Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Balfour Hospital

NHS Orkney

23 – 24 March 2026

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Published July 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

The Balfour is situated near the centre of Kirkwall. It is a small rural hospital with 48 beds containing an emergency department, inpatient and day wards and an integrated maternity and women's health service as well as several outpatient services such as physiotherapy, audiology and radiography. Patients requiring specialist treatment may be transferred to the Scottish mainland. In 2025, there was 100 births recorded at NHS Orkney.

About this inspection

We carried out an unannounced maternity services inspection in conjunction with an acute safe delivery of care inspection to Balfour Hospital, NHS Orkney on Monday 23 March and Tuesday 24 March 2026 using our safe delivery of care inspection methodology. An inspection report for the acute inspection will be published on our website. During the maternity inspection, we inspected the following areas:

- Combined antenatal, labour suite and postnatal 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 peoples health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Orkney 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.

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 Orkney and in particular all staff at maternity services for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection.'

Throughout our inspection we observed staff providing person-centred, compassionate and responsive care to women and their families.

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

Staff were actively engaged with their own learning and development with plans in place to ensure they all complete their mandatory training.

Women and their families were complimentary of their care and would recommend NHS Orkney to friends and family.

During inspection, some areas of improvement were identified. These included the improved oversight and governance of the review of policies, guidelines and procedures.

Further improvements are required to ensure timescales of adverse events are achieved. This includes feedback to staff to support and improve the safe delivery of care.

NHS Orkney must ensure that clinical leaders have protected time to lead to fulfil their leadership roles.

Improvement in the completion of the electronic staffing tools was also identified to ensure the service is safe to start and that mitigations to ensure patient safety are consistently recorded.

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

This inspection resulted in 12 areas of good practice, two recommendations and nine 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, birthing people 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 Orkney 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 Balfour Hospital resulted in 12 areas of good practice.

Domain 1	
1	Staff were observed to provide responsive, compassionate and family-centred care (see page 11).
2	NHS Orkney has implemented a dedicated 'red phone' system within maternity triage to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff (see page 11).
3	The maternity ward was clean, organised and maintained to a high standard (see page 11).

Domain 2	
4	We observed an open and transparent culture with respectful, multidisciplinary team communication (see page 14).

5	Staff reported feeling well supported and able to escalate concerns to senior managers including the use of QR codes (see page 14).
6	NHS Orkney has introduced the Daisy Award programme to celebrate and recognise staff (see page 14).
7	A trigger list was available to all staff to aid and encourage the submission of incident report forms following an adverse event (see page 14).
8	NHS Orkney is engaging with and responding to, feedback from service users (see page 14).

Domain 4.1	
9	We observed the implementation of a local newborn ultrasound screening programme for neonatal hip dysplasia to reduce carbon emissions from travel to mainland health boards as well as reduce the travel burden on families (see page 19).
10	All equipment examined was clean and stored safely ready for use (see page 19).

Domain 6	
11	Women, families and visitors that we spoke with were highly complementary of the multidisciplinary team and the care provided (see page 23).
12	Women and families were supported by staff to build confidence in their infant feeding choice and supported to develop close and loving parent-infant relationships (see page 23).

Recommendations

The unannounced inspection to Balfour Hospital resulted in two recommendations.

Domain 4.1	
1	NHS Orkney should consider introducing a structured communication format such as an SBAR (Situation, Background, Assessment, Recommendation) during handovers and at times of escalations (see page 19).

Domain 6	
2	NHS Orkney should consider improving trauma informed training compliance rates for all staff (see page 23).

Requirements

The unannounced inspection to Balfour Hospital resulted in nine requirements.

Domain 1	
1	NHS Orkney must ensure governance and oversight to ensure venous thromboembolism risk assessment compliance (see page 11). This will support compliance with: The Quality Assurance Framework (2022) criteria 2.6.

Domain 2	
2	NHS Orkney must ensure timescales of adverse events are achieved. This includes feedback to staff and action plans to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland's National Framework (see page 14). 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	
3	NHS Orkney must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use (see page 19). This will support: Quality Assurance System: Quality Assurance Framework (2022) criterion 2.5 and 2.6.
4	NHS Orkney must ensure an effective system is in place to record patient documentation. This includes but is not limited to: i. The maternity early warning score is accurately completed to support the safe delivery of care (see page 19). This is to comply with Nursing and Midwifery Council (NMC) The code (2018) and NHS Scotland and Healthcare Improvement Scotland Quality Assurance Framework (2022) criteria 2.6.
5	NHS Orkney must ensure that employees receive time and resources to undertake training which is essential to their role (see page 19). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
6	NHS Orkney must ensure that all staff complete statutory fire safety training (see page 19). This will support: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3 and Fire Safety (Scotland) Regulations (2006).

Domain 4.3	
7	NHS Orkney must ensure senior charge midwives have appropriate and protected leadership time to fulfil their leadership and management responsibilities. This will include but is not limited to: i. Staff appraisals This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls (see page 21). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Health and Social Care Standards (2017) criteria 3.14, 3.15 and 3.19.

