety, efficiency and communication.

Best practice described by the Royal College of Obstetricians and Gynaecologists recommends only women requiring unscheduled care are seen within maternity triage to prevent competing priorities and to allow for the provision of focused unscheduled emergency care. However, NHS Fife triage department covers out of hours scheduled day appointments during the weekends. During discussions with the senior managers

they were aware that at times of high acuity this contributed to competing demands on staff. However, they were unable to provide assurance around the impact on care. A requirement has been given to support governance and oversight in this area.

NHS Fife has implemented 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 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. A further national consideration from the fatal accident enquiry recommended health boards consider recording triage calls to support quality improvement and learning from adverse events. Following work undertaken through their quality-of-care review, NHS Fife has secured funding to introduce call recording within maternity triage which will be implemented in January 2026.

The consultant led delivery unit within Victoria Hospital is situated on the first floor and is well signposted from the maternity entrance. Each of the seven ensuite birth rooms has space to enhance mobility and movement around the room and make access easy in emergency situations. Within the birthing rooms resuscitaires are in place. This family integrated approach reduces unnecessary separation of mother and baby whilst ensuring any immediate resuscitation and stabilisation needs for the baby are initiated promptly when required.

Obstetric emergencies are time sensitive, and 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 stored safely and appropriately.

The induction of labour suite is located alongside the consultant led unit. It comprises of four single rooms with ensuite facilities including baths and had multiple aids for mobilising during the induction process. Induction of labour is a practice that is undertaken to artificially induce labour; this can be in response to concerns with the mother or unborn baby's health. NHS Fife offer an induction of labour leaflet which informs women that delays to the procedure may occur and the process for women to follow if they have any concerns.

At the time of inspection there was no delays to the induction of labour process. Within evidence, NHS Fife provided guidance which supports the escalation of staffing risk concerns to support the safe delivery of patient care. Staff we spoke with were aware of the escalation process in the event of delays to induction. Senior managers advised us 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. We asked NHS Fife 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 2.2% of all reported incidents related to delays to induction of labour process however the impact was unclear. The service has over several years aimed to improve their induction of labour process and to reduce delays by, but not limited to, introducing a dedicated team who cares for women admitted for induction of labour, implementing a more effective appointment system and welcoming partners to stay overnight.

The observation bay is located within the consultant led delivery unit. The four bedded bay is well organised; all bed spaces had working call bells and bathroom facilities. The area is staffed by the midwifery observation team in collaboration with the multidisciplinary team. The observation bay supports mothers and babies being kept together. Maternity staff working in the area had previously been on courses to upskill in critical care. However, staff advised us that due to the limited frequency of women being admitted with higher dependency levels, retaining skills and upkeeping competence might at times be challenging for midwives. We observed a system of close working with the multidisciplinary team which staff spoke highly of.

The classification of urgency for caesarean birth in the UK is based on the potential risk to mother or baby. Planned caesarean births are scheduled at a time to suit the woman or healthcare provider. Within NHS Fife women are admitted for planned caesarean births every weekday with dedicated midwifery staffing to provide care of women admitted to the service. However, there is only dedicated obstetric, anaesthetic, theatre staff and theatre availability on a Wednesday. Obstetricians, anaesthetists and senior midwives shared their concerns about the lack of dedicated workforce resources and theatre allocation to consistently support planned caesarean births through the week. Staff told us that the lack of a dedicated team and theatre directly affects the service due to competing demands and the need to prioritise the provision of emergencies and scheduled work. This results in planned caesarean births often being postponed or rescheduled to another day. When this occurs, mitigations are in place to assess the safety of maternal and fetal wellbeing through antenatal assessment, fetal monitoring and review of current clinical priority by the obstetric team. In 2024, 16% of all births in NHS Fife were planned caesarean births with 11 women cancelled on the day and allocated a new date as soon as clinically possible. In review of incident reports submitted, no incident reports were related to delays or cancellations of planned caesarean births. Senior managers are currently progressing the issue through governance meetings for board oversight and requesting a current resource review.

