



Improvement Action Plan

Healthcare Improvement Scotland: Unannounced Maternity Services safe delivery of care inspection

Royal Infirmary of Edinburgh, NHS Lothian

23 – 24 June 2025

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: _____

Full Name: Professor John Connaghan CBE

Date: 28/04/2026

NHS board Chief Executive

Signature: _____

Full Name: Professor Caroline Hiscox

Date: 28/04/2026

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Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Recommendation Domain 1-1	Mandate bereavement training for all midwifery staff.	31/10/25	Director of Midwifery	Bereavement training has been formally ratified as mandatory training at the Professional Midwifery Leadership Group (November 2025). A decision had been taken at director level to mandate this training, which was subsequently confirmed through the appropriate governance process. Staff communications have been issued to advertise the change and outline the available training options. Delivery of training materials forms part of a wider training programme being rolled out across 2025/26. Action closed: 26th November 2025.	November 2025
Recommendation Domain 1-2	We will enhance the identification of families who have experienced bereavement in the past by introducing a discreet, bespoke sticker system.	31/10/25	Director of Midwifery	A sticker system to discreetly identify women who have experienced previous baby loss has been agreed and implemented. The approach was refined following staff feedback, with the service deciding to embed identification within antenatal conversations, supported by a standard operating procedure (SOP). The SOP was signed off in December 2025 and staff communications have been issued. Supporting evidence has been added to the evidence folder. Action closed: 10th December 2025.	December 2025

Requirement Domain 1-1	Improve MEWS compliance and escalation to 95% by 31/03/26 (this is our improvement aim).	31/03/26	Associate Medical Director/Director of Midwifery	<p>MEWS compliance is monitored across four measures through an established quality improvement programme, with data reviewed monthly at the Maternity and Neonatal Programme Board. The direction of travel remains positive across all four measures. Documentation of MEWS on admission rose from 80% to 93%, and completion of vital signs observations within required timeframes improved from 87% to 94% between June 2025 and March 2026. Together, these measures form the MEWS frequency dimension on the CAIR and SPSP national dashboards, where overall compliance is approximately 80% and approaching the national median. Accuracy of MEWS charting improved from a median of 73% to 92% over the same period. Staff responding correctly to elevated scores increased from a median of 42% to 75%. These latter two measures comprise escalation compliance, which has seen consistent increase, with NHS Lothian Maternity MEWS CAIR escalation measures performing above the national median. The data pack presented to the Maternity and Neonatal Services Programme Board in March 2026 was reviewed by the Executive Sponsor and the Short-Life Working Group, who agreed the evidence was sufficient to close this action. Data pack added to evidence folder. This project will continue as part of the active 2026 Reducing Avoidable Harm Quality Improvement programme. Action closed: 1 April 2026.</p>	April 2026
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	<p>Ensure that all women are reviewed within 15 minutes of attending OTA.</p> <p>Improve clinical review times in line with appropriate BSOTS defined timescales.</p>	31/03/26	Associate Medical Director	<p>Ensure that all women are reviewed within 15 minutes of attending OTA</p> <p>Progress has been made in increasing the proportion of women triaged within 15 minutes of attending the Obstetric Triage Area at the RIE, with a quality improvement aim of achieving over 80% by end of March 2026. Performance rose from a median of 31% in early 2022 to 75% in June 2025, reaching 83% by March 2026.</p> <p>Improve clinical review times in line with appropriate BSOTS defined timescales</p> <p>A review of triage waits was completed in November 2025, examining 14,034 attendances between January and September 2025. Time stamps showed that 93 (0.7%) were over 12 hours, with a sample review confirming very few genuine long stays and appropriate clinical care in all confirmed cases. Based on these findings, a recurring monthly 5% sample audit methodology was established in December 2025 to monitor compliance with BSOTS timescales for ongoing care. From December 2025 to March 2026, ongoing midwifery care achieved median compliance of 87%. Medical review compliance achieved median of 73%, with orange category patients identified as a priority for improvement. All patients with stays over 12 hours in triage continue to be reviewed. Between December 2025 and March 2026, 4,485 attendances included 92 (2.1%) records flagged as over 12 hours, with the majority being administrative errors and all clinical cases reviewed by clinical staff.</p>	April 2026
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				Data on both measures is tracked and presented monthly at the Maternity and Neonatal Services Programme Board. The data pack presented in March 2026 was reviewed by the Executive Sponsor and the Short-Life Working Group, who agreed the evidence was sufficient to close this action. Run charts, data pack, and OTA review paper added to evidence folder. Action closed: 1 April 2026.	
	Identify variation contributing to long waits for women on an Induction of Labour pathway.	31/12/25	Associate Medical Director	An Induction of Labour (IOL) coordinator post was created to support the management of IOL activity while longer-term improvement work got underway. IOL was progressed through the quality planning stage of a formal Quality Improvement programme to identify improvement aims. A presentation on IOL was made to the Maternity and Neonatal Programme Board in November 2025, which was reviewed and accepted as sufficient evidence of progress against this action. Action closed: 17 December 2025.	December 2025
	NHS Lothian Maternity Divert SOP created and implemented.	05/09/25	Service Director	A Maternity Divert standard operating procedure (SOP) was developed in collaboration with staff and implemented in September 2025. Supporting evidence, including documentation from the period following implementation and an analysis of incident reports relating to maternity diversions, has been gathered and added to the evidence folder. Action closed: September 2025	September 2025