8	NHS Orkney must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real-time staffing risk across all clinical professional groups within maternity services. This is to support consistent management of any identified staffing risks which should include, but is not limited to: i. Recording any escalation, mitigation and/or inability to mitigate and communication of outcomes to all relevant teams ii. A record of any disagreements with decisions made (see page 22). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
9	NHS Orkney must ensure that there are processes in place to support the consistent application of the common staffing method. This includes, but is not limited to: i. The application of 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 22). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We observed good multidisciplinary team work to provide prompt, responsive and compassionate care. The service supported a family-centred approach, recognising the importance of encouraging fathers, co-parents, partners and family members to be partners in care.

NHS Orkney provides maternity services to women and their families across Orkney in Balfour Hospital, Kirkwall. The maternity ward is situated on the first floor and is clearly signposted from the main entrance. The department delivers an integrated maternity and women's health service to its community which amongst others covers antenatal, intrapartum and postnatal care. The maternity ward provides midwifery led care supported by onsite consultant obstetricians.

The maternity service supports the continuity of care model described within Scottish Governments 2017 vision for maternity services; The Best Start: A five-year forward plan for maternity and neonatal care in Scotland recommending parents and babies are offered truly family-centred and compassionate care. NHS Orkney provides a team midwifery model where women are allocated to a small team of midwives who provide their care. We observed no restrictions to visiting and the service supported a family-centred approach, recognising the importance of encouraging fathers, co-parents, partners and family members to be partners in care. Women and families who we spoke with told inspectors that they were provided with appropriate information relating to their care, had time to ask questions and felt actively

involved in their care plans. They described that their wishes were heard and respected and felt like they were partners in care.

The maternity service is accessible 24 hours a day, seven days a week following a telephone assessment carried out by midwives, allowing maternity staff oversight of women attending. Staff document calls on a standard maternity electronic patient communication log developed to record telephone conversations. Women who require to attend the maternity service are reviewed promptly upon their arrival. This is consistently achieved due to low acuity within the department.

NHS Orkney supports both scheduled and unscheduled care within the maternity unit with staff able to support this. During inspection, inspectors observed that calls were answered promptly and there were no delays observed. Staff and senior managers did not describe any delays to prioritising triage calls or care. We asked NHS Orkney to provide all incident reports submitted by staff for the six months prior to our inspection in relation to patient safety. From review of submitted reports we observed no incidents related to delays to prioritising triage or care.

The maternity ward has recently implemented a dedicated ‘red phone’ system to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff. The availability of a ‘red phone’ was raised as a recommendation following a recent fatal accident inquiry within another NHS board. This system facilitates timely, clear and prioritised communication during critical information sharing, supporting safer and more effective coordination of patient care. Due to a small staffing model, the senior management team confirmed that the midwife on shift always carries the maternity phone when away from the desk ensuring uninterrupted access to maternity staff. This arrangement mitigates any potential safety risk and aligns with their local escalation procedure.

Within the maternity ward there are two spacious birth rooms, one with a birthing pool. There are a further two side rooms that are flexibly used for antenatal or postnatal care depending on requirements. Staff highlighted that these rooms, at times of high acuity within the wider hospital, may be used as surge beds with staff from the acute ward continuing to care for their patients. Should this be required, the maternity unit can be reconfigured with a set of closed doors to protect safety. There are further consultation rooms which have multipurpose usage such as triage, clinical appointments as well as ultrasound services. Throughout our inspection, the maternity ward was clean, organised and maintained to a high standard.

During the onsite inspection, the unit was busy but calm and we did not observe any delays to care. Women were reviewed immediately and call bells were answered promptly. We observed staff providing responsive and person-centred care. Senior managers informed us that although delays occasionally occur, these are rare. As a mitigation and particularly during out of hours where only one midwife is on duty within the unit, there is an agreed on-call model to ensure the availability of a second midwife when required. NHS Orkney was able to provide a policy which supports the escalation of staffing risk concerns to support the safe delivery of patient care. Data relating to delays to care, including delays to induction of labour and if medical staff were unavailable to attend a patient, would be captured through the incident reporting system. Through the review of evidence submitted, there were no reported incidents of delays to care observed in the six months prior to our inspection.

Obstetric emergencies and concerns over the wellbeing of the unborn baby are time sensitive, requiring a systematic approach which identifies women of the highest clinical priority to improve outcomes. The appropriate equipment to manage these situations should be readily available. An emergency trolley provides immediate access to critical equipment and medications during an obstetric emergency. Essential medications which would be used during obstetric emergencies were observed to be stored safely and appropriately. During the onsite inspection, we noted that emergency trolleys were placed appropriately within the maternity ward. They were clean, organised and accessible to all staff for their prompt use.

