Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Dr Gray's Hospital

NHS Grampian

27 – 28 April 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 maternity 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

Dr Gray’s Hospital serves Elgin and the surrounding region. The hospital provides a variety of services including an emergency department, maternity, mental health and paediatric services.

In May 2025 NHS Grampian were escalated to level four of NHS Scotland: support and intervention framework by Scottish Government. Further information can be found here.

About this inspection

During the week of 27 April 2026, we carried out three safe delivery of care inspections within two hospitals in NHS Grampian. We carried out an unannounced maternity services inspection in conjunction with an acute and mental health safe delivery of care inspection to Dr Gray's Hospital on Monday 27 and Tuesday 28 April 2026 using our safe delivery of care inspection methodology. We inspected the following areas within maternity services:

- Ward 3 - Maternity unit

On 29 and 30 April 2026 we also carried out a safe delivery of care maternity inspection of maternity services at Aberdeen Maternity Hospital. Three reports will be published on our inspection findings available on our website.

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, visitors and ward staff, and
- accessed women's health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Grampian to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On Thursday 4 June 2026, we held a virtual discussion session with key members of NHS Grampian 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 Grampian and in particular all staff at Dr Gray's 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.'

Maternity services within Dr Gray's Hospital are undergoing work to increase place of care options for the women of Grampian. At the time of our inspection the unit inspected operated as a midwifery led care unit supported by obstetric consultants between 9am and 10pm.

During the onsite inspection, the unit was busy but calm. We observed women awaiting assessment were reviewed immediately and call bells were answered promptly. Staff were providing responsive and person-centred care. Staff described an open and transparent culture

with respectful working relationships with senior managers, feeling well supported and were able to raise concerns.

We observed respectful and caring interactions between women, their families and members of the multidisciplinary team. We observed women being cared for with respect and attention to detail to maintain privacy and dignity. Women described having access to regular analgesia and being informed of their available options prior to the birth of their baby.

However, staff described challenges accessing consultant input out of hours and when arranging transfers to Aberdeen Maternity Hospital or Raigmore Hospital. Midwives reported that their clinical judgement was sometimes questioned by colleagues in receiving units. We were informed of mitigations, such as allocating a charge midwife each shift to support difficult conversations. The clinical lead midwife highlighted positive senior level relationships between units, with issues addressed collaboratively to improve communication and services.

A recently concluded significant adverse event review carried out by NHS Grampian identified improvement was required in pathways to ensure women receive the right care, by the right team in the right clinical setting. Concerns raised within the review in relation to the safe delivery of level two high dependency care remained evident at the time of our inspection. This related to the sustainability of the medical model required to safely deliver level two critical care as part of our acute safe delivery of care inspection. This impacted on maternity services.

In May 2026, Healthcare Improvement Scotland wrote to NHS Grampian to formally raise serious concerns relating to level two critical care within the High dependency Unit (HDU) at Dr Gray's Hospital. This was in accordance with level one of our escalation process: Healthcare Improvement Scotland and Scottish Government operating framework.

Healthcare Improvement Scotland have requested NHS Grampian complete and implement the planned review of the HDU model of care at Dr Gray's Hospital to support consistently safe and high-quality care, including its relationship with Aberdeen Royal Infirmary, the consultant and multidisciplinary staffing model, governance arrangements and the sustainability of telemetry and medical cover. To gain the necessary assurances, a formal update on the outcome of the review and its actions have been requested to be provided by NHS Grampian by the end of October 2026. More information regarding this can be found here within our acute and mental health inspection report.

We wrote to NHS Grampian on 23 July 2026 to raise concerns about low compliance with staff annual appraisals, an absence of a clear structure to implement clinical supervision within maternity services and variable compliance with essential mandatory training. This included core mandatory training and two-yearly updates in fetal monitoring and neonatal resuscitation. In response NHS Grampian acknowledged appraisal compliance reported during inspection was below expected organisational standard. A formal appraisal improvement plan is in place with an aim of 70% of appraisals being signed off by 31 March 2027. NHS Grampian also acknowledged variable training compliance rates informing us of an improvement approach to increase midwifery and obstetric compliance with maternity specific training to 90% by March 2027. Progress will be monitored monthly by the director of midwifery through the women's and children's clinical governance meeting with oversight monitored through the acute sector governance structure.

Further areas for improvement have been identified throughout this inspection including oversight of data to support recognition of pregnant and postnatal women at risk of clinical deterioration. Other areas for improvement include trauma-informed training and bereavement care training for staff, improved fire safety training for staff and compliance with water flushing regimes.