Requirement Domain 1-2	Call bell system installed in RIE OTA.	01/10/25	Service Director	A call bell system was installed in the Obstetric Triage Area (OTA) in August 2025. All staff in Triage were informed of the change through local handover huddles at the time of installation. Supporting evidence, including committee minutes, have been added to the evidence folder. Action closed August 2025	August 2025
Requirement Domain 1-3	Develop a video for women about our IOL process and share via our website and through Maternity Voices Partnership (MVP) meetings.	01/09/25	Director of Midwifery	An Induction of Labour video was developed in collaboration with the Maternity Voices Partnership and is available via the NHS Lothian website. Midwifery Unit Coordinators are encouraged to signpost staff to the resource. Action closed.	September 2025
Requirement Domain 1-4	Review the appropriateness of SOPs for Transitional Care across the system.	30/11/25	Associate Medical Director	A review of standard operating procedures (SOPs) for Transitional Care was undertaken. Updated guidelines were developed in both maternity and neonatal versions, reflecting the different platforms used across the two services, with the same underlying content. The updated documentation was reviewed and approved at the Women's Services guideline meeting in December 2025. Action closed: 10 December 2025.	December 2025

Requirement Domain 1-5	<p>The service will aim to improve the data collection process for ethnicity by:</p> <ol style="list-style-type: none"> 1. issuing a communication to all community midwives to remind staff of the importance of recording ethnicity information. 2. reviewing the options available on our electronic patient record system for recording ethnicity to ensure we minimise the number of 'unknown' answers. 	31/03/26	Director of Midwifery	<p>A review of ethnicity data recording was undertaken, which confirmed that over 95% of mothers have the ethnicity field completed in the maternity system, with unknown or refused responses accounting for less than 5% of total cases. Staff communications were issued to community midwives reinforcing the importance of recording ethnicity information. Following this review, it was determined that changes to the electronic patient record system were not required to meet the action's objectives. Data extracts evidencing completion rates have been added to the evidence folder. Action closed: 9 February 2026.</p>	February 2026
Requirement Domain 1-6	<p>Embed routine checks to ensure interpretation needs are identified and met at key maternity touchpoints - booking and labour.</p>	31/01/26	Director of Midwifery	<p>Requirement Domain 1-6 (1): Routine Checks for Interpretation Needs</p> <p>A process was established for monitoring interpretation provision at key maternity touchpoints. The Interpretation and Translation Service (ITS) will produce monthly reports tracking the number of interpretation requests received versus those fulfilled, with 80% of face-to-face requests currently being met. Work is underway to make interpretation-related fields in the electronic patient record system mandatory, with staff communications issued in the interim to improve recording. Action closed: 11 February 2026.</p>	February 2026