The vision for maternity services across Scotland is set within The Best Start: A five-year forward plan for maternity and neonatal care in Scotland, recommending parents and babies are offered truly family-centred and compassionate care. We observed no restrictions to visiting and there were options within the service encouraging a family-centred approach, recognising the importance of, and encouraging fathers, co-parents, partners and family members to be partners in care.

The maternity ward is a combined antenatal and postnatal ward with 13 beds. It is located on the second floor with clear signage from the main maternity entrance. During inspection, the ward was at capacity but was calm with maternity staff and clinical leadership visible and engaged within the ward. Staff were observed to provide responsive, person-centred care. Discharges were managed in a timely manner with women and families commending their care.

Transitional care is provided in the maternity ward with between three and seven babies admitted per month. Transitional care is available for babies requiring extra care but not admission to the neonatal unit. This supports mothers and babies to remain together whilst receiving the necessary care.

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. Within the Women's and Children's health directorate a dedicated bereavement lead is in place who provides direct support to bereaved families. The lead has undertaken several self-assessments to benchmark NHS Fife against the nine overarching bereavement care standards set out within the national bereavement care pathway. The audit provision against these standards supports improvement in the bereavement care offered where gaps are identified. An annual bereavement learning day as well as bimonthly update sessions are offered. This is in line with Key Action 32 which highlights that all staff who come into contact with bereaved families should be supported to access this. NHS Fife has reported that attendance fluctuates as the learning day is not mandatory and releasing staff is not always possible with many staff instead attending learning in their own time. In 2025, 49% of midwives and 10% of obstetric consultants attended the bereavement update session. We raised this with the senior leadership team who acknowledged the challenges the service face with releasing staff for learning and development. We were told staff can choose to be paid for attending outwith their shifts however the leadership team did recognise this is not a suitable solution for all. A recommendation has been given to support improvement in this area.

Held in our Hearts is a Scottish charity providing baby loss counselling and peer support to families. NHS Fife is one of four boards in Scotland who, in partnership with Held in our Hearts, has secured funding for and is offering a Hospital to Home service. It aims to support the transition from hospital to home, ensuring that all families have the right bereavement support in the early days and weeks following their loss.

The Cherry Blossom bereavement suite benefits from its own entrance and provides a private area to discuss care options, birth and spend family time following the death of a baby. Staff spoke passionately about supporting women and families experiencing the death of a baby and described opportunities for families to make memories, including taking photographs and using memory making boxes. The area has an interactive memorial mural where families are invited to add their fingerprint blossom

to the branches of the tree before leaving the unit. The mural symbolises a collective expression of love, remembrance, support and community of care for bereaved families and their babies.

Areas of good practice

Domain 1	
1	NHS Fife has implemented a dedicated 'red phone' system within maternity triage to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff.
2	We observed a family-centred approach recognising the importance of, and encouraging fathers, co-parents, partners and family members to be partners in care.
3	Staff were observed providing responsive, person-centred care.

Recommendations

Domain 1	
1	NHS Fife should consider improving bereavement training compliance rates for all staff providing bereavement care to families.

Requirements

Domain 1	
1	NHS Fife must ensure the ongoing oversight and governance in maternity triage to support the safe delivery of care.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

We observed an open and transparent culture where maternity and obstetric senior managers were visible, aiding support and care provision throughout our visit. We observed areas for improvement in the timely review of incident reports and a consistent process for staff support following adverse events.

A positive working culture and psychological safety is essential to the safe delivery of care and has been evidenced within the reviews into maternity services by Kirkup (2015) and Ockenden (2022). Psychological safety is the ability of all staff groups to feel free to speak up, ask questions, report errors, raise concerns and ask for feedback without fear of consequences or being judged. During inspection staff described a positive and supportive workplace and described NHS Fife 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 Fife 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 are key in all clinical areas where there may be multiple issues which require prioritisation and planning. Throughout the inspection, midwives and obstetricians were noted to be working well together. They shared good oversight of how and when they would contact other teams including anaesthetists, theatre teams and senior managers if the need should arise during an emergency.

