

Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Gilbert Bain Hospital

NHS Shetland

16–17 June 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 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 Gilbert Bain Hospital is a remote and rural hospital providing emergency and acute care along with planned care, diagnostics, investigative and maternity services. Visiting consultants provide outpatient clinics as well as inpatient and day case surgery to supplement the service

provided by locally based consultants in general medicine, general surgery, anaesthetics and psychiatry. The hospital is supported by a range of health and care facilities across 16 inhabited islands providing care to a population of around 23,000.

About this inspection

We carried out an unannounced inspection in conjunction with an acute services inspection to Gilbert Bain Hospital, NHS Shetland on Tuesday 16 and Wednesday 17 of June 2026 using our safe delivery of care inspection methodology. We inspected the maternity unit and Northern Star which is a designated area to provide bereavement care.

During our inspection, we:

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

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

During June and July 2026, we held virtual discussion sessions with key members of NHS Shetland 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 Shetland and in particular all staff at Gilbert Bain 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.'

NHS Shetland provides maternity services to women and their families across Shetland in Gilbert Bain Hospital, Lerwick. The maternity ward is situated on the first floor and is clearly signposted from the main entrance. The department delivers an integrated maternity service to its community which provides antenatal, intrapartum and postnatal care. The maternity ward provides midwifery led care supported by onsite consultant obstetricians.

The maternity ward was clean, organised and maintained to a high standard. Midwives and the obstetric consultant on duty were visible and working well together. Staff were able to demonstrate effective systems in place to contact other team members including anaesthetists, theatre teams and senior managers if the need should arise during an emergency.

The maternity department are undertaking work to understand and improve culture and morale within the department.

We observed maternity services form an active part of the safety huddle within NHS Shetland. Improvement regarding completion of real-time staffing data and escalation pathways was highlighted as an area for improvement.

Inspectors observed a maternity service which was able to be flexible and accommodating to the needs of women and their families living on the islands. Women described receiving assistance when required and access to analgesia when needed. Interactions between staff and families were observed to be kind, responsive and caring.

Areas for improvement included the need to develop processes that support a consistent approach to helping women make informed decisions about their care. Also establishing and maintaining standardised communication mechanisms between NHS Shetland and other boards to support the safe delivery of care during neonatal emergencies.

Improvement is required in the governance and oversight of clinical guidance to ensure they remain up to date, relevant and supportive of clinical practice.

Other areas for improvement include trauma informed training and bereavement care training for staff.

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

This inspection resulted in nine areas of good practice, two recommendations and 11 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 Shetland 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.scot>

Areas of good practice

The unannounced inspection to Gilbert Bain Hospital resulted in nine areas of good practice.

Domain 1	
1	The maternity ward was clean, organised and maintained to a high standard (see page 11).
2	NHS Shetland has implemented a dedicated 'red phone' system within Gilbert Bain Hospital to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff (see page 11).

Domain 2

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| 3 | Inspectors observed respectful, multidisciplinary team communication during inspection (see page 14). |
| 4 | 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). |

Domain 4.1

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| 5 | We observed good compliance with venous thromboembolism risk assessments (see page 17). |
| 6 | Focused quality improvement work on reducing postpartum haemorrhage (see page 17). |

Domain 4.3

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| 7 | We observed implementation of Best Start recommendation number 25 in relation to the examination of the newborn (see page 20). |
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Domain 6

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| 8 | Interactions between staff and families were kind, responsive and caring (see page 22). |
| 9 | NHS Shetland have an established maternity voice partnership (see page 22). |

Recommendations

The unannounced inspection to Gilbert Bain Hospital resulted in two recommendations.

Domain 6

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| 1 | NHS Shetland should consider improving trauma informed practice training attendance rates for all staff (see page 22). |
| 2 | NHS Shetland should consider improving bereavement training attendance rates for all staff (see page 22). |

Requirements

The unannounced inspection to Gilbert Bain Hospital resulted in 11 requirements.

Domain 1

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|---|---|
| 1 | NHS Shetland must ensure implementation of a systematic approach to unscheduled maternity care and the development of local clinical guidelines to support staff in this area (see page 11).

This will support compliance with: Quality Assurance Framework (2022) Criteria 1.5. |
| 2 | NHS Shetland must ensure guidance is in place to support women to make evidenced based decisions on the location of their birth and to reduce variance in advice given (see page 11).

This will support compliance with: Quality Assurance Framework (2022) Criteria 2.6. |

3	NHS Shetland must ensure continued governance and oversight of staff training for all staff groups (see page 11).
	This will support compliance with: Quality Assurance Framework (2022) 4.3, 4.4.
4	NHS Shetland must ensure the equipment required to communicate with supporting health boards is available at all times to support the safe delivery of care (see page 11).
	This will support compliance with: Quality Assurance Framework (2022) 2.6, 7.1.