	Reinforce the process whereby midwives can escalate concerns if virtual interpretation is unsuitable out with booking appointments and labour.	31/01/26	Director of Midwifery	Requirement Domain 1-6 (2): Standard Operating Procedure for Interpretation Services A maternity-specific standard operating procedure (SOP) was developed setting out requirements for face-to-face interpretation at planned and unplanned maternity touchpoints, as well as guidance for extenuating circumstances outside these. The finalised SOP, along with supporting communications and resources, has been added to the evidence folder. Action closed: February 2026.	February 2026
	Use the SG racialised health inequalities toolkit as a benchmark.	31/01/26	Director of Midwifery	Requirement Domain 1-6 (3): Scottish Government Racialised Health Inequalities Toolkit Benchmark A self-assessment against the Scottish Government Racialised Health Inequalities toolkit confirmed the service was meeting recommendations for interpretation provision. Evidence includes an SBAR prepared in May 2025, a self-assessment submitted to Scottish Government in October 2025, and documentation showing the improvement in the service's position between May 2025 and January 2026. A staff communication reinforcing the use of extended appointments when an interpreter is required completed the outstanding actions. Action closed: 11 February 2026.	February 2026
	Provide updated guidance to staff on when and how to access interpretation services.	31/01/26	Director of Midwifery	Requirement Domain 1-6 (4): Staff Guidance on Accessing Interpretation Services Updated staff communications were issued setting out how to access interpretation services, reflecting the revised NHS Lothian ITS policy and the new maternity-specific SOP. Evidence of the communications has been added to the evidence folder. Action closed: 11 February 2026.	February 2026

Requirement Domain 2-7	To help create a psychologically safe environment for all staff we will: 1. Support the development of our leadership team.	31/03/2026	Service Director	Requirement Domain 2-7 (1): Leadership Development Organisational development (OD) sessions have been delivered with the senior management team to support leadership development throughout 2025. Four OD sessions were held over the past year, with the final session completed on 31 March 2026. Participation has been recorded at each session. A summary of content and output from the four sessions has been prepared and added to the evidence folder. Impact will be evaluated by repeat culture survey planned for June 2026. Action closed: 1 April 2026.	April 2026
	2. Improve rates of PDP completion for all staff to ensure their own development needs and ambitions are recognized and recorded.	31/03/2026	Service Director	Requirement Domain 2-7 (2): PDP Completion Rates Work was undertaken to improve Personal Development Plan (PDP) completion rates from a baseline of 40% across the whole staff group. A plan to accelerate improved compliance by end of March 2026 was implemented, including expanding appraiser capacity beyond clinical managers and establishing a weekly tracker to monitor progress. A team-specific approach was adopted, with particular focus on areas with lower compliance. The interim April 2026 target of 40% was met, with Women's Services achieving 42.5% PDP compliance as confirmed by TURAS data in April 2026. An anonymised tracker evidencing concerted efforts and achievements was developed alongside TURAS reporting. The Short-Life Working Group reviewed the evidence and agreed this action was closed. Ongoing progress will continue to be monitored as a critical action. TURAS compliance data and anonymised tracker added to evidence folder. Action closed: 15 April 2026	April 2026

	<p>3. We will continue to encourage our staff to record all incidents and “near miss” situations through DATIX.</p>	31/03/2026	Service Director	<p>Requirement Domain 2-7 (3): Encouraging Incident and Near Miss Reporting Through Datix This action is being progressed jointly with Requirement Domain 2-10 (1), which covers the same area of work around encouraging incident and near miss reporting through Datix and the Speak Up service. Evidence includes: an updated DATIX trigger list approved at Clinical Governance on 20 March 2026; all-staff communications circulated on 23 March 2026; the trigger list made available on the intranet; a run chart demonstrating improvement in DATIX reporting in 2025 compared to the previous year; and briefing of Cultural Ambassadors to support consistent messaging. The Short-Life Working Group reviewed this evidence and agreed this action was closed. Action closed: 26 March 2026.</p>	March 2026
	<p>4. Continue to highlight opportunities to escalate concerns through NHS Lothian's Speak Up service.</p>	03/10/25	Service Director	<p>Requirement Domain 2-7 (4): Speak Up Service A week-long Speak Up campaign was delivered in Women's Services in October 2025, including face-to-face contact opportunities between management, leadership and staff. Staff communications and evidence of the campaign have been added to the evidence folder. Action closed November 2025</p>	November 2025