In the event of an unwell or unexpected premature newborn baby who needs enhanced support at birth, it is fundamental that staff have the required skills to respond effectively. Maternity staff described undertaking enhanced learning in emergency skills and stabilisation of the newborn baby. Stabilisation of the newborn is a process where midwives, neonatologists and paediatricians are involved in providing care to a baby who requires increased support whilst awaiting the attendance of a neonatal transport team. ScotSTAR is a national service for the safe and effective transport and retrieval of newborn babies as well as critically ill children throughout Scotland. In NHS Orkney midwives are required to stabilise newborn babies as there are no neonatologist or paediatricians on site but the anaesthetic team are available to support where required. During the antenatal care, women are made aware that if their baby requires immediate support, midwives and the medical teams will provide the initial support but that an emergency transfer to the most appropriate neonatal unit may be required. Midwives consistently described respectful partnerships with medical teams from mainland health boards when they required support or guidance to ensure that immediate neonatal care is initiated to provide safe delivery of care. In evidence submitted by NHS Orkney, we observed 94% of midwifery staff had undertaken the Scottish Neonatal Resuscitation Course (SNRC) with the remaining two midwives scheduled for attendance. Obstetric consultants had a 67% compliance rate, reflecting one new member of staff recently commencing in post.

If any concerns are identified regarding the wellbeing of the mother or her baby, staff may in collaboration with mainland health boards, arrange for a transfer to ensure the continued safe delivery of care. In evidence submitted, we noted that due to Orkney's geographical location, urgent transfers to the mainland are facilitated by air, though this is determined by the availability of aircraft, crew and weather conditions. In evidence reviewed, we observed a reduction in local births from 145 in 2020 to 100 in 2025. However, the service has observed a rise in transfers from 45 in 2020 to 54 in 2025. The increase in transfers is linked to an increase in maternal complexity which is consistent with national trends. Of overall transfers during 2025, 39% were classified as emergency maternal transfers and 6% were neonatal transfers to mainland health boards.

Mother and babies: reducing risk through audits and confidential enquiries across the UK (MBRRACE-UK) aim to improve outcomes for women and babies through learning from national audit. The 2024 report demonstrated the leading cause for maternal death in the UK being attributed to venous thromboembolism. Learning from the report highlighted a need for continuous evidence-based risk assessment throughout pregnancy and following birth. In evidence submitted by NHS Orkney, we observed that 95% of inpatients had their risk assessments done. However, only 78% of antenatal and 87% of postnatal risk assessments were completed. Patient safety incident reports submitted did not highlight any submissions or concerns relating to thromboprophylaxis being omitted. A requirement has been given to

support further improvement in the consistent completion of venous thromboembolism assessments.

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 that bereaved families would be allocated a room in the maternity ward due to the limitations of the ward and hospital environment. Staff raised some concerns regarding the location of caring for bereaved families in the maternity ward and were conscious of the emotional and mental challenges this might cause women and their families. Staff spoke with empathy and compassion of providing holistic and compassionate care ensuring women and families were empowered to create memories as part of their Memory Box. Within the maternity services the role of the bereavement lead is undertaken by a midwife. Evidence reviewed demonstrate that learning and development sessions are offered to all staff. This is in line with Key Action 32 of the National Bereavement Care Pathway Scotland which highlights that all staff who are caring for bereaved families should be supported to access learning opportunities. In 2025, 88% of midwives, 100% of health care support workers and 67% of obstetric consultants had attended bereavement training, the lower rate among obstetric consultants reflected one new member of staff recently commencing in post.

Areas of good practice

Domain 1	
1	Staff were observed to provide responsive, compassionate and family-centred care.
2	NHS Orkney has implemented a dedicated 'red phone' system within maternity triage to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff.
3	The maternity ward was clean, organised and maintained to a high standard.

Requirements

Domain 1	
1	NHS Orkney must ensure governance and oversight to ensure venous thromboembolism risk assessment compliance.

Domain 2 – Leadership and culture

Quality indicator 2.1 – shared values

We observed an open and transparent culture where senior midwifery managers and obstetric consultants were visible, aiding support and care provision. We observed areas for improvement in the timely review of incident reports and consistent feedback.

Inspectors observed respectful and inclusive multidisciplinary team communication during inspection. The Nursing and Midwifery Council and General Medical Council emphasise the importance of effective team working and communication to provide good and safe patient care within their 'Good teamwork means better maternity care' document. Further information can be found here. Communication and effective multidisciplinary working are key

in all clinical areas where there may be multiple issues that require prioritisation and planning. Throughout the inspection, midwives and obstetricians were noted to be working closely together and shared good oversight of how and when they would contact other teams including anaesthetists, theatre teams and senior managers if the need should arise during an emergency to ensure the safe delivery of care. Staff told inspectors that they felt well supported when they escalated issues such as understaffing and increased acuity to the senior management team. Within evidence received, NHS Orkney was able to provide the escalation policy which supports staff in and out of hours to escalate any staffing concerns to senior managers.

A positive working culture and psychological safety is essential to the safe delivery of care and has been evidenced within the reviews into maternity services by Kirkup (2015) and Ockenden (2022). Psychological safety is the ability of all staff groups to feel free to speak up, ask questions, report errors, raise concerns and ask for feedback without fear of consequences or being judged. During our inspection staff described a positive and supportive workplace culture. Staff told inspectors that they felt well supported by senior managers when they escalated issues such as staffing and increased acuity. During the inspection, we observed posters that provided staff with an option to use a Quick Response (QR) barcode displayed within the maternity unit to raise their concern anonymously if they wished.