Domain 2

5	NHS Shetland must continue the development of a positive culture where staff feel safe and supported to highlight risks and concerns in relation to staff and patient safety (see page 14).
	This will support compliance with: Quality Assurance Framework (2022) 2.1, 2.3, 4.3, 7.1.
6	NHS Shetland must ensure incident reporting monitoring and governance aligns with Healthcare Improvement Scotland's A national framework for reviewing and learning from adverse events 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 (2025) criteria 2.5 and 2.6.

Domain 4.1

7	NHS Shetland must ensure clinical guidelines are up to date and reviewed within agreed timescales (see page 17).
	This will support compliance with: Quality Assurance Framework (2022) criteria 5.4 and the Health and Social Care Standards (2017) criteria 4.11.
8	NHS Shetland must ensure that all patient documentation is accurately and consistently completed with actions recorded. This includes, but is not limited to, risk assessment tools such as the maternity early warning system (MEWS) (see page 17).
	This is to comply with Nursing and Midwifery Council (NMC) The code (2018) and NHS Scotland and Healthcare Improvement Scotland Quality Assurance Framework (2022) criteria 2.6.

Domain 4.3

9	NHS Shetland must have oversight of all staff working hours to ensure adequate rest and wellbeing to support the safe delivery of care (see page 20).
	This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and quality assurance framework (2022) criteria 2.3.

10	NHS Shetland must ensure pathways for escalation including the Business Continuity Plan are updated and understood by staff (see page 20).
	This will support compliance with: Quality Assurance Framework (2022) 3.2, 7.1.
11	NHS Shetland must ensure clear real-time staffing data is consistently recorded and communicated and clear escalation processes and any mitigations/inability to mitigate are recorded clearly and accurately (see page 21).
	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

The maternity ward was clean, organised and maintained to a high standard. Areas for improvement included the need to develop processes that support a consistent approach to helping women make informed decisions about their care. Also establishing and maintaining a standardised communication mechanism between NHS Shetland and other boards to support the safe delivery of care during neonatal emergencies.

NHS Shetland provides maternity services to women and their families across Shetland in Gilbert Bain Hospital, Lerwick. The maternity ward is situated on the first floor and is clearly signposted from the main entrance. The department delivers an integrated maternity 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.

There is secure buzzer entry that was answered promptly during onsite inspection. There are seven single rooms, one utilised for triage and four ensuite rooms that are flexibly used for antenatal or postnatal care depending on the requirements of the service. A further two spacious birth rooms, one with a birthing pool, are available. A consultation room which has multipurpose use such as clinical appointments and facilitation of the ultrasound services was also situated within the department. Throughout our inspection, the maternity ward was clean, organised and maintained to a high standard.

NHS Shetland supports both scheduled and unscheduled care within the maternity unit. The 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 any calls on patient electronic records. Staff explained women who require to attend the maternity service are reviewed promptly upon their arrival and that this can be consistently achieved due to low acuity. No patients were in the department for unscheduled care during the onsite inspection.

Inspectors observed that calls were answered promptly and there were no delays to care observed. Staff and senior managers did not describe any delays to prioritising triage calls or care. Through review of incident reports submitted by the board there were no incidents of delays to maternity care observed in the six months prior to inspection. However, in review of NHS Shetland maternity services clinical governance minutes, we observed senior managers had identified several areas for improvements for maternity triage including a lack of clinical

guidelines to support staff with clinical prioritisation of women attending for unscheduled care. From evidence and in discussion with senior managers, we were told of plans to establish a short life working group within NHS Shetland to improve unscheduled care but this has not yet commenced. A requirement has been given to support ongoing work in this area.

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. Within the maternity unit, emergency trolleys were placed appropriately within the ward and accessible to all staff for prompt use. An emergency trolley provides immediate access to critical equipment and medications during an obstetric emergency. Essential medications which would be used during obstetric emergencies were in date, stored safely and appropriately.

MBRRACE 2026 report Saving Lives, Improving Mothers' Care details the maternal deaths across the UK between 2021-2023. Over half of the women who died (56%) were known to have a pre-existing medical condition. Best practice described by the Royal College of Obstetricians and Gynaecologists recommends a system is in place to ensure women are directed to the correct department. The standards set within the Nursing and Midwifery Code to preserving safety stipulate nurses and midwives work within limits of their competency. Further information can be found [here](#).

Senior managers explained the communication pathways between the Scottish Ambulance Service and hospital staff through the availability of a 'red phone.' This was a recommendation following a recent fatal accident inquiry within another NHS board. This system facilitates timely, clear and prioritised communication, supporting safer and more effective coordination of patient care. The red phone for NHS Shetland Gilbert Bain Hospital is located within the acute emergency department. Staff in the emergency department communicate details of expected patients with the maternity unit where appropriate. This arrangement mitigates potential safety risk and aligns with their local escalation procedure.

