Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Borders General Hospital

NHS Borders

16 - 17 March 2026

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About our inspection

Background

In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. Taking account of the changing risk considerations and sustained service pressures, the methodology was adapted to minimise the impact of our inspections on staff delivering care to women, birthing people and families. Our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records.

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

The Healthcare Improvement Scotland (HIS) Maternity Care Standards, published on 23 March 2026, set out national expectations for the delivery of safe, effective and person-centred maternity care across all settings, including midwifery units, community and home settings, hospitals, primary care and prisons. In March 2026, the Chief Operating Officer (COO) formally advised all health boards that the Maternity Care Standards will be incorporated into HIS inspection activity from Monday, 21 September 2026 onwards. More information can be found here.

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

Borders General Hospital is a district general hospital situated on the outskirts of Melrose. It has 197 inpatient beds plus intensive therapy beds and offers a wide range of healthcare specialities including maternity services, supporting approximately 850 births a year.

About this inspection

We carried out an unannounced inspection to Borders General Hospital, NHS Borders on Monday 16 and Tuesday 17 March 2026 using our safe delivery of care inspection methodology. We inspected the following areas:

- Ward 16 – combined antenatal, postnatal ward and triage area
- Labour ward

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 Borders 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 Wednesday 14th April 2026, we held a virtual discussion session with key members of NHS Borders 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 Borders and in particular all staff at Borders General 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 calm, person-centred care with good multidisciplinary working. We observed staff working together to maintain good communication and provide compassionate, responsive and respectful care. Women and families we spoke with were complimentary of the care received and would recommend maternity services within Borders General Hospital to family and friends. The maternity unit was calm, tidy, clean and maintained to a high standard.

A positive, supportive working culture was evident with staff describing NHS Borders as a good place to work and feeling confident to escalate concerns. Senior midwifery and obstetric

leaders were visible within the service and demonstrated active engagement with the wider maternity team.

Staff were actively engaged in their own learning and development and described sufficient time within their working hours to support the completion of this.

During inspection we identified some areas for improvement. These included improved assurance of timely access to unscheduled care to support ongoing improvements in patient safety. Further improvement is required in the timeliness of incident reviews and significant adverse event reviews, including the timely commissioning of a significant adverse event when a clinical incident meets the criteria for this level of review and improved completion of significant adverse event reviews in line with the national adverse events framework.

Other areas for improvement include assurance of fire safety requirements, ongoing improvement to the hospital environment, safe storage and management of medicines, access to interpretation services and improvements in the consistent application of the common staffing method.

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

This inspection resulted in 10 areas of good practice, one recommendation and 10 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 Borders 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 Borders General Hospital resulted in 10 areas of good practice.

Domain 1	
1	Good working relationships and collaborative approach from NHS Borders and supporting services, such as Scottish Ambulance Service and ScotStar, was evident during inspection. (see page 12).

Domain 2	
2	Staff described a supportive culture following an adverse event. Senior managers were open, honest and transparent regarding the journey within the unit to improve the service culture (see page 16).
3	Senior managers provided evidence of management team and charge midwife development days which were designed to support the team in strengthening positive leadership (see page 16).
4	Staff described support following adverse events as positive learning experiences (see page 16).

Domain 4.1	
5	Inspectors observed the use of quality improvement and quality assurance proactively being used and discussed within the service (Page 19).

Domain 4.3	
6	Obstetricians within NHS Borders have taken on supportive roles to help develop the skills of middle tier doctors, contributing to workforce resilience and the continuity of specialist expertise (see page 22).
7	We observed a respectful and compassionate discussion of women's needs, with clear care plans communicated to the team (see page 22).
8	Staff described having confidence to raise staffing concerns with their clinical management team who would assist and would be supportive with patient care or staff break relief (see page 22).

Domain 6	
9	We observed staff working to provide compassionate, responsive and respectful care (see page 24).
10	We observed that maternity staff were proactive in discussing and providing contraception with postnatal women (see page 24).

Recommendations

The unannounced inspection to Borders General Hospital resulted in one recommendation.

Domain 6	
1	NHS Borders should consider improving trauma-informed training compliance rates for all staff (Page 24).

Requirements

The unannounced inspection to Borders General Hospital resulted in 10 requirements.

Domain 1	
1	NHS Borders must ensure ongoing oversight and governance to support the safe delivery of care, including but not limited to: (i) unscheduled care (Page 12). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) criteria 2.5 and 2.6.
2	NHS Borders must ensure improvement in governance and oversight of ethnicity completeness data for all women and birthing people booking for perinatal care (see page 12). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) Criteria 2.4 and 2.6.
3	NHS Borders must ensure access to interpretation services for all women and families accessing care and consider ways to improve oversight and staff feedback of interpretation services to ensure any areas for improvement can be identified and addressed (Page 13). This will support compliance with: Health and Social Care Standards (2017) Criteria 2.8, 2.9 and 2.10

Domain 2	
4	NHS Borders must ensure timescales of commissioning and completion of significant adverse event reviews align with the timeframes in Healthcare Improvement Scotland's Adverse Events National Framework (see page 16). 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.