In evidence submitted by NHS Orkney, we reviewed the 2025 iMatter Health and Social Care Staff Experience Survey for maternity services. The survey is structured around key enablers of staff engagement, allowing teams and health boards across health and social care to reflect on their progress against the five strands of the Staff Governance Standard. This standard supports staff to feel well informed, appropriately trained, involved in decisions, treated fairly and working in an environment that promotes their health and wellbeing. More information can be found here. The survey results demonstrate that 100% of maternity staff participated in the survey which is a considerable increase from 58% responding in 2023. The 2025 results show a high Employee Engagement Index of 86 across the five Staff Governance Standards. Staff particularly rated being appropriately trained and developed as well as being treated fairly and consistently with dignity and respect. These results enable the maternity service to recognise and celebrate their achievements and for the board to explore opportunities for continuous improvement where staff have identified areas where this is needed.

Staff described a positive culture where staff wellbeing was promoted. The maternity team has weekly team meetings which staff spoke highly of as a time to come together, learn and consider suggestions for improvements. Staff who inspectors spoke with during the onsite inspection highlighted high levels of support and psychological safety through these meetings. Senior staff demonstrated commitment and awareness to role model respectful, compassionate communication and through their leadership improving workplace culture, individual and team performance and in doing so, improving patient care.

The maternity service has introduced the Daisy Award which is a programme to celebrate and recognise staff for the care and kindness they have provided. Staff may collect nominations from women, families and their peers. During the inspection, we observed several posters and Daisy nomination cards that could be submitted into a nomination box, or nominees could use the QR barcodes that were displayed. Maternity staff spoke of the positive impact the Daisy Award has on acknowledging their colleagues, receiving nominations from peers or from the women and families they have cared for.

The national perinatal mortality review tool (PMRT) is a national tool designed to standardise the review and identify learning following stillbirths and neonatal deaths. NHS Orkney uses the national review tool and includes the experiences of families involved. NHS Orkney submits all data in relation to perinatal deaths and uses the PMRT to support adverse events reviews.

The learning from adverse events national framework highlights that all adverse incidents should be reviewed. The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. Further information on the adverse event framework can be found here. A trigger list was available to all staff to aid and encourage the submission of incident report forms following an adverse event.

A significant adverse event is an event which caused or could have caused significant harm. Significant adverse event reviews are essential to ensure key learning and reduce the risk of future harm. Through the review process, NHS Orkney ensures patients and families are informed, involved and supported throughout the review and allocates a named contact who may answer their questions. Patients and families are offered the opportunity to contribute through face to face or virtual meetings to ensure their perspectives, concerns and experiences form part of the review process. The most serious adverse events are categorised as level one, requiring a significant adverse event review which should be completed within 140 working days. In evidence provided, we observed that the maternity service commissioned and completed the review within the expected timeframe in line with national and local processes, however delays were noted within the wider hospital setting. The maternity service developed an action plan to address the recommendations outlined in the review. These actions were agreed through clinical governance processes with most of the improvements implemented. The final action is expected to be concluded at the end of May 2026.

During the inspection, we spoke with staff who described feeling able to submit incident reports without concern. However, some staff told us that they do not report all incidents mostly due to long delays before feedback is provided, or in some cases that they did not receive feedback. Inconsistent incident reporting might have an impact on learning from adverse events thus reducing opportunities to understand what went wrong, why it happened and improve safety within the system. In the national framework for reviewing and learning from adverse events level two incidents require a review completed within 30 working days whilst level three incidents should be completed within 10 working days. In review of evidence, we observed that the maternity service at NHS Orkney has a delay of up to four months in reviewing some incidents. This delay limits timely improvement, feedback and learning. In discussion with senior managers, they described good oversight, governance and system progress to improve their compliance in accordance with the national framework however, the delay to complete the review of these adverse events remains. This was also highlighted in the acute inspection and a requirement has therefore been given to support further improvement in this area.

In Healthcare Improvement Scotland National Framework for Reviewing and Learning from Adverse Events, it outlines that NHS boards should ensure immediate access to support for staff involved in adverse events. Staff at NHS Orkney spoke highly of their peers for support whilst recognising other support options such as occupational health and NHS Scotland wellbeing and mental health support services, should they prefer. Staff described the use of the hot debrief technique to support and promote psychological safety following an adverse

event. Initiating a hot debrief or discussion immediately following the event is an important element of staff support and opportunity to ensure there are no immediate patient safety risks. Facilitating this acknowledges what has happened and ensures staff receive proportionate support in a timely and person-centred manner. Senior staff acknowledged the emotional and professional impact adverse events might have and discussed reaching out to staff involved to ensure their wellbeing. Staff told the inspection team that they felt well supported without fear of blame. Staff articulated that they viewed adverse events as an opportunity of learning and to improve future care displaying a culture of continuous learning as integral to delivering safe, effective and compassionate care to the community.