Staff we spoke with described Gilbert Bain Hospital processes for providing appropriate care and patient placement for women who present to the emergency department with non-obstetric complaints. Staff described examples of multidisciplinary working, for example maternity staff attending the emergency department to perform fetal monitoring which was supported by a continued multidisciplinary approach to any ongoing care requirements including potential transfer off island. There were no concerns raised regarding non-obstetric patients being directed to the maternity department during inspection and no incidents submitted within the six months prior to inspection.

Although Gilbert Bain Hospital is classed as a general hospital, there are limited facilities. With no neonatal unit and no epidural service, in some circumstances, it is required that women are transferred to a mainland health board to birth their baby, to meet safe delivery of care needs. We were provided with the NHS Shetland guidance to support obstetric input for women with complex needs during pregnancy, for example multiple pregnancy or medical conditions such as diabetes. However, this was three years overdue review which is discussed further, later in the report.

Staff we spoke with explained women are routinely risk assessed at multiple stages throughout pregnancy and provided with NHS Shetlands birth choices leaflet. This outlines options for birth and a recommended criteria for remaining on Shetland for intrapartum care as well as information on limitations of the unit and the potential need for transfer in emergency situations.

However, there was no standardised guidance to support clinicians in the counselling of women on the best location for intrapartum care. We were advised individualised management plans were made in consultation with women when they attended obstetric clinics. It is essential that there is a standardised approach to reduce clinician variance, inconsistencies and risk. We reviewed feedback from service users which highlighted inconsistent advice from different consultants and midwives as an issue, particularly in relation to whether women should give birth locally or transfer to a mainland hospital. The need for clear, consistent, evidence-informed messaging was recognised by senior managers who plan to review the process. A requirement has been given to support ongoing work in this area.

In an event where a baby is born prematurely or requiring increased support at birth, it is essential that the staff have the emergency skills and training to be able to respond. Stabilisation of the newborn is a process of providing care to a baby who requires increased support whilst awaiting the attendance of a neonatal transport team. This is carried out with the support of ScotSTAR, a national service for safe and effective transport and retrieval of newborn babies (neonates) and critically ill children throughout Scotland. Staff we spoke with were clear of the stabilisation and transfer process and explained guidance and pathways to support in these clinical situations, was available. We received details of the number of emergency neonatal transfers for 2024 and 2025 within NHS Shetland. The number of transfers increased from nine in 2024 to 12 in 2025. We were provided with evidence that 100% of midwives and obstetricians were compliant with statutory training relating to neonatal resuscitation.

Obstetricians within the unit spoke of a greater level of involvement during a neonatal emergency in comparison to obstetricians within mainland boards, due to the absence of a neonatal team. Anaesthetists within Gilbert Bain Hospital take the lead clinical role during neonatal stabilisation care whilst awaiting transfer. We were provided with evidence of enhanced training to support clinicians in stabilisation of the newborn. Senior managers also described multiple opportunities for training available to all staff groups which was inclusive of the wider acute multidisciplinary team. Core anaesthetic, obstetric and midwifery staff demonstrated a 100% compliance. However, the continuous governance and oversight of compliance within the medical locum workforce used regularly within NHS Shetland unit was unclear. A requirement has been given to support improvement in this area.

Any urgent transfer from NHS Shetland relies on air transport and depends on the availability of aircraft, crew and weather conditions. We were provided with operational guidance “Accessing Neonatal Advice and Pathways for Transfer of Newborn infants delivered in Gilbert Bain Hospital to Aberdeen Neonatal Unit” which supports staff with the decision making around transfer of newborns requiring additional neonatal care. However, this guidance was also three years overdue review and states that when urgent transfers are delayed, support can be provided by Aberdeen Neonatal Unit via video link. The maternity ward at the time of inspection did not have the equipment to facilitate a video link. We raised this with senior managers whilst onsite who advised procurement for equipment to enable a video link during

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any neonatal emergency was in progress by NHS Shetland. As part of evidence, we received confirmation that equipment to facilitate video communication during a neonatal emergency is now available. A requirement has been given to support ongoing improvement in this area.

Areas of good practice

Domain 1	
1	The maternity ward was clean, organised and maintained to a high standard.
2	NHS Shetland has implemented a dedicated 'red phone' system within Gilbert Bain Hospital to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff.

Requirements

Domain 1	
1	NHS Shetland must ensure implementation of a systematic approach to unscheduled maternity care and the development of local clinical guidelines to support staff in this area.
2	NHS Shetland must ensure guidance is in place to support women to make evidenced based decisions on the location of their birth and to reduce variance in advice given.
3	NHS Shetland must ensure continued governance and oversight of staff training for all staff groups.
4	NHS Shetland must ensure the equipment required to communicate with supporting health boards is available at all times to support the safe delivery of care.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

Inspectors observed respectful, multidisciplinary team communication during inspection. Work was in progress to support a positive working culture within the unit and improve staff morale.