Domain 4.1	
5	NHS Borders must ensure effective systems and processes are in place to support assurance of a safe healthcare environment and that all essential maintenance works are completed (see page 19). This will support with compliance of National Infection Prevention and Control Standards (2022) and Infection Prevention and Control Standards, Criteria 8.1.
6	NHS Borders must ensure the safe storage of medicines (see page 19). This will support compliance with: Royal Pharmaceutical Society on the Administration and storage of Medicines in Healthcare Settings (2019) and Nursing and Midwifery Council (NMC) The Code (2018).

7	NHS Borders must ensure all fire exit signage is present and maintained to support safe fire evacuation (see page 19). This will support compliance with: Fire Safety (Scotland) Regulations (2006).

Domain 4.3	
8	NHS Borders must ensure that there are processes in place to support the consistent application of the common staffing method. This should include, but is not limited to: (i) the correct application of running the mandated staffing level and professional judgement tools (ii) a reporting template demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement (see page 23). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
9	NHS Borders must have robust systems and processes in place to ensure that all staff have completed mandatory training essential to their role (Page 23). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

Domain 6	
10	NHS Borders must ensure that recurring themes from patient feedback is utilised to support service improvements (see page 24). 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.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We observed calm, person-centred care with good multidisciplinary working. Staff were working together to maintain good communication. Improvements identified include assurance of access to timely unscheduled care within the service.

NHS Borders provides maternity services within a rural setting to women and their families across the southeast region of Scotland. The maternity unit provides both midwifery led and consultant led care supporting approximately 850 births per year.

The maternity unit is situated on the second floor of the hospital and is accessed via the main entrance. During the onsite inspection, staff from the multidisciplinary team were observed

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

Women have access to care 24 hours a day, seven days a week. Midwives undertake the telephone triage service and are available to answer calls and complete the initial triage assessment utilising a structured telephone assessment. Due to the remote and rural area that NHS Borders serves, consideration of the women's proximity to the hospital and the ease of accessing the services is applied during telephone assessment.

The provision of triage care is shared between the labour ward and ward 16 depending on the women's clinical presentation and care need. An audit was undertaken by the service with the aim of reviewing the provision of scheduled and unscheduled care which recognised the need to adopt some aspects of an evaluated system to support the safe delivery of unscheduled care. As part of evidence, we observed a scoping exercise has been undertaken to integrate parts of the evaluated Birmingham symptom specific obstetric triage system (BSOTS) into the service. This is an identified improvement priority for 2026 within NHS Borders.

Staff described that on arriving in the unit women are reviewed immediately which is achievable due to the typical activity levels within the department. We asked senior managers how they currently ensure women receive the right care, in the right place at the right time. They explained that this is overseen by the labour ward coordinator. However, senior managers acknowledged a current lack of data and audit oversight to support assurance and improvement in key areas, such as time to first assessment when women attend the unit and during ongoing care. For example, when medical review is required, which would enhance understanding of risk within the unscheduled care system. A requirement has been given to support improvement in this area.

We requested NHS Borders provide any incident reports submitted by staff for the six months prior to inspection. From this we observed no adverse events related to delays in time to first assessment or delayed medical care.

We observed oversight of care by the multi-disciplinary team through effective communication at safety huddles and ward rounds. During our onsite inspection we did not observe any delays to scheduled or unscheduled care. Senior managers highlighted that delays to care do occur and this is currently monitored through the lead midwife and captured within the daily huddle sheet. Delays are also discussed at safety huddles throughout the day to ensure mitigations are put in place to maintain safety. NHS Borders provided documentation relating to mitigations from safety huddles and associated staff guidance.

We were provided audit data from 2025 assessing barriers when delays to the induction of labour process did occur. This demonstrated delays were mainly related to staffing and capacity issues within the labour ward. We were provided with guidance that supports staff to escalate staffing risk concerns in order to support the safe delivery of patient care. Staff we spoke with were aware of the escalation process in the event of delays occurring. Review of the incident reports submitted by NHS Borders demonstrated there were no patient safety incidents related to delays to scheduled and unscheduled care for the six months prior to inspection. We were provided with evidence of monthly oversight of delays to care monitored through maternity services governance meetings.

Women were offered informed choice regarding their method of induction of labour. Due to the rural context of Borders General Hospital, the use of the outpatient induction service provides an opportunity for some women to return home and remain with their families during early induction. This provision aligns with the vision for maternity services across Scotland set within The Best Start: A five-year forward plan for maternity and neonatal care in Scotland in which parents and babies are offered truly family-centred and compassionate care.

Labour ward is situated on the second floor and is well signposted from the main hospital entrances. There are five birth rooms available within the obstetric led unit which also supports bereavement care and a birthing pool room. During inspection, the ward was calm with good visibility of staff and clinical leadership.

All five birthing rooms provided ample space to support women's mobility and freedom of movement, whilst also allowing staff clear access in the event of an emergency. A range of birthing aids were available, including a birthing pool, birthing balls and a birthing cube. Each room was equipped with a discreet, wall-mounted resuscitaire to ensure that any immediate neonatal resuscitation needs could be met promptly. This reduces the impact of separating mother and baby and prevents unnecessary separation in the immediate period after birth.