Listening to service users is a key component in a quality management system and in improving the quality of services. As part of the inspection, we noted multiple thank you cards displayed within the maternity unit and observed several posters with QR codes encouraging and welcoming feedback from service users. In discussion with staff and senior managers as well as in the evidence received from NHS Orkney, there was an acknowledgement of receiving limited feedback through Care Opinion. This is an anonymous platform where patients can share their experiences which are passed on to the health service in an aim to improve care and experiences. Senior managers highlighted that patient experiences and feedback reported to the board are shared though the monthly Clinical Quality Group providing oversight and supporting the use of service users' experiences to inform service improvement. In evidence received, we observed that the maternity service had developed a postnatal questionnaire in 2025 to obtain feedback and suggestions for improvements from mothers. The survey responses demonstrated few suggestions for change, with respondents praising the person-centred care, compassion and outstanding support they had received throughout their care journey.

Areas of good practice

Domain 2	
4	We observed an open and transparent culture with respectful, multidisciplinary team communication.
5	Staff reported feeling well supported and able to escalate concerns to senior managers including the use of QR codes.
6	NHS Orkney has introduced the Daisy Award programme to celebrate and recognise staff.
7	A trigger list was available to all staff to aid and encourage the submission of incident report forms following an adverse event.
8	NHS Orkney is engaging with and responding to, feedback from service users.

Requirements

Domain 2	
2	NHS Orkney must ensure timescales of adverse events are achieved. This includes feedback to staff and action plans to support and improve the quality and safety of care. This should be aligned with the timeframes in Healthcare Improvement Scotland's National Framework.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

All areas inspected were calm and well organised with staff working hard to support the safe delivery of care. However, during inspection we observed that many clinical policies and guidelines were overdue their review date.

Quality improvement in maternity care aims to make a difference to women by improving safety, effectiveness and experience of care. We asked for evidence of data oversight and quality improvement initiatives to improve patient safety and experiences within the maternity services. In discussion with inspectors, staff described being aware of ongoing quality improvement projects. We observed a list of improvement ideas that everyone was encouraged to add their suggestions to. This enables staff to become actively involved with quality improvements and advance a culture of continuous learning within their workplace. We were told of innovation to support quality improvement. This includes the Green Maternity Challenge initiative focusing on sustainable maternity care. The proposal included the implementation of a local newborn ultrasound screening programme for neonatal hip dysplasia to reduce carbon emissions from travel to mainland health boards as well as reduce the travel burden on families. The project has now been implemented and maternity staff described how this environmentally sustainable model has had a positive impact on families, reducing stress from travelling whilst enhancing efficiency, care and experiences within a more environmentally sustainable care model.

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

Many of the clinical guidelines within maternity services which should be available to support and guide staff in clinical practice were overdue their review date, for example, the Emergency In-Utero Transfer standard operating procedure and the Additional Support Pathway for Women with Vulnerabilities. Some policies had been developed in other health boards or were national guidance documents including the Accessing Neonatal Advice and Pathways for Transfers of Newborn Infants without clear oversight and governance for their implementation in NHS Orkney. There appeared to be no maternity section noted on the intranet for staff to locate policies and guidelines and whilst a folder with guidelines was available, some staff we spoke with were not sure of where to find these. We asked senior managers about what processes are in place for the oversight of policies and procedures. They advised us that in May 2025 they had developed a document to provide oversight and prioritisation of policies required to be reviewed, developed or were requiring approval by clinical governance processes. Senior leaders told us that the maternity clinical governance group had recently been set up and would, amongst others, review and approve process documents for maternity services and to provide formal oversight. In discussion with senior leaders, it was evident that whilst there was acknowledgement of the delay to renewing and developing policies, the timely review process was, in part, also delayed due to limited senior leadership capacity which may compromise the safe delivery of care. Whilst we recognise the initial steps taken to

improve governance and oversight, a requirement has been given to support improvement in this area.

The Scottish Patient Safety Programme (SPSP) is a national quality improvement programme which aims to improve the safety and reliability of care and reduce harm. Through its perinatal programme, boards submit quarterly progress updates which form the basis of coaching conversations between teams and Healthcare Improvement Scotland. This identifies any improvement support required to meet the aims and objectives set. In evidence submitted by NHS Orkney, we observed the maternity service aims and progress updates between April and December 2025, such as to implement the continuity of carer model. The progress report outlines that where obstetric care is required, women now have a named primary consultant obstetrician. The service anticipates developments in compliance with the continuity of carer by the woman's primary or buddy midwife. NHS Orkney's published Integrated Performance Report from February 2026 demonstrate good oversight of performance in relation to national and local reporting requirements and includes performance updates in relation to the continuity of carer model. The report highlights that 67% of intrapartum care was provided by the woman's primary or buddy midwife which is exceeding NHS Orkney's target of 50%. Following some staff changes, 59% of women now receive scheduled antenatal care by their primary or buddy midwife demonstrating progress towards their target of 75%. However, only 26% of postnatal care was provided by the primary or buddy midwife which remains below NHS Orkney's target of 75%. As a result, postnatal continuity of care has now been recognised as a key priority area for improvement with a new dedicated postnatal team identified as a test of change.