Inspectors observed respectful, multidisciplinary team communication during inspection. The Nursing and Midwifery Council and General Medical Council emphasise the importance of effective team working and communication to provide good and safe patient care within their 'Good Teamwork Means Better Maternity Care' document. Further information can be found [here](#). Communication and effective multidisciplinary working is key in all clinical areas where there may be multiple issues which require prioritisation and planning. Midwives and the obstetrics staff on duty were working well together within the maternity unit with good understanding of how they would contact other team members including anaesthetists, theatre teams and senior managers if the need should arise during an emergency.

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 \(2022, 2026\)](#). Student midwives we spoke with reported being well supported by the whole multidisciplinary team and had a positive placement experience throughout their training. Staff described a positive and supportive workplace and described NHS Shetland as a good place to work. Some staff told inspectors that they felt well supported when they escalate issues such as

understaffing and increased acuity to senior managers and that any clinical concerns were taken seriously. However, through discussion with some staff members and staff feedback received through different Healthcare Improvement Scotland processes, this is not the experience for all staff.

We reviewed the 2025 and 2026 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](#). Results from the survey 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.

Following the iMatter 2025 survey which demonstrated a need to improve in all five areas of staff governance, the staff development team within NHS Shetland were commissioned by the chief midwife to undertake an exploration of the culture and perceptions of culture within the maternity department with the main aim of understanding the culture and morale within the service. This review identified that bullying behaviours and low psychological safety was prevalent within the unit. In response, senior managers have undertaken focused improvement work including a culture programme which will run within the maternity unit over the next 12 months and is intended to provide time and space to strengthen how people work together.

The comparative analysis of iMatter results following initiation of improving culture work were available in evidence. The survey results showed that 44% of maternity staff participated in the survey in 2026, compared to 57% in 2025. This represents a 13% decrease in participation. The 2025 results reported an Employee Engagement Index of 63 across the five Staff Governance Standards. With results indicating the need to “monitor to further improve.” The lowest score related to staff “being involved in decisions relating to organisation.” Following the engagement work within the department to understand and improve culture and morale, the 2026 iMatter results showed a higher Employee Engagement Index of 75. This represents a 12-point increase from 2025 and is closer to the national average of 77. With all five Staff Governance Standards indicating “strive and celebrate” results in 2026. No members of staff we spoke with during the inspection reported any concerns with culture or team working and several members of staff discussed active steps taken to promote wellbeing and psychological safety amongst the team. Whilst we acknowledge the work already underway a requirement has been given to support ongoing work in this area.

The maternity team has monthly team meetings which staff described positively as an opportunity to come together, share learning and consider suggestions for improvements. A meeting was taking place during our onsite inspection.

Midwives within NHS Shetland have taken on or adopted additional roles to support the service. Additional roles, including sonographer training to enable more pregnancy scans to be performed, infant feeding support, contraceptive champions, instructors for emergency scenario training and a project role for developing bereavement services, were described during inspection. The staff we spoke with were proud of working to meet the needs of the

community, describing remote and rural midwifery as a vocation. Respectful and engaging relationships were observed between staff and families.

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 national framework can be found [here](#).

Inspectors observed a “trigger list” to support staff with which events and incidents should be reported through the electronic incident reporting system. The trigger list was readily available for staff and on display in the unit. Staff spoken with did not describe any barriers to submitting incident reports. 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. There were no outstanding or ongoing serious adverse event reviews within the service at the time of inspection. A joint case review in the six months prior to inspection was observed as part of evidence. The review aimed to improve cross-boundary working communication following a complicated transfer of a woman to a mainland board. Evidence of learning was shared with all staff through a presentation and actions were implemented within the six months to strengthen clinical practice in relation to communication and documentation.

In the national framework for reviewing and learning from adverse events, level two incidents require a review completed within 70 working days whilst level three incidents should be completed within 10 working days. In review of evidence, 25% (six) of incidents provided were finally approved, 62.5% (15) were awaiting final approval and 12.5 % (three) incidents were awaiting review. This demonstrated delays of up to four months in reviewing and closing of some incidents. In discussion with senior managers, they acknowledged challenges with both categorisation of incidents and delays to completion of incident reviews in line with national framework expectations. This was also reflected in the acute inspection. Senior managers informed us of an ongoing review of the process. We were provided with a draft policy for adverse events management that reflects up to date national guidance. Delays and mis-categorisation of adverse events could impact timely improvement, feedback, learning and duty of candour. A requirement has been given to support improvement in this area.