During these inspections, Healthcare Improvement Scotland wrote to NHS Grampian on a number of occasions to raise concerns, formally escalate issues and seek clarification or additional information. Whilst NHS Grampian engaged with this process and subsequently corrected inaccuracies, there were several instances where inaccurate updates or assurances were provided. This affected Healthcare Improvement Scotland's confidence in the reliability and consistency of the information received.

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

This inspection resulted in nine areas of good practice, two recommendations and 15 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.

Maternity services within NHS Grampian apply a Grampian wide approach to governance therefore many of the areas for improvement in both safe delivery of care inspections findings of Aberdeen Maternity Hospital and Dr Gray's Hospital are mirrored in both inspection reports, resulting in 11 requirements reflecting similar areas for improvement.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Grampian 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: https://www.healthcareimprovementscotland.scot/

Areas of good practice

The unannounced inspection to Dr Gray's Hospital resulted in nine areas of good practice.

Domain 1	
1	Women are supported to make evidence-based decisions on their place of birth by their midwife supported by information available on the birth in Grampian website (see page 15).
2	Dr Gray's Hospital operates a 'red phone' system to support direct, prioritised communication between the Scottish Ambulance Service and hospital staff (see page 15).

Domain 2	
3	Staff described a positive culture where staff wellbeing was promoted (see page 19).
4	NHS Grampian has introduced the Daisy Award programme to celebrate and recognise staff (see page 19).
5	NHS Grampian uses the national Perinatal mortality review tool as part of local review and includes the experiences of families (see page 19).

Domain 4.1	
6	Staff we spoke with described supportive senior leadership (see page 25).

Domain 6	
7	Women and their families spoke highly of the care they received (see page 27).
8	We observed no restrictions to visiting and the service supported a family-centred approach to care (see page 27).
9	NHS Grampian's maternity voices partnership work closely with Aberdeen ethnic minority women's group (see page 27).

Recommendations

The unannounced inspection to Dr Gray's Hospital resulted in two recommendations.

Domain 6	
1	NHS Grampian should consider improving bereavement training compliance rates for all staff (see page 27).
2	NHS Grampian should consider improving trauma-informed training compliance rates for all staff (see page 27).

Requirements

The unannounced inspection to Dr Gray's Hospital resulted in 15 requirements.

Domain 1	
1	NHS Grampian must ensure timely review for women presenting for unscheduled care to support the safe delivery of care (see page 15).

	This will support compliance with: Health and Social Care Standards (2017) 4.11, 4.4 and Quality Assurance Framework (2022) criteria 1.3 and 1.5.
2	NHS Grampian must ensure ongoing oversight and governance of telephone access to the maternity service to support the safe delivery of care (see page 15). This will support compliance with: Healthcare Improvement Scotland Quality Assurance Framework (2022) criteria 2.5 and 2.6.
3	NHS Grampian must ensure the continued development of a culture which promotes and supports staff psychological safety (see page 15). This will support compliance with: Healthcare Improvement Scotland Quality Assurance Framework (2022) Criteria 2.1.
4	NHS Grampian must ensure robust systems and processes are in place to ensure that all staff are appropriately trained to carry out their role. This includes consideration of skills and experience when deploying staff to other health boards (see page 15). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
5	NHS Grampian must ensure that women are provided with the right care, in the right place, at the right time by right professional team (see page 15). This will support compliance with: Health & Social Care Standards (2017) Standard 1, criteria 1.19, 1.20 and Standard 3, criteria 3.14-3.19,and Standard 4, criteria 4.11,4.14,4.27.

Domain 2	
6	NHS Grampian must ensure effective governance and oversight of adverse events to support and improve the quality and safety of care, including but not limited to: (i) reliable and timely reporting of all adverse events (ii) thorough review is carried out to establish what happened, how it happened and why it happened. (iii) ensure compliance with the Healthcare Improvement Scotland national adverse events framework. (iv) feedback and lessons learned from incidents are shared with relevant staff and improvement actions are implemented (see page 19). This will support compliance with: Healthcare Improvement Scotland A National Framework for Reviewing and learning from Adverse Events in NHS Scotland (2025), Healthcare Improvement Scotland Quality Assurance Framework (2022) criteria 2.5 and 2.6 and Healthcare Improvement Scotland Clinical Governance Standards (2026).
7	NHS Grampian must ensure the safe and secure use of medicines at all times, including administration of medicines (see page 19). This will support compliance with: The Royal Pharmaceutical Society Professional guidance on the safe and secure handling of medicines (2024) and relevant codes of practice of regulated healthcare professions.