The Maternity Early Warning Score (MEWS) is a bedside screening tool which supports observation of physiological parameters such as blood pressure and heart rate. The aim of this is to improve the recognition of pregnant and postnatal women at risk of clinical deterioration, facilitating early intervention to improve outcomes. In evidence submitted, we observed monthly MEWS audits of compliance with appropriate completion and escalation showing progress from 75% in September 2025 to 100% in February 2026 with the service working towards demonstrating a sustained improvement over time. However, the small sample size may impact the reliability of the results. Staff advised us that they use a hybrid approach to MEWS documentation where electronic patient care records and paper-based documentation are both used. A hybrid documentation approach may increase potential risks to patient safety due to, but not limited to, loss of information from other records, duplication of records and a non-standard approach and inconsistency in escalation parameters across different documentation formats. Staff told us that the hybrid approach to MEWS documentation was based on individual preference, though for some due to their proficiency of the implemented electronic records system. A requirement has been given to support improvement in this area.

Effective communication is acknowledged as one of the most crucial elements to ensure the delivery of quality assured healthcare services. The SBAR tool refers to a structured communication framework used widely in healthcare and the maternity services to improve clarity, efficiency and safety of the exchange of all relevant information between healthcare professionals, such as at shift handovers or when escalating concerns. Within the maternity services at NHS Orkney, staff told us that they do not utilise the electronic SBAR communication tool or a paper-based version but are instead relying on verbal handovers. This

approach may increase the risk of ineffective communication, omissions of information and unclear responsibilities with the potential to compromise patient safety and contribute to adverse events. A recommendation has been given to support improvement in this area.

Staff we spoke with told us they were encouraged and supported to undertake regular training, including mandatory training and that senior staff were working hard to accommodate these requirements. Core mandatory training requirements for midwives and obstetricians in Scotland were published by Scottish Government in 2018. This required each NHS board to establish training around fetal (unborn baby) heart monitoring, obstetric emergencies and neonatal resuscitation. Wider national reports on the provision of safe maternity care over the last decade such as Ockenden (2022) and Each baby counts (RCOG 2019) have highlighted the essential safety feature of teams working and training together to improve outcomes for patients. Evidence received from NHS Orkney demonstrated that as of 31st August 2025, varying rates of compliance were noted within the maternity services. 65% of midwives and 33% of obstetric consultants had undertaken the practical Scottish Core Obstetric Teaching and Training in Emergencies (SCOTTIE) course with future course dates planned for staff requiring updates and for new colleagues. This course is designed to train the multidisciplinary team in the management of obstetric emergencies. Cardiotocography (CTG) and intermittent auscultation are used to record and interpret the fetal heart rate in pregnancy and during labour. It is an important tool used in conjunction with clinical assessment to determine fetal wellbeing. NHS Orkney provided evidence that 94% of midwives had completed the yearly fetal heart monitoring training and 88% had completed the two-yearly requirement. An additional 94% of midwives attended a CTG masterclass in 2024. 100% of obstetric staff had undertaken the yearly fetal monitoring training and 67% the two-yearly learning package. Senior managers told us that they have recently recruited to a vacant consultant obstetric post and some midwives were on maternity leave impacting their overall compliance. However, the service demonstrated oversight and had taken a proactive approach to facilitate multidisciplinary and cross-departmental training as well as ensuring staff who were required and available to attend training were booked on upcoming courses. Whilst we recognise this, a requirement has been given to support improvement in this area

Some midwives within NHS Orkney have taken on further roles through the development of their skills and competencies to support and enhance the local service provision. Additional roles include sonographer training to enable more pregnancy scans to be performed within the service, as well as the newborn ultrasound screening programme for neonatal hip dysplasia. One midwife has an education focused role to strengthen the oversight and development of a robust core mandatory update programme and the identification of training needs through audit and incident reviews. Others are instructors for emergency scenario training, lead midwife for bereavement services, hypnobirthing, aqua natal instructors or aromatherapy. Staff spoke of their pride in taking on these roles to facilitate the best care and service to women, babies and families.

We were provided with evidence of health care support workers and maternity care assistants who have further training to provide support and assistance to the midwife and wider multidisciplinary team to deliver safe care. Health care support workers and maternity care assistants are non-registered health care staff working under the guidance of the midwife within a hospital or community setting. They provide important support to staff and women across the maternity journey. Healthcare assistants who inspectors spoke with felt they had

good opportunities to carry out their role with women and families and understood how to escalate their concerns to midwifery staff. Respectful and engaging relationships were noted between support staff and families.

We observed fire risk assessments were completed in October 2025. NHS Scotland Fire code SHTM 86: 'Fire Risk Assessment' states that hospitals and other healthcare premises with sleeping accommodation should have a yearly fire safety review. A fire risk assessment within the maternity unit was noted. Fire escape routes and exits were clear, well signposted and unobstructed. All staff must be aware of fire evacuation processes and maintain up to date fire safety training modules. Staff e-learning training compliance for fire safety submitted by NHS Orkney demonstrated that 82% of midwifery staff had attended the mandatory fire safety training in the last 12 months whilst 67% of consultant obstetricians had attended. A requirement has been given to support improvement in this area.