We spoke with student midwives during the inspection who spoke very positively of their learning placement and support from the multidisciplinary team within clinical areas, some having requested to come to NHS Fife. Newly qualified midwives also reported feeling well supported during their employment and being able to raise any concerns and questions. The senior leadership team recently undertook a survey to explore newly qualified midwives' views and experiences of their rotation at NHS Fife to inform future rotations and support colleagues effectively.

Most staff described a supportive working culture where staff wellbeing was promoted through a range of initiatives. Greatix is a reporting mechanism designed to capture positive feedback within healthcare settings, aimed at encouraging peer-to-peer recognition among staff. Staff are actively encouraged to use Greatix to share positive feedback and a positivity box to write a positive note or thank you to any staff member who they feel has worked well or supported them. Through evidence submitted, we observed evidence of culture work sessions undertaken by the extended leadership team demonstrating an investment to understand and enhance their workplace culture. These sessions covered a wide range of topics and activities assessing what is working well, what could be better and any actions to enhance culture. A 'Civility Saves Lives' day has been planned for their next session which also includes the senior charge midwives. Civility Saves Lives is a clinician led initiative that raises awareness of the impact that behaviour, including incivility, has on staff and patients and how respectful, compassionate communication and leadership improves workplace culture, improve individual and team performance and in doing so, improves patient care.

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 adverse event 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. The most serious events are categorised as level one, requiring a significant adverse event review which should be completed within 140

working days. In evidence provided, we observed that there were delays for some significant adverse event reviews action plans to be completed, in one instance by over two years due to constraints within the neonatal service. A requirement has been given to support improvement in this area.

We spoke with staff who discussed feeling able to submit incident reports without concern and would receive constructive feedback on these once they had been reviewed by the senior charge midwife or risk manager. Within evidence, we observed monthly senior managers oversight of the volume of submitted incident reports and discussion of these were evident in minutes of clinical governance meetings. However, in review of evidence, we observed that NHS Fife has a delay of up to four months in reviewing level two incidents which should have a review completed within 30 working days and level three incidents which should have reviews completed within 10 working days. This delay limits timely improvement, feedback and learning. In discussion with senior managers, they described oversight of all submitted incident forms which allows for immediate patient safety concerns to be addressed. However, the delay to complete the review of these incidents remains. A requirement has been given to support improvement in this area.

The obstetric and midwifery teams spoke highly of their immediate peers for support following adverse events. Senior midwives discussed the use of wellbeing “check-ins” and reaching out to staff involved in adverse events to ensure staff wellbeing. However, most staff reported mixed feedback of formal support received following adverse events. Within evidence reviewed, an Acute site wide staff survey from August 2025 explored staffs' experiences of support following an adverse event. The outcome of the survey demonstrated that some staff felt an inconsistent level of support was provided, some had to ask for support and many would welcome a more consistent and timely support structure. Learning and development sessions for senior midwifery staff to enhance their competencies to support staff after adverse events have been arranged. A requirement 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 Fife submits all data in relation to perinatal deaths and uses the perinatal mortality review tool to support adverse events reviews. In discussion with senior managers, they advised us that they have recently commenced a meeting to review audits, electronic fetal monitoring reviews and any issues to enhance knowledge and learning between the teams. The maternity services arrange weekly clinical risk multidisciplinary meetings to discuss cases as well as monthly Maternal Morbidity and Mortality Review Group meetings. The clinical risk team reviews and analyses trends, themes and produce learning summaries which are shared with all staff through clinical governance meetings, newsletters and study days. The service also arranges a monthly medical and midwifery meeting where cases and learning are shared with all staff to promote a culture of safe delivery of care.

An environment of learning and openness was discussed and all staff we spoke with demonstrated an awareness of the importance of this and recognised how it supports

improvements of patient care and safety. Skills and drills sessions are undertaken weekly by the senior charge midwife with the team on duty to help support interim learning and awareness of any emergency situations that could arise. As part of the inspection, we have observed the written feedback from attendees, which demonstrates that staff find the sessions supportive and that they improve clinical skills and confidence.