All women, birthing people and their families should receive safe, kind and accessible care throughout their pregnancy journey. NHS Scotland Birthplace Decisions guidance emphasises the importance of informed choice around place of birth. At the time of inspection, senior managers told us the homebirth service had been temporarily paused due to staffing challenges within the community midwifery team. Whilst this limits birth choice, the mitigation prioritises safe staffing, the delivery of wider maternity services and staff wellbeing. The absence of a homebirth service inevitably reduces available birth options. NHS Borders has demonstrated awareness of this by developing evidence-informed guidance to support women who choose to give birth without a registered healthcare professional (freebirth/unassisted birth). The guidance supports person-centred care, promotes informed decision making, outlines clinical risks and clarifies staff roles, responsibilities and escalation pathways within legal and professional frameworks such as the nursing midwifery council, The Code. Senior Managers informed us that every woman who wished a homebirth is given an opportunity to discuss individualised birth choices with their primary midwife. This includes access to low-risk care in the birthing pool and accessing NHS Lothian's midwifery led units, if appropriate.

The maternity ward is a combined antenatal and postnatal ward with eight beds. It is located on the second floor with clear signage from the main maternity entrance. Ward 16 provides antenatal, postnatal and triage care offering access to two side rooms, a multiuse triage/induction of labour room and two bays, with scope to increase to 12 beds in contingency circumstances. The configuration of the ward is flexible and can be adjusted as required depending on demand. Senior managers discussed future planning to dedicate areas primarily to antenatal and postnatal care to improve patient flow and protect dignity during the inpatient stay.

Transitional care is care provided to babies that require additional support above normal neonatal care with the aim of preventing separation of mum and baby and unnecessary

admissions to the neonatal unit. This approach supports the principles of The Best Start initiative which emphasises keeping families together wherever safe and appropriate. NHS Borders provide transitional care within the maternity ward and have guidance in place outlining admission criteria to the transitional care area, which was aligned with the British Association of Perinatal Medicine (BAPM) Transition Care Guidance. Through evidence and staff feedback we observed healthcare support workers have received bespoke training in transitional care and were able to assist the midwifery team in delivering transitional care tasks.

Borders General Hospital has a level two special care baby unit. When concerns are identified due to complications affecting the wellbeing of the mother or unborn baby (less than 32 weeks gestation) staff will arrange, if appropriate, to have the woman transferred to a level three neonatal unit. A level two special care baby unit will provide neonatal care for infants born from 27 weeks gestation, including high-dependency care, however a level three neonatal unit provides neonatal care for infants of all gestational ages, including sustained intensive care, prolonged ventilation and specialist support.

As part of our inspection, staff told us that transfer of the pregnant woman would be arranged as promptly as possible. Senior managers highlighted that transfer may not always be possible due to an emerging risk to the mother or baby or due to advancing stages of labour. However, due to the geographical challenges of remote and rural living, the team discussed the good working relationships and collaborative approach from NHS Borders and supporting services such as Scottish Ambulance Service and ScotSTAR. ScotSTAR is a national service for safe and effective transport and retrieval of newborn babies (neonates) and critically ill children throughout Scotland. We were provided evidence of a clear pathway for both unplanned and planned transfers of women. There is guidance as to the responsibilities of each clinician in the facilitation of a safe transfer of the patient and prompts them to consider the most appropriate destination for such patients. This is strengthened by a midwifery staffing escalation standard operating policy and special care baby unit escalation plan that supports integrated decision making across services.

The National Bereavement Care Pathway Scotland is a project funded and developed by Scottish Government in partnership with Sands, the stillbirth and neonatal death charity, with the aim of standardising and improving the quality of bereavement care for the families of Scotland. Further information can be found here. During our inspection, we observed a dedicated room used to provide bereavement care, designed to support the full in-hospital bereavement journey. The space offered a private and quiet environment where care options could be discussed sensitively, the birth could be supported and families could spend time together following the death of a baby. Senior managers described a partnership with Held in Our Hearts, a Scottish charity with over 40 years' experience in baby loss counselling and peer support. Within the maternity unit the role of the bereavement lead is undertaken by two senior midwives, who have the responsibility of overseeing midwifery bereavement training and facilitating training, as well as providing clinical support. Staff bereavement training is a recognised standard recommended by the National Bereavement Care Pathway. NHS Borders provide a yearly bereavement update to staff through their maternity mandatory update day. Evidence submitted demonstrated 83% staff compliance for this training.

Ethnicity data is vital information in pregnancy as it helps to identify and address inequalities in maternal and perinatal adverse outcomes. Ethnicity data completeness available through Public Health Scotland demonstrated missing ethnicity data for 20.8% of women was recorded for all women booking within NHS Borders. Public Health Scotland had highlighted this to senior managers as significantly higher than the Scottish average for this quarter. In discussion with senior managers, a review of process had identified this missing data was in relation to two systems utilised within NHS Borders to capture the information required. Senior managers have an active improvement plan in place to ensure the data is processed more efficiently. They also advised of a current action within clinical governance meetings to continue to monitor this until improvement is achieved and sustained. A requirement has been given to support ongoing improvement in this area.

Staff told us that when communication barriers arise for women and birthing people, they can access both online and face to face interpretation services as required. Face to face interpreters should be available through the interpretation service. However, variation in access to interpreters due to the availability of specific languages can result in interpretation services not being immediately accessible and digital translation tools used to support basic communication. However, staff advised that they do not routinely submit incident reports when challenges occur with interpretation or translation services. Encouraging more consistent reporting of interpretation related issues would support NHS Borders to identify themes and implement improvements in this area.