During the inspection, all equipment examined was stored safely, clean and ready for use. Storerooms were tidy and well organised.

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

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 stipulate that chlorine-based cleaning products must be stored securely and kept in a secure area such as a locked cupboard. We observed chlorine-based cleaning products stored safely in an access restricted sluice.

Hand hygiene is an important part of standard infection control precautions to reduce the risk of infection as outlined in the National Infection and Control Manual. In evidence submitted, the service demonstrates a 100% compliance with hand hygiene procedures in the three months prior to inspection. During the onsite inspection, we observed good compliance with hand hygiene and that no opportunities to perform hand hygiene were missed.

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

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

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

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

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

Areas of good practice

Domain 4.1	
9	We observed the implementation of a local newborn ultrasound screening programme for neonatal hip dysplasia to reduce carbon emissions from travel to mainland health boards as well as reduce the travel burden on families.
10	All equipment examined was clean and stored safely ready for use.

Recommendations

Domain 4.1	
1	NHS Orkney should consider introducing a structured communication format such as an SBAR (Situation, Background, Assessment, Recommendation) during handovers and at times of escalations.

Requirements

Domain 4.1	
3	NHS Orkney must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use.
4	NHS Orkney must ensure an effective system is in place to record patient documentation. This includes but is not limited to: i. The maternity early warning score is accurately completed to support the safe delivery of care.
5	NHS Orkney must ensure that employees receive time and resources to undertake training which is essential to their role.
6	NHS Orkney must ensure that all staff complete statutory fire safety training.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

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

Workforce pressures including recruitment and retention of staff continue to be experienced throughout NHS Scotland. Senior managers were able to discuss the ongoing challenge of recruitment within midwifery and obstetrics in NHS Orkney, though a recent recruitment to an obstetric consultant post had been completed. This is contributed to by the fact that island communities are more remote and includes a requirement to work on-call across day and night. The consultant obstetric team currently work a one in two on-call rota pattern with the requirement to cover on-call extending during periods of annual leave. During discussion with the senior obstetric team, we asked regarding the opportunity for middle grade obstetric

training within the unit to support both the quality of the service and as an opportunity for succession planning and attracting new recruitment and retention to the unit. Whilst the senior team highlighted the potential limitations to middle grade obstetric training within the service regarding the number of service users and potential exposure to learning they acknowledged its essential nature for succession planning, recruitment and retention.

In the workforce data reviewed from NHS Orkney, it demonstrated a 19% shortfall in the Band 8b Lead Midwife role which is currently undertaken on a part time basis and incorporates dual responsibilities as a Deputy Nurse Director whilst the senior charge midwifery role had a 28% shortfall. We consider a shortfall of 10% vacancy as high. Whilst it was evident that both roles were delivered with significant commitment and goodwill, it was noticeable that due to ongoing and competing demands for the senior charge midwife such as management duties, leading on a variety of quality improvement initiatives and supporting the clinical workload, time to lead was, at times, compromised. Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019) to ensure clinical leaders have protected time and adequate resource to facilitate appropriate staffing alongside other professional duties to lead the delivery of safe, high-quality and person-centred healthcare. A requirement has been given to support improvement in this area.

In evidence received, we observed that all consultant obstetricians had their appraisals undertaken within the last 12 months. In the same timeframe, 63% of midwives had received an appraisal by their line manager. Whilst a small number of staff were only recently due an appraisal, 21% of midwives had not had an appraisal since 2024. Staff appraisals are essential to support and enable staff to feel valued and support their individual development. Inspectors discussed this with senior midwives during inspection, who acknowledged that competing demands and capacity was making it challenging to complete in a timely manner. A requirement has been given to support improvement in this area.

Midwives work a day, back and night shift pattern that incorporates an on-call model. Inspectors explored the on-call commitment with staff and senior managers who highlighted that the on-call model is to ensure a second midwife is always available to support the safe provision of intrapartum care during the day and throughout the night where one midwife and one clinical support worker is rostered to work within the unit. Staff spoke of having a low threshold to call in the on-call midwife or escalate any clinical care concerns to the senior midwifery and obstetric team. Midwifery staff consistently spoke very positively of the support they would receive from the multidisciplinary team when concerns occurred or when they required advice. We asked how shortfalls within the shift rota and on-call would be managed. Senior managers were able to describe that covering these were, at times, challenging due to staff currently on maternity leave. Any shortfall across shifts and the on-call rota were supported by staff and senior managers who would cover any gaps. In discussion with senior managers, they demonstrated monitoring and oversight of all on-call activity to ensure staff wellbeing and adequate rest periods are facilitated in line with local policy.