Public Health Scotland published data (September 2025) highlights that maternity services at NHS Fife have a higher than Scottish average percentage of babies with an Apgar score below seven at five minutes. An Apgar score is an assessment tool to evaluate a newborn's condition immediately after birth. It assesses five criteria: appearance, pulse, grimace, activity and respiration resulting in a score between zero and 10. A score at five minutes after birth of seven and above is considered normal, whilst a score below seven is considered low and may indicate a need for support and observations of the newborn in the postnatal period. In the Public Health Scotland data, we observed that since the reporting period April to June 2024, NHS Fife has had a higher incidence of babies with an Apgar score below seven at five minutes compared to the Scottish average. The latest reporting period April to June 2025 prior to the inspection demonstrated that 4.1% of babies in NHS Fife had an Apgar score below seven at five minutes, compared to a Scotland average of 2.2%. We raised this with the management team who were aware of this trend in data. As a result, senior managers have undertaken quality assurance audits to assess any immediate action required. However, initial analysis of the data has not identified a root cause. In response, the service has recently updated their incident reporting trigger list to support continued oversight in this area. A requirement has been given to support continued improvement in this area.

Listening to service users is a key component in a quality management system and in improving the quality of services. As part of the inspection, we noted the compliments and complaints NHS Fife received in feedback from women and families. These are summarised and displayed on posters to staff every month. Within evidence we observed the last three posters displayed prior to the inspection. Whilst there were many service users highlighting positive examples of commendable care by staff, there were consistent themes emerging of incidents of poor communication or conflicting advice being raised as areas for improvement. In the evidence received from NHS Fife, there is acknowledgement of patient feedback in the clinical governance papers, however actions on improvements to address these were not clear. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 2	
4	Student midwives reported positive practice and learning environments and support from the multidisciplinary team within clinical areas.
5	We observed an open and transparent culture with respectful, multidisciplinary team communication.

Requirements

Domain 2	
2	NHS Fife must ensure timescales of incident reviews and significant adverse event reviews are achieved. This includes feedback to staff and action plans to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland's National Framework.
3	NHS Fife must ensure they facilitate a consistent supporting structure for staff following adverse events.
4	NHS Fife must ensure ongoing oversight of care assurance data; this includes but is not limited to: (i) Apgar specific data.
5	NHS Fife must ensure that improvement points from patient feedback are utilised to guide structured learning and improvements.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

We observed staff working hard to support and improve the safe delivery of care. Improvements with regard to adherence to fire safety regulations and risk assessments including an increase in fire safety training are required.

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. Through evidence received, we observed the maternity services at NHS Fife have up to date policies and guidelines in place. Staff knew how to access these and how to raise concerns.

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 above 95% compliance with venous thromboembolism assessments. The patient safety incident reports submitted did not highlight any submissions or concerns relating to thromboprophylaxis being omitted.

The Scottish Patient Safety Programme is a national quality improvement programme which aims to improve the safety and reliability of care and reduce harm. Through its perinatal programme they, amongst other measures, request data for all postpartum haemorrhages which occur from 1500ml and above in an aim to reduce morbidity and mortality related to maternal haemorrhage following childbirth. Improving quality requires a robust and methodical approach. Following review of NHS Fife's incident reports, we observed the service has oversight of postpartum haemorrhages from 1000mls. Postpartum haemorrhages above 1000ml relates to 64.7% of all submitted incidents with incidents of postpartum haemorrhages above 1500ml constituting 20.4% of reported incidents during the six months prior to our inspection. NHS Fife reports data of all blood loss above 1500ml to the Scottish Patient Safety Programme. In review of evidence submitted, we observed the service demonstrating an ongoing commitment on reducing postpartum haemorrhage rates by implementing a postpartum haemorrhage bundle and ensuring all patients have completed risk assessments, staff drill and skills learning opportunities, monitoring data as well as reviewing incident reports to facilitate ongoing learning and improvement.