Domain 4.1

8	NHS Grampian must ensure effective and appropriate governance approval and oversight of guidelines, policies and procedures are in place to ensure the most up-to-date evidence-based guidance is available (see page 22). This will support compliance with: Quality Assurance Framework (2022) criteria 2.5 and 2.6.
9	NHS Grampian must ensure effective governance and oversight to ensure: (i) venous thromboembolism risk assessment compliance. (ii) compliance with Maternity Early Warning System. (iii) compliance with SBAR communication tool (see page 22) This will support compliance with: The Quality Assurance Framework (2022) criteria 2.6. and Healthcare Improvement Scotland Clinical governance standards (2026) criteria 7.1.
10	NHS Grampian must ensure effective governance and oversight to ensure all women who require translation services have access to approved translation services (see page 23). This will support compliance with: Health and Social Care Standards (2017) 1.19, 2.9, 2.10 and Quality Assurance Framework (2022) criteria 3.1 and 6.1 and 6.2.
11	NHS Grampian must ensure staff receive time and resources to undertake training essential to their role. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls (see page 23). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
12	NHS Grampian must ensure staff carry out mandatory fire safety training (see page 23). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3 and Fire Safety (Scotland) Regulations (2006).
13	NHS Grampian must ensure infrequently used water outlets are flushed in line with current national guidance (see page 23). This will support with compliance with: National Infection Prevention and Control Manual (2023) and Scottish Health Technical Memorandum SHTM 04- 01part B (2014) 'Water Safety for healthcare premises Part B: Operational management.'

Domain 4.3

14	NHS Grampian must ensure that there are processes in place to support the consistent application of the common staffing method. This should include but not limited to: (i) the correct application of running the mandated staffing level and professional judgement tools

	(ii) a reporting template demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement (see page 25). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
15	NHS Grampian must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and management responsibilities including, but not limited to: (i) staff appraisals (ii) clinical supervision (see page 25). 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

During inspection the unit was busy but calm, with staff providing responsive and person-centred care. Improvement is required to ensure women receive the right care in the right place by the right team within Dr Gray's Hospital.

Since 2023 NHS Grampian, in collaboration with NHS Highland, has been undertaking improvement work aimed at restoring the availability of consultant-led obstetric care within Dr Gray's Hospital. This work is intended to increase care options for women with complex maternity care needs, allowing them, where appropriate to receive care closer to home and their families. Throughout this transition Dr Gray's Hospital continues to work closely with Aberdeen Maternity Hospital (NHS Grampian) and Raigmore Hospital (NHS Highland) in Inverness to support the provision of maternity care. Dr Gray's Hospital provides remote and rural care to women throughout their pregnancy spanning large geographical areas and facilitates approximately 100 births per year.

In May 2025 NHS Grampian were escalated to level four of NHS Scotland: support and intervention framework by Scottish Government. Further information can be found here. We observed the maternity system in the early stages of governance improvement and transition which aims to support greater assurance over time**.**

The maternity ward within Dr Gray's Hospital 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 supporting amongst others, antenatal, intrapartum and postnatal care. Midwifery led care is supported by obstetric consultants between 9am and 10pm. Out with these hours women who require obstetric care require to be transferred to Aberdeen Maternity Hospital or Raigmore Hospital.

Women are supported to make evidence-based decisions on their place of birth by their midwife supported by information available on the NHS Grampian website. The website provides details on available services including analgesia options, transfer times between units and information from NHS Scotland birthplace decisions resource to support women's decisions regarding their care.

Dr Gray's Hospital supports both scheduled and unscheduled care within the maternity unit and is accessible 24 hours a day, seven days a week following a telephone assessment carried out by midwives. This allows maternity staff oversight of women attending and supports the redirection of women's care where required. For example, women with more complex care needs would be advised and supported to attend Aberdeen Maternity Hospital for review and care. Staff document calls on a standard maternity electronic patient communication log developed to record telephone conversations.

During inspection, inspectors observed calls being answered promptly. Staff and senior managers did not describe any delays to prioritising triage calls or care. We were provided with the "pathways of care for maternity and obstetrics in Dr Gray's Hospital"; staff guidance which supports the delivery of care when women contacted the unit for unscheduled care. NHS Grampian provided evidence which demonstrated on average 77% of women attending for

unscheduled care between March and May 2026 received an initial assessment within 30 minutes of their arrival to the service.