We discussed this with senior managers who were aware that availability of some languages can pose an issue for unscheduled or emergency care. They explained a proactive approach to reduce this within scheduled care including double appointments for those attending appointments in both the community and hospital setting. A double appointment is allocated to allow adequate time for the initial booking appointment to ensure clear communication throughout the consultation for patients who do not speak English. If issues arise, especially out of hours, there is guidance in place for staff to gain support from the site and capacity team. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 1	
1	Good working relationships and collaborative approach from NHS Borders and supporting services, such as Scottish Ambulance Service and ScotStar, was evident during inspection.

Requirements

Domain 1	
1	NHS Borders must ensure ongoing oversight and governance to support the safe delivery of care, including but not limited to: (i) unscheduled care
2	NHS Borders must ensure improvement in governance and oversight of ethnicity completeness data for all women and birthing people booking for perinatal care.

3	NHS Borders must ensure access to interpretation services for all women and families accessing care and consider ways to improve oversight and staff feedback of interpretation services to ensure any areas for improvement can be identified and addressed.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

A positive, supportive working culture was evident, with staff describing NHS Borders as a good place to work and feeling confident to escalate concerns. However, delays to commissioning and completing adverse events reviews is an area for improvement.

A positive working culture is essential to the safe delivery of care and has been evidenced within the reviews into maternity services by Kirkup (2015) and Ockenden (2022). During the inspection, staff described a positive and supportive working environment and reflected that NHS Borders is a good place to work. Staff told us they felt well supported when escalating concerns including issues related to staffing levels, increasing patient complexity and higher acuity. Within evidence we observed the escalation policy which supports staff in and out of hours to escalate any staffing concerns to senior managers.

Effective communication and strong multidisciplinary working are essential in clinical environments where issues may require rapid prioritisation and coordinated planning. We observed cohesive multidisciplinary team working with supportive, respectful communication during inspection. A recent publication from the Nursing and Midwifery Council (NMC) in collaboration with the General Medical Council (GMC) highlighted the positive impact of effective communication within the multidisciplinary team on the safe delivery of maternity care. More information can be found here. Within the maternity unit, midwives and obstetric consultants were visible and working collaboratively. Staff demonstrated good awareness of how to contact wider teams when needed including other speciality clinicians, anaesthetists, theatre staff and senior managers, ensuring a clear escalation pathway during emergency situations.

Senior midwifery and obstetric leaders were visible within the service and demonstrated active engagement with the wider maternity team. Staff described having a clear understanding of senior managers' roles and responsibilities and were able to articulate the difference between strategic and clinical leadership, including how each contributes to the wider organisation. Staff spoke of being very proud of their team and the care they provide. Staff spoke highly of the support received from the senior multidisciplinary team and described having appropriate time to carry out their tasks during their shift. A supportive working culture where wellbeing was promoted in their daily work and following an adverse event which may occur within the service was described by staff. Senior managers were open, honest and transparent regarding the journey within the unit describing several initiatives utilised to support the improvement in culture. NHS Borders undertook a comprehensive, appreciative inquiry to gather staff perspectives on Leadership, Empowerment, Accountability and People (LEAP). This approach was designed to capture strengths, experiences and

opportunities for improvement and to inform the development of a targeted improvement programme aligned to organisational values and priorities.

All staff we spoke with described a positive supportive culture. We were provided with evidence of a range of staff wellbeing initiatives. This included access to local staff emotional support drop-in sessions and a wellbeing support team that offered flexible locations and appointment times to meet staff needs. Staff were also able to access support through virtual appointments and scheduled telephone consultations arranged to accommodate shift patterns. Staff described good use of wellbeing initiatives within the service including a regular ‘Wellbeing Update’ newsletter and the recent addition of a social group which supported team building exercises and activities. Staff updates provided a mix of essential work-related information such as birth statistics, infection control and facilities updates, protocol changes and upcoming training dates whilst also recognising and celebrating staff members’ personal and professional milestones. There has been an implementation of staff development training days for health care support staff within paediatrics, maternity and new recruits. This development opportunity was set up in response to staff request.

Senior managers provided evidence of management team and charge midwife development days. The purpose of which was to support the team to strengthen positive leadership, focus on individual self-awareness and awareness of others, raise awareness of collective strengths as well as areas for development and identification of some actions to take forward in a practical way. These took place in September 2025 with a follow up in February 2026. This day took a ‘What Matters to You’ approach and was well received by the team. “What Matters to You?” is a Healthcare Improvement Scotland initiative that supports more meaningful, person-centred conversations by encouraging staff to ask individuals what is most important to them beyond their clinical needs. This helps ensure care is shaped around personal priorities, values and goals. Evidence shows that such person-centred approaches can improve wellbeing, support better decision making and lead to more personalised and coordinated care.

NHS Education for Scotland 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 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. Within evidence, we observed NHS Borders overall compliance was currently 79.5%.