The Scottish Maternity Early Warning Score is a bedside screening tool which supports observation of physiological parameters such as blood pressure and heart rate. The aim of this is to improve the recognition of pregnant and postnatal women at risk of clinical deterioration, facilitating early intervention to improve outcomes. The Scottish Maternity Early Warning Score is recorded on the electronic patient record and will highlight any further action which is required. In evidence submitted, we observed good compliance with the correct completion and escalation of Scottish Maternity Early Warning Score charts. In maternity triage, monthly audits of compliance with appropriate escalation demonstrate progress from 57.1% in September to 96.4% in November with the service working towards demonstrating a sustained improvement over time.

As part of the inspection, we observed innovation to support quality improvement. An example of this included the implementation of a system to raise awareness of newborn babies who require increased observations. This was represented by either a green, amber or red coloured teddy bear attached to the relevant bed space. Staff highlighted that using the bear was a helpful visual aid to raise awareness of care required as well as providing a visual ward oversight for the multidisciplinary team, enhancing care and collaboration.

Obstetric anal sphincter injury can significantly impact a woman's physical and emotional wellbeing and can lead to long term complications such as faecal incontinence, pain and psychological distress. In April 2025 NHS Fife introduced an

obstetric anal sphincter injury learning package in an aim to improve knowledge and outcomes related to obstetric anal sphincter injuries. Subsequent monthly data indicates a downward trend in obstetric anal sphincter injuries rates, decreasing from 4.9% in March 2025 to 1.7% by August 2025. We observed the service has recently updated their incident reporting trigger list to ensure obstetric anal sphincter injuries are now a reportable incident.

SBAR (Situation, Background, Assessment and Recommendation) is a structured communication method used in maternity services to ensure effective handovers between healthcare professionals. Within maternity services at NHS Fife, SBAR communication was noted to be used at each handover of care. This was verified by the receiving and discharging midwife. Inspectors observed that staff had awareness of the need to check any specialist review notes prior to discharge to ensure any plans which have not been added into the SBAR have been considered.

Staff we spoke with told us they are encouraged to undertake regular training including mandatory training, however there are times when it is not possible to release staff from their clinical work. 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 Fife demonstrated varying rates of compliance within the maternity services. 80% of the midwifery and 72% of the 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 are 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 Fife provided evidence that 64% of midwives had completed the yearly fetal heart monitoring training and 67% the two-yearly requirement. 100% of obstetric staff had undertaken the fetal monitoring training. Neonatal resuscitation compliance rates for midwives were 69% within the yearly requirement and 75% compliance rate for the four yearly neonatal resuscitation requirements. 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 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. From evidence we observed the last fire risk assessment was

undertaken in July 2025. During inspection we observed that due to the layout of the maternity ward, no storerooms for larger pieces of equipment are available, which has resulted in equipment being accommodated in the ward corridor. Within the main corridor, there were items awaiting uplift from the estates department. In discussion with the senior charge midwife this has been raised to estates on several occasions. We note this was also detailed as an area for action within July's fire risk assessments. We raised this in discussion with senior managers who acknowledged the need for further focus to ensure adherence to legislative requirements. A requirement has been given to support improvement in this area.

All staff should be aware of fire evacuation processes and maintain up to date fire safety training modules. Staff e-learning training compliance for fire safety varied between 53% to 83% in the clinical areas inspected. The fire risk assessment from July 2025 highlighted the need to facilitate staff fire drills in discussion with senior managers who acknowledged the need for further focus to ensure adherence to legislative requirements. A requirement has been given to support improvement in this area.

During onsite inspection, medicines were observed to be stored in locked cupboards inside an appropriately locked preparation room which was pass controlled. Medicines for each patient are stored in locked bedside cabinets and dispensed from there. Medicines required to treat obstetric emergencies were appropriately stored in the preparation room and were able to be accessed if needed.

Mealtimes were well organised. Staff highlighted that it was easy to obtain specialist meals for women with differing dietary requirements. Women were able to have snacks such as tea, toast and sandwiches as they wished.

Care equipment can be easily contaminated and a source of transferring infection if equipment has not been effectively cleaned. During inspection, patient care equipment was clean and ready for use. However, it was observed that baby scales and baby changing mats were placed on trolleys which had no brakes. This was discussed with staff and the senior charge midwife as a concern that the trolleys cannot be secured during use and could result in injury. The senior charge midwife advised inspectors that they would action this. A requirement has been given to support improvement in this area.