Maternity triage within NHS Grampian is currently under review with the aim of centralising telephone triage within a dedicated hub and introduce an evaluated approach to unscheduled care. This will support a consistent NHS Grampian wide approach when women contact maternity services for review. Senior managers advised an evaluated maternity triage system within NHS Grampian is expected to be in place by October 2026. A requirement has been given to support ongoing improvement in this area.

During the onsite inspection, the unit was busy but calm. 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. Within requested patient incident forms submitted by staff for the six months prior to inspection we observed none related to delays to care.

The maternity ward operates a 'red phone' system to support direct, prioritised communication between the Scottish Ambulance Service and hospital staff, enabling safer and more effective coordination of care. Due to the small staffing model, the clinical charge midwife carries the maternity phone when away from the desk, ensuring continuous access in emergencies. However, we observed that this phone is also used for triage calls, often for extended periods. Staff also highlighted that delayed telephone communication during a recent adverse event was highlighted as an area for improvement. This was discussed with the charge midwife and clinical lead, who confirmed that triage and incoming call numbers have now been separated to maintain an open line of communication. A requirement has been given to support continued improvement in this area.

Within the maternity unit there are four spacious birth rooms including a birthing pool, a triage room, three side rooms and four multi-bedded bays. The facilities are flexibly used for antenatal or postnatal care depending on requirements. Staff highlighted that two of the multi-bedded bays may be used as medical surge beds with staff from the acute wards continuing to care for their patients at times of high capacity within the wider hospital. These beds have not been utilised by maternity services for the last 24 months. We observed controlled entry doors between each area to protect safety. At the time of inspection, no surge beds were in use.

All birthing rooms provided ample space to support women's mobility and freedom of movement, whilst also allowing staff clear access in the event of an emergency. A range of birthing aids were available, including a birthing pool and birthing balls. Each room could accommodate a resuscitaire to ensure that any immediate neonatal resuscitation needs could be met promptly preventing unnecessary separation of mother and baby in the immediate period after birth.

Members of the multidisciplinary team described a supportive, open and trusting culture within the unit. Senior midwives and leaders were visible and easily accessible. Staff spoke highly of the senior leadership team, including the lead midwife and director of midwifery.

Staff described challenges accessing consultant input out of hours and when arranging transfers to Aberdeen Maternity Hospital or Raigmore Hospital. Midwives reported that their clinical judgement was sometimes questioned by colleagues in receiving units, requiring escalation to the shift's charge midwife and creating anxiety for staff regarding seeking advice

or requesting transfers. Charge midwives also described supporting these situations as challenging, needing to engage in cross-site clinical discussions to facilitate safe transfers.

We raised these concerns with senior managers who were aware of and outlined mitigations, such as allocating a charge midwife each shift to support difficult conversations. The clinical lead midwife highlighted positive senior level relationships between units, with issues addressed collaboratively to improve communication and services. Staff are encouraged to submit incident forms when transfer challenges occur; one such incident was submitted in the six months prior to inspection.

Over the past 18 months, senior clinical leaders have led a multidisciplinary improvement programme to strengthen relationships and team culture across NHS Grampian maternity services. Two civility surveys provided insight into staff experiences and highlighted some cultural improvement. In response, a programme launched in early 2025 has prioritised staff engagement, introducing scenario-based training and the PAUSE tool to support respectful communication and real-time de-escalation. Staff co-produced a new "values and behaviours agreement" with the aim of establishing expectations for behaviour across all professional groups. In a repeat civility survey in November 2025 staff reported their working environment as "feeling better." However, staff also reported incivility remains, particularly during high-pressure interactions such as handovers and transfers, which was also raised by staff in discussion with inspectors. Whilst cultural change will take time, continued staff engagement and visible leadership are essential. A requirement has been given to support ongoing improvement in this area.

During intrapartum care, if a woman's or fetus' condition deteriorates, transfer to Raigmore Hospital, Inverness is required. The midwife accompanying the woman from Dr Gray's Hospital remains her care provider until the end of their shift, supporting continuity of care. This is an important factor in patient safety improving outcomes and experiences for women.

However, midwives reported this process as a source of anxiety, as it requires working outside their usual environment where they are less familiar with local policies and procedures. We were provided with a standard operating procedure outlining roles and responsibilities when women do require this type of transfer, along with guidance to support NHS Grampian midwives working in NHS Highland, including gaining access to electronic records and incident reporting. Senior managers request an incident form for all intrapartum transfers to ensure the safe delivery of care. Evidence demonstrated 7% of reported incidents for the six months prior to inspection related to intrapartum transfers. A requirement has been given to support improvement in this area.