	<p>5. Co-creation and implementation of a Culture Charter for Women's Services building on the NHS Lothian Values, supported by training and awareness raising.</p>	31/03/26	Service Director	<p>Requirement Domain 2-7 (5): Culture Charter A Culture Charter was co-developed with Cultural Ambassadors and the senior management team through three sessions held between January and March 2026. The Charter sets out shared commitments to model effective and positive cultural behaviours, improve visibility and communication, and foster greater engagement. Cultural Champions were embedded into existing workstreams to progress actions and feed back to peers. The Charter was published on the Women's Services intranet pages on 17 April 2026, with all-staff communications issued by the Triumvirate Directors inviting feedback to inform the second phase of work. The Charter is designed as a living record of adaptive and evolving culture. Action closed 22nd April 2026</p>	April 2026
	<p>6. We will recruit a cohort of cultural ambassadors who will work with our senior management team to create a new culture charter.</p>	31/10/25	Service Director	<p>Requirement Domain 2-7 (6): Cultural Ambassador Recruitment A cohort of 23 Cultural Ambassadors was recruited from across clinical and non-clinical roles following an open advertisement. A video pitch was produced by the Service Director to encourage expressions of interest. Staff were notified of their selection in December 2025 and two sessions with the ambassador cohort have been held to date. Action closed: December 2025.</p>	December 2025

Requirement Domain 2-8	Improve staff wellbeing opportunities as per the Staff Engagement & Experience Delivery Plan 2024-2026 (also see other actions as per requirement 2-7).	31/03/26	Service Director	<p>Requirement Domain 2-8 (1): Staff Wellbeing Opportunities</p> <p>Work is underway to further improve staff wellbeing opportunities in line with the Staff Engagement and Experience Delivery Plan 2024-2026. A local staff experience and wellbeing group was relaunched in February 2026 to develop a plan for 2026/27, with consideration given to involving Cultural Ambassadors to create a feedback loop between the group and the wider cohort. Evidence submitted against this item includes examples of extensive staff communications advertising wellbeing events, analysis of staff feedback and attendance presented by the Women's and Children's Wellbeing Facilitator at the Clinical Management Team meeting, and the 2026/27 Staff Wellbeing plan informed by staff feedback on service priorities. The Short-Life Working Group reviewed the evidence and agreed there was sufficient demonstration that staff wellbeing opportunities have improved in line with the 2024-2026 plan, with clear intentions for wellbeing opportunities planned for 2026/27. Action closed: 26 March 2026.</p>	March 2026
	Ensure robust local arrangements for provision of midwifery staff breaks across all areas.	31/11/25	Director of Midwifery	<p>Requirement Domain 2-8 (2): Staff Breaks</p> <p>A standard operating procedure (SOP) for facilitating and recording staff breaks, including time off in lieu where breaks cannot be taken, was developed and approved at the Maternity Operations Meeting in October 2025. An audit of compliance was undertaken following the SOP launch, with ongoing monthly audits planned to evidence continued progress. Evidence of the SOP and audit data has been added to the evidence folder. Action closed: 24 November 2025.</p>	November 2025