Storage issues within clinical areas resulted in equipment being stored in corridors within wards, however this did not appear to cause any obstruction or impact on the safe delivery of care.

Hand hygiene is an important part of standard infection control precautions to reduce the risk of infection as outlined in the National Infection and Control Manual. In evidence submitted, the service demonstrates a 100% compliance with hand hygiene procedures between May and October 2025. However, inspectors observed there were some missed opportunities to perform hand hygiene at important moments before and after patient care. This was fed back to the senior charge midwife at the

maternity ward as an area of monitoring. A requirement has been given to support ongoing improvement in this area.

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

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 stipulate that chlorine-based cleaning products must be stored securely and 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 an unrestricted access sluice but in a lockable cupboard, however the cupboard was unlocked and the key accessible. A requirement has been given to support improvement in this area.

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 stored appropriately when not in use.

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.

NHS boards are required to have water safety systems in place for the control and management of risks posed by waterborne organisms that may cause disease. Evidence submitted by NHS Fife demonstrate compliance with water flushing regimes in the areas inspected.

Areas of good practice

Domain 4.1	
6	We observed Implementation of system to raise awareness of newborn babies who require increased observations.

Requirements

Domain 4.1	
6	NHS Fife must ensure that employees receive time and resources to undertake training which is essential to their role.
7	NHS Fife must ensure staff carry out mandatory fire safety training and that all fire exits are free of obstructions.
8	NHS Fife must ensure that equipment used is safe and suitable for its purpose, including when placing baby mats and scales on appropriate equipment to ensure patient safety.

9	NHS Fife must ensure that all staff comply with hand hygiene in line with the National Infection and Prevention control manual.
10	NHS Fife must ensure all hazardous cleaning products are securely stored.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Staff we spoke with described supportive and responsive leadership at all levels when staff required to raise concerns. However, we observed senior charge midwives did not always have protected time to lead.

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 Fife. Workforce data reviewed demonstrates a 9.8% shortfall in the Band 6 midwifery staffing establishment and 5.1% for Band 7 midwives. We consider a rate of over 10% high. The obstetric team openly discussed the challenges to recruit to obstetric vacancies which had been initially difficult to fill and had resulted in gaps in the obstetric rota. This had required the increased use of locum obstetric registrar and consultant staff which had resulted in staff raising concerns around patient safety. Senior staff spoke candidly of the challenges faced by the service during this period and the mitigations put in place to support staff escalation of concern and maintain safety. Midwifery and obstetric staff informed inspectors they felt listened to by senior managers and the executive team during this phase. At the time of inspection, the recruitment to the obstetric posts was now complete. Inspectors had the opportunity to speak with some new obstetricians joining the team who described being made to feel very welcome, and in a short period of time felt settled and part of the team.

Health and Care (Staffing) (Scotland) Act 2019 requires all NHS Boards ensure they have a real-time staffing assessment in place in order to capture risk caused by staffing levels to the health and safety of patients. As part of our inspection, we were able to attend the different safety huddles within NHS Fife which support the safe delivery of care and occurred at different points throughout the day. 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. Senior midwifery and senior obstetric staff were visible and engaged with the whole maternity team during times of staff handover and within safety huddles. However, oversight of maternity community services did not appear to be included. 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.

We were able to observe how maternity services fed into the site safety and capacity huddle during which staffing was discussed. NHS Fife utilises the Operations Pressure Escalation Level framework however this is not applied to maternity services. This

system has been well established within the acute nursing team in NHS Fife and we were told it is currently being developed to include a maternity metric. During onsite inspection it was observed that whilst there was input from maternity services into the site huddles, the process for real-time staffing risk assessment and management within maternity services was not clear. The evidence provided by NHS Fife did not indicate how decisions about staffing are captured, where this is recorded and where staff can record within the system their feedback on decisions made. It is also unclear how this data is captured over time to feed into service improvement. In discussion with senior managers, they acknowledged this as an area for improvement and informed us of the intention to implement safe care by summer 2026. A requirement has been given to support improvement in this area.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024 and requires all NHS Boards ensure appropriate staffing for the provision of safe and high-quality care. NHS Boards have a duty to apply the Common Staffing Method (CSM). The common staffing method triangulates and analyses all relevant service specific data, evidence and intelligence to support clinical leaders understand staffing requirements for a given area. As part of common staffing methodology it is mandated that the given areas undertake a staffing level tool and professional judgement tool run concurrently over a 2-week period once a year.