Induction of labour is not currently offered within Dr Gray's Hospital. Where suitable the use of the outpatient induction of labour service allows some women the option to commence the induction process within Dr Gray's Hospital then transfer to Aberdeen Maternity Hospital. This allows women who establish in labour to return to Dr Gray's Hospital where appropriate or transfer to Aberdeen Maternity Hospital when further treatment is required. This provision aligns with the vision for maternity services across Scotland set within The Best Start: A five-year forward plan for maternity and neonatal care in Scotland in which women and babies are offered truly family-centred and compassionate care. We observed oversight of women to commence and currently undergoing the induction of labour process formed part of the cross-site huddle during our inspection.

The classification of urgency for caesarean birth in the UK is based on the potential risk to mother or baby. Planned or category four caesarean births are scheduled at a time to suit the woman or healthcare provider. Planned caesarean birth has been a birth option within Dr Gray's Hospital since April 2025 and available one day a week supported by midwives from the maternity unit. Where caesarean birth occurs out with this scheduled time the quality, risk and improvement team review and discuss with the senior team to ensure oversight and learning. We were provided with evidence of oversight of this through the women's and children's governance group detailing no unplanned caesarean birth occurred in the first quarter of 2026.

Obstetric consultants are not resident and are not on call for maternity services overnight within Dr Gray's Hospital. However, they are rostered on call for gynaecology and will attend when available for emergency situations, such as where transfer to Aberdeen Maternity Hospital would impact the outcome for women or their baby. This limits the service admission of antenatal patients meaning women who require complex care or overnight antenatal care admission to maternity services should be transferred to Aberdeen Maternity Hospital.

We were provided with a standard operating procedure outlining detailed criteria and pathways of care for admission to the maternity unit and where transfer to a supporting unit should be considered. In discussion with senior managers, they advised individualised assessments on clinical presentation are carried out to support the admission and appropriate transfer of women. For the six months prior to inspection, we observed no incident forms submitted in relation to inappropriate antenatal admissions. However, a recently concluded significant adverse event review identified improvement was required in pathways to ensure women receive the right care, by the right team in the right clinical setting.

We observed reporting, commissioning of the adverse event review, action plan and shared learning from the review followed NHS Grampian governance processes. However, concerns raised within the review in relation to the safe delivery of level two high dependency care remained evident at the time of our inspection. This related to the sustainability of the medical model required to safely deliver level two critical care. We formally escalated these concerns at level one in line with Healthcare Improvement Scotland and Scottish Government Operating Framework as part of our acute safe delivery of care inspection. Further detail regarding this can be found within our acute inspection report. A requirement has been given to support improvement in this area.

There is no neonatal or special care baby unit within Dr Gray's Hospital. During the antenatal period, women are made aware that if their baby requires neonatal care emergency transfer may be required. In the event of an unwell or unexpected birth of a premature newborn baby who needs enhanced support at birth, it is fundamental that staff have the required skills to respond effectively. Midwives within the team are currently undertaking the Qualification in Speciality (QIS) course to further support neonatal care to ensure learning and safety within this remote and rural maternity unit. To maintain safety within the unit, staff were able to describe that QIS trained staff are rostered onto duty the day of any planned caesarean birth to support any necessary observations or interventions.

Access to a neonatal stabilisation room is available which provides access to equipment to stabilise neonates requiring advanced life support. A paediatrician is available on call to support any immediate concerns, and telemedicine supports emergency communication between NHS Grampian neonatal unit if required. Midwifery 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. In evidence submitted by NHS Grampian, we observed 93% of midwifery staff had undertaken the Scottish Neonatal Resuscitation Course (SNRC).

As part of our inspection, staff told us that transfer of a neonate would be arranged as promptly as possible, and the team discussed the good working relationships and collaborative approach between NHS Grampian and supporting services such as the Scottish Ambulance Service and ScotSTAR. ScotSTAR is a national service for safe and effective transport and retrieval of newborn babies (neonates) and critically ill children throughout Scotland. National guidance produced by the Scottish Perinatal Network is utilised within the service to support staff to gain advice and arrange transfer when required. Where delays to transfer occurred we observed incident reports are submitted by staff and for the six months prior to inspection 4% (three) of incidents related to delays in transfer.