Staff spoke of a good understanding of the incident reporting system. We were provided with an incident trigger list which aims to encourage submission of an incident form following an adverse event to ensure review and learning is undertaken. Within the trigger list, we noted submission of a patient incident report is requested when a third or fourth degree tear is sustained by a woman during childbirth. However, in the six month period prior to inspection there had only been one reported (0.2%). At the time of inspection, Public Health Scotland data reports the instance of an obstetric anal sphincter injury occurs for 3.2% (Oct-Dec 2025) of women who birth in NHS Borders, which is below the Scottish national average of 3.8% for the same reporting period. The review of the electronic systems at the beginning of 2026 by

senior managers against submitted incident reports had identified that the number of obstetric anal sphincter injuries were not aligning with incident reports submitted. Following this review the trigger list was updated and communication with staff was undertaken to support improved reporting. The oversight of third-degree tears is also captured through the service dashboard on a monthly basis and NHS Borders have increased their oversight of obstetric anal sphincter injuries by including this at clinical governance meetings until assurance has been achieved. We observed continued oversight of all monthly incident reporting within the service through this governance meeting.

NHS Borders uses the national Perinatal Mortality Review Tool (PMRT) to support a standardised review of all stillbirths and neonatal deaths, ensuring that learning is identified consistently. The PMRT is designed to include families' experiences and questions within a robust, objective and standardised local review of care following the death of a baby. Its primary purpose is to provide bereaved parents and families with clear answers about whether care was safe, personalised and appropriate and whether different care may have altered the outcome.

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.

Families are included within the significant adverse events and perinatal mortality review process by assigning a key contact to the family. The contact acts as a spokesperson for the family and is independent from the review team to ensure the families' experience forms part of the review process and learning. However, in evidence we observed there are often delays in both commissioning and completion of reviews when adverse events occurred. We observed four significant adverse event reviews (SAER) are currently in progress within NHS Borders maternity services. All of which demonstrated delays to both commissioning and completing reviews. The time frames for commissioning a SAER within NHS Borders ranged between one and five months. SAER reviews were seen to be still in progress up to 18 months following a significant adverse event. This delay can impact significantly on the mental health and grieving journey of the family involved and delays systematic learning and improvement within the service. Guidance within Healthcare Improvement Scotland's framework highlights SAERs should be commissioned within 10 working days and complete within 140 working days.

Senior managers acknowledged the current delays with SAERs and described immediate actions which include a rapid review of any significant adverse events which ensures any immediate patient safety concerns are identified and mitigations can be put in place. This also included protected multidisciplinary time fortnightly to support any immediate review of clinical care which may be required. Communication with families affected by an adverse event is maintained through their assigned contact. Senior managers explained that, due to the small size of the obstetric team within Borders General Hospital, it is beneficial to obtain external, independent expertise through the involvement of external panel members. External panel members also form a requirement within the maternity and neonatal (perinatal) adverse event review process published by Scottish Government. Whilst it is

considered essential to support robust review and organisational learning, this can result in significant delays to the process. A requirement has been given to support improvement in this area.

Reviews into maternity services such as Ockenden (2022) states incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner. Recommending a change in practice arising from an incident investigation should be implemented within six months after the incident occurred. We observed action plans generated following adverse events reviews were monitored until completion through the monthly service governance meeting. However, we noted that on occasion there were no assigned completion dates for the actions and some actions were not achieved within their completion date which could impact timely systematic learning and change. We raised this with senior managers who advised us that omission of completion dates was an administrative error and that oversight of all actions remained within the governance group until achieved. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 2	
2	Staff described a supportive culture following an adverse event. Senior managers were open, honest and transparent regarding the journey within the unit to improve the service culture.
3	Senior managers provided evidence of management team and charge midwife development days which were designed to support the team in strengthening positive leadership.
4	Staff described support following adverse events as positive learning experiences.

Requirements

Domain 2	
4	NHS Borders must ensure timescales of commissioning and completion of significant adverse event reviews align with the timeframes in Healthcare Improvement Scotland's Adverse Events National Framework.

Domain 4.1 – Pathways, procedures and policies

Quality indicator 4.1 – Pathways, procedures and policies

We observed several quality improvement projects to support and improve the safe delivery of care within the service. Improvements in relation to the hospital environment, storage of medications and fire safety training were highlighted.

Quality improvement aims to improve safety, effectiveness and experience of care. Inspectors observed the use of quality improvement and quality assurance proactively being used and discussed within the service.

The Scottish maternity early warning score (MEWS) is a bedside screening tool which supports observation of physiological parameters such as blood pressure and heart rate in an aim to improve the recognition of pregnant and postnatal women at risk of clinical deterioration. This facilitates early intervention to improve outcomes. NHS Borders provided us with audits which demonstrated consistent oversight of areas for improvement within MEWS score charts, which at the time of inspection demonstrated overall compliance of above 80%.

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 audits. 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 compliance with VTE risk assessment for booking was 94% and 98% of postnatal risk assessments were completed and the service utilised up to date national guidance to support staff.