Requirement Domain 2-9	Improve timelines for completion of reviews of all SAEs by 10%.	31/01/26	Associate Medical Director	<p>Requirement Domain 2-9: Timelines for Serious Adverse Event Reviews</p> <p>A programme of work was undertaken to reduce the backlog of open Serious Adverse Event Reviews (SAERs) and improve completion timelines. Using a baseline established in September 2025, the service achieved an overall 30% reduction in the total number of open SAERs and a 12% reduction in the number of cases open for longer than six months by January 2026. Progress on clearing the oldest cases was also demonstrated over this period. Action closed: 4th February 2026.</p>	February 2026
Requirement Domain 2-10	We will encourage our staff to record all incidents and “near miss” situations through DATIX, and if needed to escalate reporting their concerns through NHS Lothian's Speak Up service.	31/03/26	Service Director	<p>Requirement Domain 2-10 (1): Encouraging Incident and Near Miss Reporting</p> <p>Datix reporting and the Speak Up service are reinforced through daily safety huddles and regular staff engagement sessions. An updated DATIX trigger list was developed and approved at the Clinical Governance meeting on 20 March 2026. The trigger list was circulated to all staff on 23 March 2026 via an all-staff communication and is now available on the intranet. The communication included a run chart demonstrating overall improvement in DATIX reporting in 2025 compared to the previous year, alongside analysis of divert episodes in February 2026. Cultural Ambassadors were briefed to support consistent messaging across the service. The Short-Life Working Group reviewed the evidence and agreed closure of this action. Action closed: 26 March 2026.</p>	March 2026

	Introduce a governance process to monitor adherence to reporting guidelines for all incidents highlighted.	31/10/25	Director of Midwifery	Requirement Domain 2-10 (2): Governance Process for Monitoring Incident Reporting A governance process was established to monitor adherence to incident reporting guidelines, utilising twice-daily safety huddles to identify and follow up on incidents from the previous day. Weekly debrief meetings were introduced to review reporting data. Evidence of the process, including records of weekly debrief meetings, has been added to the evidence folder. Action closed: 24 November 2025.	November 2025
	Adopt the HIS learning summary document.	31/01/26	Associate Medical Director	Requirement Domain 2-10 (3): Adoption of HIS Learning Summary Document A HIS Learning Summary document was developed to share findings from a recent Significant Adverse Event Review (SAER) with staff. Prior to wider circulation, assurances were obtained that all staff directly involved in the adverse event selected for the initial summary had received a copy of the SAER report. The learning summary was introduced to staff via an all-staff email in February 2026. Action closed: 16 February 2026.	February 2026
Requirement Domain 4.1-11	To ensure efficient senior management and oversight is provided we will: 1. Strengthen the Realtime escalation protocol.	01/08/25	Service Director	Requirement Domain 4.1-11 (1): Realtime Escalation Protocol The NHS Lothian PREP Stat reporting tool was adapted for use in daily safety huddles from January 2025, with ongoing refinements to better reflect service status. Meeting times have been adjusted in response to staff feedback. Evidence of safety huddle data has been added to the evidence folder. Action closed September 2025	September 2025

	2. NHS Lothian Maternity Divert SOP created and implemented.	05/09/25	Service Director	<p>Requirement Domain 4.1-11 (2): Maternity Divert SOP A Maternity Divert standard operating procedure (SOP) was developed in collaboration with staff and implemented in September 2025. Data on diversions and related incident reports has been presented at governance meetings and staff engagement sessions, with supporting evidence added to the evidence folder. This action is also referenced under Requirement Domain 1-1. Action closed 17th September 2025.</p>	September 2025
	3. We will clarify and strengthen the Midwifery Unit Coordinator role description and will strengthen the rota for this role to ensure consistent 24/7 cover.	31/03/2026	Director of Midwifery	<p>Requirement Domain 4.1-11 (3): Midwifery Unit Coordinator Role Work was undertaken to clarify and strengthen the Midwifery Unit Coordinator (MUC) role. The MUC job description, including a role-specific addendum, was finalised and supported by the job evaluation panel on 26 March 2026. Cover has been maintained through wider Band 7 charge midwives while longer-term recruitment is progressed. MUC availability is monitored through monthly staffing analysis presented at the Performance Support Oversight Board. The service recognises that achieving sustainable 24/7 MUC cover would require additional permanent Band 7 establishment beyond current funded levels. A position statement outlining progress achieved has been prepared. The Short-Life Working Group reviewed the evidence and agreed this action was closed. MUC job description, staffing analysis, and position statement added to evidence folder. Action closed: 8 April 2026.</p>	April 2026