In the review of evidence, we observed that whilst staffing level tool runs were undertaken in October 2024 and October 2025, missing data from the professional judgement tool rendered the outputs from the run incomplete. Common staffing methodology requires triangulation of all service specific data however evidence was not seen to demonstrate this was being undertaken. In discussions with senior managers they recognised consistent application of the common staffing method as an area of improvement and were collating risk data over time to support this work. A requirement has been given to support improvement in this area.

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. Staff at agenda for change bands 6 and 7 highlighted good opportunities for professional development. The role of the unit coordinator is currently a vacant position within the maternity service. It is currently covered by the senior charge midwife cohort who are taking on the role in rotation. The senior charge midwives described this as a good opportunity to understand the wider system across the unit and to further their professional development. The multidisciplinary team highlighted that the unit coordinator role was a positive support for the senior charge midwife, as well as staff who were able to escalate any concerns due to patient acuity, staffing or flow to them, to support the safe delivery of care by prioritising review or transfer to the appropriate care area. Staff reported that the unit coordinator was visible and that they felt able to escalate any concerns to them.

Senior charge midwives reported feeling well supported by the senior leadership team, however highlighted that due to clinical demands their time to lead can be compromised. Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019) to ensure clinical leaders have protected time and adequate resource to facilitate appropriate staffing alongside other professional duties to lead the delivery of safe, high-quality and person-centred healthcare. This was reflected in evidence received, where only 47% of midwives and maternity care assistants had received an appraisal by their line manager in the last 12 months. Staff appraisals are essential to support and enable staff to feel valued and support their individual development. We observed that 100% of obstetricians had appraisals undertaken within the same timeframe. In discussion with senior managers, they acknowledged the importance of protected time to lead and are currently scoping systems to ensure its consistent application. A requirement has been given to support improvement in this area.

Through evidence, NHS Fife provided information describing wellbeing initiatives, highlighting access to staff support via their occupational health service and the availability of spiritual care. National Education for Scotland (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 Fife provide regular opportunities for staff to attend clinical supervision with consistent attendance rates.

Areas of good practice

Domain 4.3	
7	Staff reported the leadership team are supportive and responsive when staff required to raise concerns.

Requirements

Domain 4.3	
11	NHS Fife must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real-time staffing risk across all clinical professional groups within maternity services. This is to support consistent management of any identified staffing risks and must include: • recording any escalation, mitigation and or inability to mitigate and communication of outcomes to all relevant teams • a record of any disagreements with decisions made. This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
12	NHS Fife must ensure that there are processes in place to support the consistent application of the common staffing method. This should include but not limited to: • the correct application of running the mandated staffing level and professional judgement tools • a reporting template demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement. This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
13	NHS Fife 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. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls. This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

Domain 6 – Dignity and respect

Quality 6.2 – Dignity and respect

We observed women and their families being treated with dignity, kindness and compassion. Women were supported with their infant feeding choice and supported to develop close and loving parent-infant relationships.

We observed staff providing compassionate, responsive and person-centred care. Women, families and visitors that we spoke with were highly complementary of the

multidisciplinary team and the care provided. Many families would recommend other family members and friends to use the maternity services at NHS Fife.

Inspectors observed staff taking time to answer questions and allowing the women and families time to seek clarifications and to ask further questions. All interactions observed during inspection between staff and women, babies and families were positive and respectful. Women described staff as being responsive to their needs and spoke highly of the staff and the care provided, including receiving assistance and receiving analgesia when needed.