The Health and Care (Staffing) (Scotland) Act 2019 requires all NHS boards ensure they have a real-time staffing assessment in place to capture risk caused by staffing levels to the health and safety of patients. 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. We were able to observe how maternity services fed into the site safety and capacity huddle during which staffing was discussed and collective solutions found where required. We observed maternity services form an active part of the huddle ensuring that NHS Orkney senior managers had oversight of real-time staffing, acuity and safety concerns within maternity services. Whilst inspectors observed this overview as part of the wider hospital huddles, it was unclear which process the maternity service undertook to achieve this oversight. The evidence provided by NHS Orkney did not indicate how decisions about staffing are captured, where this is recorded and where staff can record within the system their feedback on decisions made. It is also unclear how this data is captured over time to feed into service improvement. In discussion with senior managers, they acknowledged this as an area for improvement and informed us of the intention to implement SafeCare in May 2026. A requirement has been given to support improvement in this area.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024 and requires all NHS boards ensure appropriate staffing for the provision of safe and high-quality care. NHS boards have a duty to apply the Common Staffing Method (CSM). The CSM triangulates and analyses all relevant service specific data, evidence and intelligence to support clinical leaders understand staffing requirements for a given area. As part of common staffing methodology, it is mandated that the given areas undertake a staffing level tool and professional judgement tool run concurrently over a two week period once a year. In review of evidence, NHS Orkney did not provide the CSM report, instead providing a BOXI report which is capturing inpatient and triage activity only. The service explains this rationale with the complexity of accurately capturing the full scope of their activities within the CSM as they are providing an integrated maternity and women's health service within the maternity unit. However, the service is preparing to transition to the maternity staffing level tools within SafeCare from May 2026. A requirement has been given to support improvement in this area.

A plan to develop a robust system of workforce support, nurturing leadership to prepare staff to take on senior leadership roles, including a focus on succession planning is outlined within the National Workforce Strategy for Health and Social Care in Scotland. More information can be found here. Staff we spoke with highlighted good opportunities for development within their current banding. In evidence reviewed, NHS Orkney is introducing a clinical leadership programme for nurses and midwives at agenda for change bands 6 and 7 with the first cohort commencing in April 2026. This investment in its existing workforce, supports career progression whilst reducing leadership fragility in a remote and rural health board.

Requirements

Domain 4.3	
7	NHS Orkney must ensure senior charge midwives have appropriate and protected leadership time to fulfil their leadership and management responsibilities. This will include but is not limited to: i. Staff appraisals This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls.

8	NHS Orkney must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real-time staffing risk across all clinical professional groups within maternity services. This is to support consistent management of any identified staffing risks which should include but is not limited to: i. Recording any escalation, mitigation and/or inability to mitigate and communication of outcomes to all relevant teams ii. A record of any disagreements with decisions made.
9	NHS Orkney must ensure that there are processes in place to support the consistent application of the common staffing method. This includes, but is not limited to: i. The application of 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.

Domain 6 – Dignity and respect

Quality 6.2 – Dignity and respect

We observed women and their families being treated with compassion, dignity and respect and supported to develop close and loving parent-infant relationships.

Inspectors observed staff providing holistic and person-centred care. Women and families who we spoke with were complementary of their care from the multidisciplinary team with many highlighting that all staff went above and beyond, respecting their preferences and choices.

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

The Scottish Trauma-Informed Leaders Transformation (STILT) programme is a national leadership webinar delivered by NHS Education for Scotland to support senior and emerging leaders to understand their role in creating trauma-informed systems, cultures and ways of working. The programme provided a shared framework, resources and a clear roadmap for leading trauma-informed change across services, emphasising that sustainable impact requires leadership alignment rather than isolated training. Members of the senior leadership team recently participated in STILT together with Orkney Islands Council. This collaboration plans the implementation on how trauma-informed training and development can be embedded across both organisations as a co-ordinated joint approach, supporting consistent practice, shared language and collaborative system-wide change across health and local authority services. Staff across the organisation have access to trauma informed modules which will be signposted as recommended training with no compliance rates yet available. A recommendation has been given to support improvement in this area.

UNICEF Baby Friendly Initiative supports families with evidence-based advice relating to infant feeding and developing close and loving parent-infant relationships. NHS Orkney is UNICEF Baby Friendly Initiative joint maternity and health visiting Gold accredited and has demonstrated commitment to continuous learning and improvements in the four pillars around leadership, culture, monitoring and progression. The most recent UNICEF annual board response letter to NHS Orkney highlights the commitment by the service and the positive outcomes being achieved as a result, such as the introduction of a peer support service. In a recent audit by the infant feeding team submitted to UNICEF, 100% of women audited reported being very happy with their overall care and 100% thought staff were always kind and considerate. Women we spoke with described staff as compassionate and responsive providing person-centred care as well as supporting building confidence in their infant feeding choice.

During the onsite inspection, we observed information displayed regarding the Patient Charter. The charter of patient rights and responsibilities outlines the right to safe, effective person-centred and sustainable care and treatment which should be provided at the right time, in the right place and by the most appropriate person. This applies to anyone using NHS services ensuring their care is delivered with dignity, respect and fairness. Throughout our maternity inspection within NHS Orkney, we observed these principles implemented in practice.

Areas of good practice

Domain 6	
11	Women, families and visitors that we spoke with were highly complementary of the multidisciplinary team and the care provided.
12	Women and families were supported by staff to build confidence in their infant feeding choice and supported to develop close and loving parent-infant relationships.

Recommendations

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

Appendix 1 - List of national guidance

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

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

Published July 2026

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