	4. The service will review the current out of hours on-call rota to ensure it is fit for purpose and safely staffed by appropriately trained senior staff members.	30/06/26	Service Director	<p>Requirement Domain 4.1-11 (4): Out of Hours On-Call Rota</p> <p>A short-life working group was established in August 2025 to review the out of hours on-call rota, including consideration of whether it should be clinically or managerially delivered. A review of on-call SOPs across NHS Lothian midwifery services was completed and a new SOP was approved at Women's Services CMT in March 2026 and added to evidence folder against this item. The new rota was launched in April 2026, with the two service managers in Women's Services now active participants. The remaining item to secure action closure is the setting up of recurring resilience training dates. Action ongoing</p>	
Requirement Domain 4.1-12	Covered under Requirement 2-7 above.				
Requirement Domain 4.1-13	Review current VTE guidance and risk assessments to ensure alignment.	31/01/26	Associate Medical Director/ Director of Midwifery	A review of VTE guidance and risk assessments was undertaken, including updates to reflect a switch in anticoagulant medication. Updated guidelines and supporting documentation have been added to the evidence folder. Action closed: 10th December 2025.	December 2025

Requirement Domain 4.1-14	Create a streamlined process for auditing patient records.	31/03/26	Director of Midwifery	The service undertakes 14 routine audits which incorporate documentation review: three yearly, ten monthly, and one weekly. Sampling approaches vary by audit type, with approximately 200-300 women per month having at least one aspect of their maternity care documentation audited against a monthly delivery rate of approximately 600 births. A paper summarising the considerable number of audits and the streamlined process in place for their delivery was prepared and reviewed by the Short-Life Working Group. The service has committed to designing and implementing a specific documentation audit tool once parameters are agreed by the Midwifery Professional Leadership Group in conjunction with the Lothian Nursing and Midwifery Quality Improvement and Standards team. The Nurse Director Acute discussed the approach with the Executive Sponsor, who supported the proposed closure. The Short-Life Working Group reviewed the evidence and agreed this action was closed. Documentation audit summary paper added to evidence folder. Action closed: 1 April 2026.	April 2026
Requirement Domain 4.1-15	NHS Lothian will implement the new Scottish Government Maternity Care pathways, and as part of this work we will review our internal processes to ensure supportive conversations are facilitated for all patients at all stages of pregnancy.	31/03/26	Director of Midwifery	A paper was prepared outlining work undertaken to support women's choices and ensuring supportive conversations are facilitated at all stages of pregnancy. This includes the use of the BRAIN framework to support informed decision-making, support for intrapartum choices including mode of delivery and place of birth, and postnatal choices including infant feeding. The service is working towards UNICEF Baby Friendly Initiative re-accreditation. Considering the evidence paper, the Short-Life Working Group agreed this action was closed. Supporting women's choices summary paper added to evidence folder. Action closed: 1 April 2026.	April 2026

Requirement Domain 4.1-16	NHS Lothian to continue the Lifecycle programme of environment improvements as planned	31/12/27	Service Director	<p>Requirement Domain 4.1-16 (1): Environment Improvements</p> <p>Environmental improvement work is progressing across the service. Lifecycle improvements were completed in Wards 211, 119, and 210, with the final move on 17 April 2026. Scoping work is underway for Labour Ward improvements, which must be completed before December 2027 when NHS Lothian receives handover of the building from PFI partners. Part of Ward 119 (LDRP corridor) nearest to Labour Ward is currently unavailable for use pending final checks. The service is working with the PFI partner to check whether this space can be temporarily reprovioned to allow Labour Ward Lifecycle works to proceed. Action ongoing.</p>	
	Remind staff about the process of escalation for environmental concerns.	31/10/25	Service Director	<p>Requirement Domain 4.1-16 (2): Escalation of Environmental Concerns</p> <p>Staff communications regarding the process for escalating environmental concerns have been issued and added to the evidence folder. Quarterly staff communications on this topic have been scheduled in the yearly planner, with monthly staff engagement sessions also used to reinforce the escalation process. Action closed 6th November 2025</p>	November 2025
Requirement Domain 4.1-17	Remind staff to prioritise monthly walk rounds to monitor compliance with safe storage of medicines and ensure that any identified gaps are addressed immediately.	31/10/25	Director of Midwifery	<p>Monthly walk rounds to monitor compliance with safe storage of medicines are in place, supported by the Women's Services Care Assurance Oversight Group launched in April 2025. The service participates in the wider Lothian Medicines Management Audit Meeting. Staff communications and walk round checklists have been issued and added to the evidence folder, with this topic incorporated into the quarterly staff communications schedule. Action closed 6th November 2025</p>	November 2025