Cardiotocograph training is critical to safeguarding fetal wellbeing, supporting consistent interpretation of fetal monitoring and ensuring adherence to clinical governance standards. We were provided with evidence that 83% of midwives are up to date with mandatory fetal monitoring training. Senior managers provided the quality improvement charter around cardiotocograph interpretation. This was developed in response to themes identified within SAERs and has been an ongoing project since April 2022. The aim is to achieve ‘fresh eye’ hourly reviews on 95% of all intrapartum cardiotocographs (CTG). Fresh eyes hourly CTG reviews are a safety process whereby a second, appropriately trained clinician undertakes an independent review of the CTG at least hourly to support timely recognition of concerns and appropriate escalation of care. NHS Borders have developed a comprehensive maternity dashboard that collates monthly audit data and presents it in a graphical format to support clear interpretation. This enables effective identification of trends and control points, whilst facilitating consistent and sustained oversight. The audit data provided demonstrated there is an average of 86.1% compliance with ‘fresh eyes’ over the past six months.

Inspectors received feedback from women who reported that they had been well supported in establishing feeding for their babies. Women consistently described feeling appropriately supported in their chosen method of feeding and praised the care and reassurance provided by midwives and maternity care support workers. NHS Borders were awarded ‘Gold’ reaccreditation. Within UNICEFs report, they recognised a positive working culture that was observed as part of the inspection. However, only 47% of maternity staff are up to date with Baby Friendly Initiative training compliance. A requirement has been given to support improvement in this area.

Hand hygiene is a fundamental component of Standard Infection Control Precautions (SICPs) and is considered an important practice in reducing the transmission of infectious agents which cause infections. SICPs also include appropriate patient placement, use of personal protective equipment (such as gloves and aprons), maintaining a clean care environment and the safe management of blood and bodily fluid spillages, linen and waste. They further encompass measures to prevent and manage exposure incidents including sharps injuries. During our inspection, we observed good compliance with hand hygiene practices. No

opportunities for hand hygiene were missed by staff observed. Personal protective equipment (PPE), including gloves and aprons, was readily available at the point of care. We observed appropriate use of PPE in line with SICPs. Linen trolleys were stored correctly and were appropriately covered, in accordance with the National Infection Prevention and Control Manual. Used linen that was potentially contaminated with blood or suspected to be infectious was handled and disposed of correctly.

Patient care equipment was clean and ready for use. The care environment and surrounding area were clean and maintained to a high standard. Inspectors observed evidence of wear and tear throughout the hospital environment. Inspectors observed shower areas with what appeared to be mould in the corners of the shower trays and broken shower seals. Damage to the healthcare environment can impact effective cleaning. Senior managers described an ongoing rolling programme of refurbishment within maternity clinical areas which includes the shower areas.

We observed midwives working to maintain patients' privacy and dignity, including the use of privacy screens when required. Recent renovation work has been undertaken within the labour ward to enhance both the working environment and the overall patient experience. This includes new flooring and a new staff base preparation area. At the time of the inspection, these works were still ongoing and several members of staff highlighted the continued need for further improvements within the labour ward. Senior managers were aware and had previously escalated this through NHS Borders governance structures to highlight as an area of concern and to discuss a resolution.

Whilst on site we were made aware that there was one shower room and one patient toilet available within the main corridor of the labour ward. Staff informed us that the shower room frequently became excessively warm and there had been instances where patients had fainted. As a result, the door was often left open to improve ventilation. Senior managers advised us that this had been escalated through board papers however no funding was available to upgrade these facilities at this time. A requirement has been given to support further improvement in this area.

We observed safe sharps-management practices, with sharps containers correctly labelled in line with guidelines and temporary closures in use. The use of temporary closures reduces the risk of needles or other sharp items protruding from the container or falling out if the box is dropped. Inspectors also noted that sharps containers were stored appropriately when not in use.

During the inspection, medication trolleys were locked and appropriately secured. However, medication cupboards were unlocked and therefore could have been accessed by women or members of the public. This is not compliant with professional guidance on the safe storage and administration of medicines, as set out by the Royal Pharmaceutical Society, nor with the requirements of the Nursing and Midwifery Council's Code. A requirement has been given to support improvement in this area.

Clear fire exit signage is essential to ensuring the environment is adequately prepared for a swift and safe evacuation in the event of a fire. Due to a missing fire evacuation sign, fire evacuation points were not visible from several areas within the antenatal and postnatal

ward. We observed gases being stored on the floor with no signage to indicate that medical gases are stored in the area. We raised these concerns immediately with the senior management team and we received evidence of immediate actions that included replacement signage and correctly revised storage of medical gases. Senior managers provided evidence of compliance with mandatory fire safety training, showing a staff compliance rate of 83% across all staff groups. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 4.1	
5	Inspectors observed the use of quality improvement and quality assurance proactively being used and discussed within the service.

Requirements

Domain 4.1	
5	NHS Borders must ensure effective systems and processes are in place to support assurance of a safe healthcare environment and that all essential maintenance works are completed.
6	NHS Borders must ensure the safe storage of medicines.
7	NHS Borders must ensure all fire exit signage is present and maintained to support safe fire evacuation.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Staff described confidence to raise staffing concerns with their clinical management team. This includes student midwives and trainee medical staff.

Recruitment and retention challenges for both obstetric and midwifery staff continue to be experienced across Scotland, as highlighted in the national workforce reports and Best Start recommendations for sustainable maternity services. These pressures are increasingly evident within remote and rural health boards, such as NHS Borders, where services require staff to work in broader, more generalist roles and participate in out of hours and on call rotas with greater frequency.