Evidence reviewed demonstrated several actions were generated within both clinical governance meetings and local review of incidents. We asked NHS Shetland about governance and oversight of lessons learned, identified improvement actions and the systems for monitoring for progress and completion. However, we were advised there is no current systematic approach for oversight of actions within the service. Senior managers acknowledged the need for improvement in this area and supplied templates intended to support more consistent oversight, monitoring and completion of actions in future. A requirement has been given to support ongoing work in this area.

Areas of good practice

Domain 2	
3	Inspectors observed respectful, multidisciplinary team communication during inspection.
4	A trigger list was available to all staff to aid and encourage the submission of incident report forms following an adverse event.

Requirements

Domain 2	
5	NHS Shetland must continue the development of a positive culture where staff feel safe and supported to highlight risks and concerns in relation to staff and patient safety.
6	NHS Shetland must ensure incident reporting monitoring and governance aligns with Healthcare Improvement Scotland's A national framework for reviewing and learning from adverse events framework.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

Staff described quality assurance measures to assure a safe environment for care, including a team approach to completing infection prevention control audits, cleaning schedules, mattress checks and water flushing. Governance of clinical guidelines and the use of the Scottish Maternity Early Warning Score (MEWS) are areas for improvement.

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.

During inspection senior managers informed us of work being undertaken to ensure evidence-based guidelines were available to support the safe delivery of care. This had been identified as a risk by NHS Shetland and seen within evidence on the risk register for maternity services. At the time of the inspection, NHS Shetland had a bank of electronically available guidelines for clinical practice and access to a wider catalogue through sharing resources with NHS Grampian. Discussions about evidence-based guidelines were observed in Maternity Clinical Governance meeting minutes, including multi-disciplinary involvement in proposed guidance and updates. However, over half the guidelines (51%) were overdue review, the longest by four years. Senior managers provided evidence of overdue guidelines being reviewed within the guideline register during the inspection process. A requirement has been given to support ongoing work in this area.

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 2026 report demonstrated the leading cause for maternal death in the UK being attributed to venous thromboembolism (VTE). Learning from the report highlighted a

need for continuous evidence-based risk assessment throughout pregnancy and following birth. Through the review of evidence provided, we observed that 96% of antenatal booking and 95% of inpatient risk assessments were completed. NHS Shetland had been engaging with excellence in care audits to support improvement in this area. Guidelines developed by NHS Shetland in relation to “Thromboprophylaxis in Pregnancy and the Puerperium” and “Management of VTE in Pregnancy and the Puerperium” were reviewed within evidence and contain up to date best practice guidance to support clinicians in this area and are due for review in August 2026.

Quality improvement aims to make a difference to women by improving safety, effectiveness and experience of care. We asked for evidence of quality improvement initiatives to improve patient safety and experiences within maternity services. NHS Shetland provided evidence of engaging with the Scottish Patient Safety Programme. The Scottish Patient Safety Programme is a national quality improvement programme which aims to improve the safety and reliability of care and reduce harm. The most recent quarterly progress report submitted to the Scottish Patient Safety Programme by NHS Shetland referenced actively engaging in ongoing work in two areas for quality improvement including obstetric haemorrhage and MEWS compliance.

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 Shetland shared the outcome of monthly MEWS observation audits carried out over the past two years. In the three months prior to inspection these audits showed varying compliance between 20% and 75% for the full completion of MEWS. There was a low sample size, with over 50% of the months reviewed having one or no MEWS charts reviewed. Given this accounts for 14% of the units’ average intrapartum presentations, we asked NHS Shetland about potential barriers to MEWS use. Senior managers explained the sample size was reflective of NHS Shetland only applying MEWS for deteriorating or high-risk patients. However, compliance with MEWS is essential to support early recognition of deteriorating patient and should be used for all patients. This will support prompt and timely transfer of care potentially to mainland boards.

Senior managers described improvement work to ensure completion of MEWS for all patients, was undertaken. During inspection we observed visual aids intended to improve staff compliance with MEWS documentation. Senior managers acknowledged that MEWS should be used for all women within the service. The equivalent risk assessment for acute services was also identified as an area for improvement during the acute inspection. A requirement has been given to support in this area.

Major obstetric haemorrhage is a critical condition defined as significant blood loss in the antenatal, intrapartum and postnatal period exceeding 1.5 litres. We observed NHS Shetland request a patient incident report be submitted for all women who experience major obstetric haemorrhage of 1.5 litres and above to ensure oversight of these incidents. Data submitted to The Scottish Patient Safety Programme for NHS Shetland showed the service has not had a major obstetric haemorrhage in the 15 months prior to inspection. We observed the service have undertaken further improvement work in this area to review postnatal blood loss between 500 and 900mls. Following this focused work and pharmacological review, instances of postnatal blood loss over 500mls reduced in NHS Shetland by 53% in 2025 when compared with 2024 data.