UNICEF Baby Friendly Initiative supports families with evidence-based advice relating to infant feeding and developing close and loving parent-infant relationships. NHS Fife is UNICEF Baby Friendly Initiative Gold accredited and has demonstrated commitment to continuous learning and improvements in the four pillars around leadership, culture, monitoring and progression. The most recent UNICEF annual board response letter to NHS Fife maternity services highlights the quality of work that is being implemented by the service and the positive outcomes being achieved as a result, such as a guideline for staff caring for mothers attending hospital in non-obstetric areas and antenatal conversations with pregnant women living with diabetes. The infant feeding advisor is based on the maternity ward and information was displayed for families within the ward. In a recent audit by the infant feeding team submitted to UNICEF, 94.4% of women audited reported being very happy with their care and 97.2% thought staff were always kind and considerate. During inspection, women told us staff were compassionate and responsive providing person-centred care as well as supporting building confidence in their infant feeding choice.

The impact of inequalities within maternity services has been highlighted through national reports such as saving mother's lives, improving care (MBRRACE-UK 2024). All women and their families deserve safe, kind and accessible care throughout their pregnancy journey. NHS Fife support equity, diversion and inclusion in their learning and development aiming to improve the multiprofessional care, experience and outcomes for women and their babies. Discussions on ethnic diversity are included in both community and hospital Practical Obstetric Multiprofessional Training (PROMPT) days for awareness of maternal ethnicity outcomes and to support focused learning. In evidence received by NHS Fife, we observed that the service undertook a staff survey to ascertain the confidence levels in their current practice for assessing neonates from diverse ethnic backgrounds. The survey highlighted that further training for maternity staff would be beneficial. As a result, NHS Fife introduced a training package called 'Bridging the Gap' to raise awareness of neonatal assessments within diverse ethnic populations to enhance the safe delivery of care. A new education package focusing on raising awareness of women within deprived communities is proposed to be commenced within 2026.

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 Fifes latest perinatal mortality review report demonstrated 100%

compliance of data completeness in relation to maternal ethnicity with the national average for completeness at 97%.

The maternity service is in the process of introducing a multiple language welcome signage in the main foyer of the hospital. The aim is to have this in place in early 2026 to improve access for women and their families.

Trauma informed training enables the maternity staff to be a responsive workforce and service that recognise where people are affected by trauma and adversity and that can respond in ways that prevent further harm, support recovery, address inequalities and improve life chances. In evidence submitted, NHS Fife has demonstrated being committed to this by delivering trauma informed training on a dedicated study day occurring monthly and is mandatory for all staff. However, in 2024/2025, 49% of midwives attended the trauma informed training. Through specialist teams, NHS Fife also provide direct trauma informed care to vulnerable women and their families such as enhanced birth plans. The aim is to improve inpatient care and experiences, especially where this is related to past birth trauma. A recommendation has been given to support ongoing training compliance rates for all staff.

Areas of good practice

Domain 6	
8	In all areas inspected, we observed staff working hard to provide compassionate, responsive and person-centred care.
9	Women, families and visitors that we spoke with were highly complementary of the multidisciplinary team and the care provided.
10	Women and families were supported by staff to build confidence in their infant feeding choice.

Recommendations

Domain 6	
2	NHS Fife should consider improving trauma informed training compliance rates for all staff.

Appendix 1 - List of national guidance

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

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Antenatal care (NICE, August 2021)
- CMO(2018)18 - Core mandatory update training for midwives and obstetricians (Scottish Government, December 2018)
- Delivering Together for a Stronger Nursing & Midwifery Workforce (Scottish Government, March 2025)
- Fire (Scotland) Act 2005 (Fire Scotland Act, Acts of the Scottish Parliament, 2005)
- Food Fluid and Nutritional Care Standards (Healthcare Improvement Scotland, November 2014)
- Generic Medical Records Keeping Standards (Royal College of Physicians, October 2015)
- Guidance — NHS Scotland Staff Governance (NHS Scotland, June 2024)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards (Healthcare Improvement Scotland, 2022)
- Intrapartum care (NICE guideline, November 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, 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 2019)
- 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 March 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