The senior medical team openly discussed challenges to recruit to obstetric vacancies which had been initially difficult to fill and had resulted in gaps in the obstetric rota. Senior managers acknowledged the vulnerabilities associated with current workforce arrangements and recognised that acuity and activity levels may limit exposure to the variation of clinical learning required for consultant grade obstetric development. They also highlighted an awareness of the essential role of training opportunities in supporting recruitment and retention. In response, the team described innovative approaches aligned with national expectations for collaborative models of care, including working closely with NHS Lothian to enhance access to complex clinical experience and shared learning. In addition, senior

obstetricians within NHS Borders have taken on supportive roles to help develop the skills of middle tier doctors, contributing to workforce resilience and the continuity of specialist expertise.

The Health and Care (Staffing) (Scotland) Act 2019 requires all NHS boards to ensure they have a real-time staffing assessment in place 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 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. A morning community huddle, led by the lead midwife, also supported oversight of both areas enabling consideration of staffing requirements.

We also had the opportunity to observe how maternity services fed into the wider hospital safety huddle. The hospital safety huddles occur twice a day and were attended by members of the multidisciplinary team including nursing, midwifery, allied health professionals, hospital discharge team and facilities colleagues. We observed supportive discussions and evidence of maternity services staffing, acuity, capacity and safety concerns raised.

We attended the labour ward's multidisciplinary morning huddle which was well represented by both the obstetric and midwifery teams. The consultant team led a comprehensive review of all women receiving care within maternity services. The discussion supported good oversight and situational awareness, including recognition of system pressures and their potential impact on patient experience and outcomes. We observed a respectful and compassionate discussion of women's needs, with clear care plans communicated to the team.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that NHS boards have a duty to apply the common staffing method (CSM), which includes a staffing level tool run and requires this to be applied rigorously and consistently. The application of the CSM and staffing level tools supports NHS boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care. We observed daily staffing is captured within the daily huddle sheet. However, completion of the maternity staffing tool between 2025 and 2026 demonstrated some of the mandatory elements of the staffing tool run were omitted. The missing data rendered the outputs from the run incomplete and limited the level of oversight required for compliance with the staffing act. Common staffing methodology requires triangulation of all service specific data, however, evidence was not seen to demonstrate this was being undertaken. However, senior managers recognised this and plan to adopt the methodology for 2026/2027. A requirement has been given to support improvement in this area.

Within incident reports submitted for the six months prior to this inspection, we observed only one incident related to staffing concerns. We asked senior managers how staffing risk and mitigation is captured to allow for monitoring over time. Senior managers explained that as well as the incident reporting system, staff are encouraged to escalate staffing concerns through their line manager and this is documented using the real-time staffing system. We

requested this as part of evidence and observed that real-time staffing assessments are consistently completed, staffing concerns are actively escalated and responded to and that professional judgement is applied alongside real-time data.

We observed senior clinical leaders within maternity services were approachable and engaging with all team members. We observed supportive interactions between the team around care provision with prompt escalation observed to activate the multidisciplinary team when clinical need arose. Staff described an openness to raise staffing concerns with their clinical management team who would assist and would be supportive with patient care or staff break relief.

NHS Borders incorporate an obstetric consultant "hot week." This results in the rostered consultant leading oversight of unscheduled, labour ward, inpatient antenatal and postnatal care for the week in collaboration with the midwifery team. This dedicated consultant obstetrician provides a period of continuity of care from the obstetric team to women presenting to the service for emergency care or who require to be an inpatient due to complex care needs. This approach helps to support enhanced safety and efficient care coordination for women.

Staff spoke highly of the availability of and ability to attend core mandatory training, reporting that this is rarely rescheduled with a good system of oversight of when training is lapsing allowing personal ownership to learning. NHS Borders deliver this core mandatory training through Maternity Mandatory Update Days (MMUD). At the time of inspection, NHS Borders had a training compliance rate of 83%. Clinical staff complete Once for Scotland statutory mandatory online training to ensure compliance and support safe care. Core modules include fire safety, health and safety, infection prevention and control, moving and handling, information governance, cyber security, equality and human rights and adult and child protection. Through evidence we observed that midwifery and support staff had compliance of greater than 90% for statutory mandatory training, however obstetric and gynaecological medical teams had a lower compliance of 69%. A requirement has been given for improvement in this area.

NHS Borders have developed a bespoke training programme for all band 3 healthcare support workers and has provided staff with valuable opportunities to further develop their skills. The programme includes training in MEWS and PEWS (Paediatric Early Warning Score), venepuncture and nasogastric tube feeding. Healthcare support workers play a key role within maternity services by supporting midwives and the wider multidisciplinary team to deliver safe and effective care and by contributing to the experience of women and families across the maternity pathway. Healthcare support workers told us they had good opportunities to undertake their role and felt confident in escalating any concerns to midwifery staff. Inspectors observed respectful, supportive and engaging interactions between support staff, women and their families.