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 compliant 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 Shetland demonstrated that 94% of midwifery staff and 100% of obstetricians had completed the mandatory fire safety training in the last 12 months.

During the inspection, all equipment examined was stored safely, clean and ready for use. Storerooms were tidy and well organised. Staff described quality assurance measures to assure a safe environment for care, including a team approach to completing infection prevention control audits, cleaning schedules, mattress checks and water flushing. Compliance with these audits was observed on site.

The hospital environment appeared clean and although the hospital estate is around 65 years old, we did not observe evidence of excessive wear and tear within the maternity ward. Shower and toilet facilities were maintained to a high standard. Ward corridors were unobstructed due to the appropriate placement of equipment. The outer aspect of the hospital is currently being supported by scaffolding, however inspectors were advised that this had been in place for at least 18 months prior to the inspection and, although unsightly, was not causing any issues.

Call bells were available at each bed space which allowed women to call for assistance as required.

Medicines were observed stored in locked cupboards inside a preparation room. 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 a locked cabinet within the maternity ward 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. 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 were readily available at the point of care. 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.

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. Onsite inspectors observed NHS Shetland compliance with water flushing regimes in the maternity unit and found staff spoken to during inspection were aware of the process.

Areas of good practice

Domain 4.1	
5	We observed good compliance with venous thromboembolism risk assessments.
6	Focused quality improvement work on reducing postpartum haemorrhage.

Requirements

Domain 4.1	
7	NHS Shetland must ensure clinical guidelines are up to date and reviewed within agreed timescales.
8	NHS Shetland must ensure that all patient documentation is accurately and consistently completed with actions recorded. This includes, but is not limited to, risk assessment tools such as the maternity early warning system (MEWS).

Domain 4.3 – Workforce planning
Quality 4.3 – Workforce planning

We observed maternity services form an active part of the safety huddle within NHS Shetland. Improvement regarding completion of real-time staffing data and escalation pathways was highlighted as an area for improvement.

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 Shetland. This is contributed to by the fact that island communities are more remote and the nature of service provision requires staff to be willing to work in roles within the hospital and community setting rather than in one setting only. This includes a requirement to work on call across day and night. For example, within NHS Shetland, the consultant obstetric team currently work an on-call rota pattern which requires the obstetrician to be working and on call for one month every three months. At the time of inspection there was a vacancy within the obstetric rota, recruitment was in progress and the post was advertised with locum cover secured. Senior obstetric trainees are not currently rotated to NHS Shetland which limits their experience and exposure to remote and rural working. The obstetric consultant is resident on the island for the month long on call and provides cover during the day and overnight through an on-call system for the maternity unit. The service was also facing a significant change as there was no longer a resident consultant permanently residing on the island relying on consultants commuting to the island to stay for their working month.

Onsite inspectors were keen to understand how obstetric consultants were supported with their health and wellbeing given this extended period of working. No concerns were raised

during the onsite inspection by clinicians but within a recent clinical governance meeting, the medical model was identified by NHS Shetland as “fragile” with the need to review for a more resilient model. Obstetricians we spoke with described the extended rota as manageable due to the low intensity of workload within the unit. As part of the European Working Time Directive, there is a requirement on the employer to keep records of hours worked. We asked NHS Shetland how they demonstrated monitoring and oversight of all on call activity to ensure staff wellbeing and adequate rest periods are facilitated in line with the British Medical Association guidance. Senior managers told us that consultants have been asked to keep note of diary hours worked for oversight but these were not available at the time of inspection. However, senior managers completed a retrospective review of the units activity for 2025, which demonstrated 11 incidences of obstetric support out of hours in 365 days. Senior managers provided details on how compensatory rest is achieved such as flexibility in day work if called overnight and support as required from acute colleagues. However, real-time oversight of hours worked during this extended rota is essential. A requirement has been given to support ongoing work in this area.

Midwives within NHS Shetland work a mix of shifts that incorporates the on-call model of care out of hours. This is to ensure there is always an on-call midwife available during the day and night to support the safe provision of care to women during labour. During a night shift one midwife and care assistant will be present on the unit. Staff spoke of a low threshold to call in the on-call midwife or escalate any clinical care concerns to the senior midwifery and obstetric team. Staff spoke positively of the support they would receive from the multidisciplinary team when concerns arose or when advice was sought. Staff also described staffing concerns as appropriate grounds for incident reporting.

Within evidence reviewed a midwifery staffing risk had occurred twice in the six months prior to inspection due to sickness within the team. Both episodes were mitigated with continuity of service maintained. Senior managers advised shortfall within the on-call rota would be supported by staff and senior managers taking extra on call duties and was never unable to be covered. Senior managers described covering on call as challenging due to the number of staff on maternity leave and short-term sickness. However, this has now resolved and recruitment to fixed term posts had been successful. NHS Shetland provided in evidence their business continuity plan which supports the escalation and management of staffing risk concerns to support the safe delivery of patient care within the maternity unit. We observed this was accessible within the department to all staff in the event an escalation is required. Whilst staff could describe the pathways within the plan, senior managers told us the plan would be updated. This will include more detail to support situations of high absence in midwifery staffing with clinical scenario training to be developed. A requirement has been given to support improvement in this area.