Requirement Domain 4.1-18	Remind staff to prioritise monthly walk rounds to monitor compliance with SICPs.	31/10/25	Director of Midwifery	Monthly walk rounds to monitor compliance with SICPs are in place, supported by the Women's Services Care Assurance Oversight Group. This action was progressed alongside Requirement Domain 4.1-17, with the same staff communications and evidence applicable to both. This topic has been incorporated into the quarterly staff communications schedule. Action closed 6th November 2025	November 2025
Requirement Domain 4.1-19	All maternity specific fire safety actions to be reviewed in line with the general Royal Infirmary of Edinburgh fire action plan and ensure follow up actions are completed.	31/12/25	Service Director	A comprehensive review of fire safety actions was undertaken across three streams: Scottish Fire and Rescue Service visit actions, Emergency Fire and Evacuation Plans, and the RIE Fire Safety Action Plan. The majority of actions were addressed, with remaining open items being site-wide actions for which the Service Director has engaged with the Fire Safety Officer, Site Director, and Director of Estates and Facilities to agree ongoing governance arrangements. An SBAR outlining the review, action status and governance arrangements was approved by the Women's Clinical Management Team and added to the evidence folder. Action closed: 19 January 2026.	January 2026
Requirement Domain 4.3-20	In order to ensure consistent assessment, capture, and mitigation of real time staffing risks, we will: 1. Strengthen the Realtime escalation Protocol.	01/08/25	Service Director	Please refer to Requirement Domain 4.1-11 (1) for a full update on this action, which covers the same area of work around the daily safety huddle and PREP Stat reporting tool. Action closed September 2025	September 2025

	2. NHS Lothian Women's Services will implement the use of Safe Care as part of the twice daily safety huddle.	31/10/25	Director of Midwifery	Safe Care was introduced into the twice-daily safety huddle process, with all charge midwives and clinical midwifery managers trained in its use. An updated PREP Stat sheet was launched in November 2025 incorporating Safe Care status fields for all areas. Safe Care reports are presented monthly at the Performance Support Oversight Board, chaired by the Chief Executive, with evidence added to the folder on an ongoing basis. Action closed 19th November 2025	November 2025
Requirement Domain 4.3-21	To ensure that maternity and obstetric services are appropriately and effectively staffed, we will: 1. Review the medical model/ Triage Workforce.	01/12/25	Associate Medical Director	A review of the medical model and triage workforce was completed, resulting in approval for additional medical posts which have been advertised. An SBAR describing the outcome of the review and mitigation measures in place to address the unfunded portion of the request has been added to the evidence folder. Action closed: 8 December 2025.	December 2025
	2. Scope the development of an Advanced Midwifery Practitioner model.	31/03/26	Nurse Director (Acute)	The Advanced Midwifery Practitioner role has been scoped, with discussions at the Professional Midwifery Leadership Group informing the development of the model. Full implementation is dependent on workforce stability being achieved and the publication of national guidance and will be progressed once these conditions are met. Action closed: 16 February 2026.	February 2026
	3. Review the rotational model for Midwives.	10/11/25	Nurse Director (Corporate)	A multi-year rotational plan has been developed and the first scheduled movement of staff following the organisational change took place on time. Evidence has been reviewed and added to the folder. Action closed: 24 November 2025.	November 2025