Staff having the right skills and knowledge within their area of practice is essential in the safe delivery of care. Early career midwives reported they regularly rotated between labour ward and ward 16, which allowed them to build and maintain their skills and competencies in both areas. They described a positive learning environment with ease of escalation of any concerns. This extended to junior medical staff and students. We also observed good multidisciplinary

interactions with genuine support of junior staff throughout our time on inspection. Staff appraisals are essential to assessing and supporting staff performance, resulting in a positive work culture. Midwives supported the senior charge midwife by taking on additional responsibilities to strengthen the wider team. These duties included contributing to staff appraisals. We received evidence that 92% of midwifery staff and 100% of obstetric staff have had an appraisal over the last 12 months. NHS Borders utilises a maternity training passport to support individual responsibility for mandatory training compliance and to ensure effective oversight of training needs for midwives within the appraisal framework. Recent changes implemented in response to staff feedback have had a positive impact on work life balance across the service. The role of the senior charge midwife, who previously provided oversight across the labour ward, the unscheduled care service and ward 16, was recently reviewed. As a result, this role has been adjusted to allow a greater focus on management duties. This change has been supported by both senior managers and the wider clinical team. Positive feedback has been received from both groups, highlighting improvements in clarity of leadership, service development and staff support. The revised balance enables enhanced attention to service improvement initiatives, strengthened people management and effective protected time to lead. This is also being trialled at a senior level, where, until recently, the director of midwifery also held responsibilities as general manager. Following a review of duties and organisational needs, the general manager responsibilities have been removed from the role. This change supports clearer strategic leadership for maternity services and ensures dedicated capacity for professional midwifery oversight.

Areas of good practice

Domain 4.3	
6	Obstetricians within NHS Borders have taken on supportive roles to help develop the skills of middle tier doctors, contributing to workforce resilience and the continuity of specialist expertise.
7	We observed a respectful and compassionate discussion of women’s needs, with clear care plans communicated to the team.
8	Staff described confidence to raise staffing concerns with their clinical management team who would assist and would be supportive with patient care or staff break relief.

Requirements

Domain 4.3	
8	NHS Borders must ensure that there are processes in place to support the consistent application of the common staffing method. This should include, but is not limited to: (i) the correct application of running the mandated staffing level and professional judgement tools (ii) a reporting template demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement.
9	NHS Borders must have robust systems and processes in place to ensure that all staff have completed mandatory training essential to their role.

Domain 6 – Dignity and respect

Quality 6.2 – Dignity and respect

We observed respectful interactions by the multidisciplinary team. Families we spoke with told us they would be happy to recommend NHS Borders maternity services to family and friends.

We observed staff working to provide compassionate, responsive and respectful care. Women, families and visitors we spoke with were complimentary about staff and the care they received. We observed staff taking time to respond to questions from women and families, encouraging them to ask further questions and ensuring privacy was maintained by drawing curtains where required. All patients had access to call bells and appeared well cared for. On arrival, women were orientated to the ward environment and all patients reported feeling confident that they could request assistance if needed.

Partners are supported to stay overnight although not every room contains facilities to accommodate this. Staff reported that this has not posed difficulties due to the typical activity levels within the unit. We observed pull-out beds available within the single rooms of the antenatal/postnatal ward and staff described prioritising these for those with greatest clinical need.

Listening to service users is essential in improving the quality of services. As part of the inspection, we noted the compliments and complaints were displayed on maternity information boards within the ward setting, along with current improvement projects and maternity statistics. Whilst there were many service users highlighting positive examples of commendable care by staff, there were incidents of poor communication being raised as an area for improvement. In the evidence reviewed, we observed that three out of four complaints submitted in evidence had communication issues. Patient feedback and complaints formed part of clinical governance papers, however actions on improvements to address these were not clear. A requirement has been given to support improvement in this area.

Trauma-informed training equips maternity staff to recognise and understand the impact of trauma on emotional and psychological wellbeing. The training enables services to respond sensitively and effectively in ways that prevent further harm, support recovery and address inequalities for trauma survivors. We observed a proactive approach to trauma-informed practice within the multi-disciplinary team morning huddle within labour ward. The discussions around individualised care plans were compassionate, empathetic and sensitive to the women's needs.

We were provided with information on trauma-informed training opportunities for staff and signposting to relevant learning. This is included within the units maternity training passport. However, trauma-informed training compliance for staff was 30%. A recommendation has been given to support ongoing training compliance rates for all staff.

The Faculty of Sexual and Reproductive Health (FSRH) advises starting effective contraception as soon as possible after birth. Together with the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG), they recommend that contraception is discussed and offered before women leave maternity services. This helps women plan future pregnancies, avoid short interpregnancy intervals and reduces the risk of poorer outcomes. We observed that maternity staff were proactive in discussing and providing contraception with postnatal women. This approach is especially valuable for women living in rural areas, where access to contraception after childbirth may be limited by distance, transport challenges and fewer community-based services. By offering contraception before discharge, staff help remove these barriers and ensure women can access timely, convenient contraception. This supports safer pregnancy planning and promotes more equitable care for women regardless of where they live. NHS Borders provided us with an audit demonstrating 99% of patients were offered contraception prior to transferring care to the health visitor postnatally.

Areas of good practice

Domain 6	
9	We observed staff working to provide compassionate, responsive and respectful care.
10	We observed that maternity staff were proactive in discussing and providing contraception with postnatal women.

Recommendations

Domain 6	
1	NHS Borders should consider improving trauma-informed training compliance rates for all staff.

Requirements

Domain 6	
10	NHS Borders must ensure that recurring themes from patient feedback is utilised to support service improvements.

Appendix 1 - List of national guidance

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

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

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