Staff appraisals are essential to support and enable staff to feel valued and support their individual development. In evidence received, we observed that all consultant obstetricians had their appraisals undertaken within the last 12 months. In the same timeframe, 76% of midwives had received an appraisal by their line manager. The remaining 24% had joined the service within the year or were not completed due to a period of leave.

Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This is to enable clinical leaders to ensure they have protected time and resource to ensure appropriate staffing alongside other professional duties to provide the delivery of safe, Healthcare Improvement Scotland Unannounced Inspection Report (Gilbert Bain Hospital, NHS Shetland): 16 – 17 June 2026

high-quality and person-centred healthcare. Senior staff we spoke with confirmed sufficient time was available to support time to lead.

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 demonstrated that as of April 2026, 100% of midwives had undertaken the practical Scottish core obstetric teaching and training in emergencies (SCOTTIE). This course is designed to train the multidisciplinary team in the management of obstetric emergencies. Cardiotocography and intermittent auscultation are used to record and interpret the fetal heart rate in pregnancy and during labour. It is an important tool used in conjunction with clinical assessment to determine fetal wellbeing. NHS Shetland provided evidence that 100% of midwives had completed the yearly fetal heart monitoring training and 85% had completed the two-yearly requirement and 100% of core obstetric staff had completed the relevant mandatory training.

[The Best Start \(2017\)](#) recommends the newborn and infant physical examination (NIPE), a screening programme designed to identify congenital abnormalities undertaken within 72 hours of birth can, in most cases, be performed by appropriately trained midwifery staff. During our onsite inspection we observed mentoring sessions around this. Within evidence we noted 76% of midwifery staff have completed training, with 15% in process. Planned rostering and this level of competence amongst the team ensures no delays to performing the examination and meeting Best Start recommendations.

The Health and Care (Staffing) (Scotland) Act 2019 requires all NHS boards ensure they have a real-time staffing assessment in place to identify and mitigate risks linked to staffing levels, patient acuity and staff wellbeing. NHS Shetland utilises an electronic staffing system which monitors real-time staffing levels in relation to care needs and service capacity. This staffing system enables informed decision making when deploying staff to mitigate identified risks. It considers the acuity of the women and babies alongside available staffing numbers allowing professional judgement to inform the level of required staffing.

We were able to attend 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. We observed maternity services form an active part of the huddle ensuring that NHS Shetland senior managers had oversight of real-time staffing, acuity and safety concerns within maternity services. Whilst inspectors observed this onsite, it was unclear if this process was consistently applied. The evidence provided by NHS Shetland indicated completion of the real-time staffing assessment occurred 50% of the time in the two weeks prior to inspection, noting that in the absence of the senior charge midwife, it was unlikely to be completed. It is also unclear how this data is then captured over time to feed into

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service improvement with significant gaps in completion. In discussion with senior managers, they acknowledged this as an area for improvement and informed us of the intention to raise awareness and provide necessary training amongst staff. 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. NHS Shetland provided tool runs for 2025 and 2026. The document outlines the complexity of accurately capturing the full scope of their activities within the CSM as they are providing an integrated maternity service within the maternity unit. However, the report is comprehensive; utilising professional judgement narrative, outlining quality measures and providing local context to determine staffing needs. For example, regarding workforce, the 2025 report identified the need for forward planning of maternity leave cover due to a high percentage of anticipated absence. This had been actioned and reflected in the 2026 tool run. The local context section for 2026 identifies the slight increase in caesarean sections to be monitored for future workforce implications.

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 to highlighted good opportunities for development within their current banding. In evidence reviewed, NHS Shetland has introduced a clinical leadership programme for nurses and midwives at agenda for change bands 6 and 7 to undertake quality improvement projects. Within the maternity unit, two healthcare support workers have been supported with attendance at university to obtain a Diploma of Higher Education. Once completed it is anticipated this will allow for band progression and provide additional support for the women in the community. Another healthcare support worker is commencing studies in midwifery. This investment in its existing workforce, supports career progression whilst reducing leadership fragility in a remote and rural health board.