	4. Introduce a weekly prospective review of staffing levels across all areas.	31/10/25	Director of Midwifery	A weekly prospective review of staffing levels across all areas has been established, with evidence of weekly reviews from December 2025 to February 2026 added to the evidence folder. Staffing summaries are presented monthly at the Performance Support Oversight Board. Action closed 12th November 2025	November 2025
Requirement Domain 4.3-22	<p>Establish a programme of support for newly recruited internationally trained midwives in consultation with Edinburgh Napier University.</p> <p>Ensure all international medical graduates continue to be included in the wider NHS Lothian training programme for internationally trained doctors.</p>	01/09/25 Ongoing	Director of Midwifery Associate Medical Director	A bespoke enhanced support programme for internationally trained midwives has been developed and implemented, including a module delivered in partnership with Edinburgh Napier University. A skills competency framework and rotation schedule are in place for the current cohort, with individual competency plans developed for each member of staff. A Resident Doctors Committee was established in August 2025, with representation from all tiers including internationally trained doctors, ensuring international medical graduates continue to be included in the wider NHS Lothian training programme. Supporting evidence has been added to the evidence folder. Actions closed October 2025.	October 2025
Requirement Domain 4.3-23	<p>See Requirement 4.3-20: Strengthen the Realtime escalation protocol.</p> <p>See Requirement 4.3-21: Introduce a weekly prospective review of staffing levels across all areas.</p>				

Requirement Domain 4.3-24	See Requirements 2-7 and 2-12.				
Requirement Domain 4.3-25	<p>To ensure staff are appropriately trained to conduct their roles we will:</p> <ol style="list-style-type: none"> 1. Ensure protected learning time for Staff. 	31/03/26	Director of Midwifery/ Associate Medical Director	<p>Work was undertaken to establish protected learning time requirements for staff. A baseline for maternity mandatory training as per Scottish Government DL 2018 was agreed at Women's Services Clinical Management Team in March 2026. Revised learning pathways for midwifery and obstetric staff were developed, reducing unnecessary training burden while maintaining statutory compliance by removing duplicate content and modules not relevant to local practice. Analysis of roster data demonstrated that protected learning time is allocated and prioritised, with evidence showing hours provided for training over a six-month period and processes to minimise training cancellation. A report summarising this evidence was prepared by the Nurse Director Acute. The Short-Life Working Group reviewed the evidence and agreed this action was closed. Mandatory training paper and protected learning time report added to evidence folder. Action closed: 8 April 2026</p>	April 2026

	2. Establish a robust system for recording training requirements.	31/03/26	Director of Midwifery/ Associate Medical Director	A system for recording training requirements has been established within HealthRoster, with midwifery training recorded there since early 2025. Skills are assigned expiry dates to prompt rebooking of training. A Maternity Mandatory Data Management Protocol was developed in collaboration with the NHS Lothian Education Team, establishing the operational process for updating and reporting mandatory training data from April 2026 for midwifery and medical staff. The protocol is scheduled for formal sign-off at the Professional Midwifery Leadership Group on 30 April 2026. The Short-Life Working Group reviewed the protocol and agreed this action was closed. Protocol added to evidence folder. Action closed: 8 April 2026.	April 2026
	3. Develop a program to ensure maintenance of key skills to support safe workforce deployment	31/03/26	Director of Midwifery/ Associate Medical Director	A draft paper was developed outlining Phase 1 (current multidisciplinary decision-making processes for staff redeployment) and Phase 2 (longer-term strengthening of governance and oversight of the essential skills framework). Paper received professional sign-off from the Executive Nursing Director. Evidence folder supplemented with example huddle sheets demonstrating staff deployment processes. Action closed 22nd April 2026	April 2026
Requirement Domain 4.3-26	Support staff to use eRoster functionality to accurately evidence dedicated leadership time and changes to role allocation.	31/10/25	Director of Midwifery	A standard operating procedure (SOP) was developed and communicated to staff to support the accurate recording of dedicated leadership time and role allocation changes in eRoster. Spot checks were carried out prospectively by the eRoster team to support audit, with two months of data added to the evidence folder. Action closed: 26th November 2025	November 2025

	Utilise the daily safety huddle to document the rationale for changes to role allocation	31/10/25	Midwifery	The rationale for changes to role allocation is recorded within the daily safety huddle PREP Stat documentation, with plans to incorporate this into Safe Care going forward. Evidence including safety huddle recording sheets has been added to the evidence folder. Action closed: 19th November 2025	November 2025
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