Areas of good practice

Domain 4.3

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| 7 | We observed implementation of Best Start recommendation number 25 in relation to the examination of the newborn. |
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Requirements

Domain 4.3

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| 9 | NHS Shetland must have oversight of all staff working hours to ensure adequate rest and wellbeing to support the safe delivery of care. |
| 10 | NHS Shetland must ensure pathways for escalation including the Business Continuity Plan are updated and understood by staff. |

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| 11 NHS Shetland must ensure clear real-time staffing data is consistently recorded and communicated and clear escalation processes and any mitigations/inability to mitigate are recorded clearly and accurately. |
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Domain 6 – Dignity and respect

Quality 6.2 – Dignity and respect

Inspectors observed a maternity service which was able to be flexible and accommodating to the needs of women and their families living on the islands. Trauma informed training and bereavement care training for staff are areas recommended for improvement.

The maternity service within NHS Shetland 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. 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.

Inspectors observed a maternity service which was able to be flexible and accommodating to the needs of women and their families living on the islands. Women described receiving assistance when required and access to analgesia when needed. Interactions between staff and families were observed to be kind, responsive and caring.

NHS Shetland have an established maternity voice partnership. The national maternity voices partnership supports the co-production of maternity services ensuring the “voices of all women including those from diverse backgrounds” are heard and utilised to plan, design and improve maternity services. The partnership meets every three months where parents and representatives of parent’s support groups meet with midwifery and service managers in an aim to improve maternity services. Recent work undertaken by the maternity voice partnership includes developing a system that offers all women experiencing care within NHS Shetland at any point, a postnatal debrief. Information cards for this project were available within the maternity ward. However, we asked NHS Shetland for evidence of trauma informed practice training, but no attendance details were available. A recommendation has been given to support improvement in this area.

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](#). There are nine standards within the pathway relating to patient focused care, staffing and communication. An NHS board that meets these standards is providing good bereavement care. During our inspection we observed a dedicated ward area for bereaved families called “Northern Star.” This was opened in November 2023 as part of an improvement project. It benefits from a separate entrance meaning bereaved families do not have to present to the maternity ward. It is located in a quiet area away from the noise of the maternity ward. Within the room there is space to allow staff to spend time with the family in a comfortable, less clinical setting. We observed the service had a system in place to signal to the multidisciplinary team a current or previous bereavement had occurred.

Staff conveyed a sense of pride in the bereavement service, reflecting strong ownership in this essential component of the maternity service. Bereavement training compliance rates for midwifery staff groups were provided. There were six training opportunities for midwives and five relevant to healthcare support workers; 53% of midwives had participated in some form of training and 73% of healthcare support workers had undertaken some form of bereavement training. However, there was no record of obstetric attendance at bereavement training. Staff bereavement training is a recognised standard recommended for all staff groups by the National Bereavement Care Pathway. A recommendation has been given to support improvement in this area.

Interactions between colleagues, women and their families at the time of inspection were respectful, friendly, with visible leadership from the senior team and what appeared to be a culture of celebrating success. Onsite the team were celebrating Student Midwives Celebration Day together.

[UNICEF](#) Baby Friendly Initiative supports families with evidence-based advice relating to infant feeding and developing close and loving parent-infant relationships. NHS Shetland is UNICEF Baby Friendly Initiative Gold accredited and has demonstrated commitment to continuous learning and improvements in the four pillars around leadership, culture, monitoring and progression.

Areas of good practice

Domain 6	
8	Interactions between staff and families were kind, responsive and caring.
9	NHS Shetland have an established maternity voice partnership.

Recommendations

Domain 6	
1	NHS Shetland should consider improving trauma informed practice training attendance rates for all staff.
2	NHS Shetland should consider improving bereavement training attendance 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)
- [Clinical Governance Standards](#) (Healthcare Improvement Scotland, February 2026)
- [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](#) (General Medical Council, December 2024)
- [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, 2026)
- [National Infection Prevention and Control Manual](#) (NHS National Services Scotland, August 2026)
- [NMC Record keeping: Guidance for nurses and midwives](#) (NMC, August 2012)
- [Operating Framework: Healthcare Improvement Scotland and Scottish Government:](#) (Healthcare Improvement Scotland, April 2026)
- [Person-centred care - NMC](#) (The Nursing and Midwifery Council, December 2020)
- [Prevention and management of pressure ulcers standards](#) (Healthcare Improvement Scotland, October 2020)
- [Professional Guidance on the Administration of Medicines in Healthcare Settings](#) (Royal Pharmaceutical Society and Royal College of Nursing, January 2024)
- [Recommendations | Postnatal care | Guidance | NICE](#) (NICE, April 2021)
- [Scottish Patient Safety Programme \(SPSP\)](#) (Healthcare Improvement Scotland)
- [The best start: five-year plan for maternity and neonatal care - gov.scot](#) (Scottish Government, January 2017)

- [The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives](#) (Nursing & Midwifery Council, October 2018)
- [The UNCRC Act - UNCRC \(Incorporation\) \(Scotland\) Act 2024](#) (Scottish Government, September 2024)
- [The Quality Assurance System and Framework](#) (Healthcare Improvement Scotland, September 2022)

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