Areas of good practice

Domain 1	
1	Women are supported to make evidence-based decisions on their place of birth by their midwife supported by information available on the birth in Grampian website.
2	Dr Gray's Hospital operates a 'red phone' system to support direct, prioritised communication between the Scottish Ambulance Service and hospital staff.

Requirements

Domain 1	
1	NHS Grampian must ensure timely review for women presenting for unscheduled care to support the safe delivery of care.
2	NHS Grampian must ensure ongoing oversight and governance of telephone access to the maternity service to support the safe delivery of care.
3	NHS Grampian must ensure the continued development of a culture which promotes and supports staff psychological safety.
4	NHS Grampian must ensure robust systems and processes are in place to ensure that all staff are appropriately trained to carry out their role. This includes consideration of skills and experience when deploying staff to other health boards.
5	NHS Grampian must ensure that women are provided with the right care, in the right place, at the right time by right professional team.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

We observed an open and transparent culture within the unit during the onsite inspection. Staff described respectful working relationships with senior managers, feeling well supported and were able to raise concerns.

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. Inspectors observed respectful and inclusive multidisciplinary team communication during inspection. Staff told inspectors that they felt well supported when they escalated issues such as understaffing and increased acuity to the senior management team. We were provided with the escalation policy which supports staff in and out of hours to escalate any staffing concerns to senior managers.

Staff appeared happy at work and all said they had appropriate time to carry out their tasks during their shift. Staff spoke with pride of the service they provide and the impact this has within their community. Student midwives described a positive learning environment with ease of escalation of any concerns. We also observed good multidisciplinary interactions with support of junior staff throughout our onsite inspection.

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. NHS Grampian demonstrates an average response from staff of 57% in 2025 with an overall employee engagement index score of 77 which is consistent with the national average. This was consistent within maternity services staffing groups with a response rate of between 43-54% and employee engagement index of between 63-79%. Staff engagement with the survey enables 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.

Senior staff demonstrated commitment and awareness to role model respectful, compassionate communication. We were informed of a voluntary staff group established to support and promote staff wellbeing throughout Dr Gray's Hospital. Initiatives undertaken to date include national wellbeing week activities and the redevelopment of the health and wellbeing online resource. Staff spoke highly of colleagues across the multi-disciplinary team and described an encouraging, supportive and respectful culture of leadership and improvement. Staff described close working and supportive relationships with clinical leaders.

NHS Grampian 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 Daisy nomination posters and the use of quick response (QR) barcodes displayed to support submission. Maternity staff spoke of the positive impact the Daisy Award has on acknowledging their

colleagues, receiving nominations from their peers or from the women and families they have cared for. Within evidence we observed good engagement with the initiative; between December 2025 and February 2026 a total of 245 nominations for midwives across NHS Grampian were received.

Senior obstetric staff we spoke with described an improving culture of communication, review and collaborative working with colleagues at Aberdeen Maternity Hospital. We were told during the pandemic many meetings across NHS Grampian moved online and this continued to be utilised positively within the service supporting the cross-site relationships. An example of this was demonstrated in the weekly perinatal mortality review group which facilitated NHS Grampian wide representation of senior clinical staff and review of cases. This has also been utilised to develop relationships and communication with NHS Highland where the clinical lead midwife for Dr Gray's Hospital attends and contributes to the NHS Highland risk management meeting where patient safety concerns have occurred between health boards.

The multidisciplinary team within Dr Gray's Hospital have expanded their roles through the development of midwifery skills and competencies to support and enhance the local service provision. For example, early career midwives have implemented and developed a recurrent miscarriage clinic to reduce the need for women to travel to Aberdeen Maternity Hospital for investigations and preconception health advice. A maternity specialist dietician has been available within the service for just over a year supporting women with pre-existing diabetes and women who develop gestational diabetes during pregnancy, amongst other issues. Staff spoke of their pride in taking on these roles to facilitate the best care and service to women and their families.

The Healthcare Improvement Scotland National Framework for Reviewing and Learning from Adverse Events 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. During the inspection, we spoke with staff who described feeling encouraged to submit incident reports. Individual feedback and emails were described by the senior charge midwives as mechanisms of feedback and we observed a staff information board which contained learning from incident reporting displayed within the area.

Evidence submitted by NHS Grampian highlighted oversight of incidents reported had identified an emerging trend in medication safety. These related to administration and documentation of medication. Within submitted incidents we observed this contributed to 21% of the records submitted for the six months prior to our inspection. In response, senior charge midwives were leading on work to improve medication safety within the service and we observed staff safety briefs and information boards supporting communication of this with staff. A requirement has been given to support improvement in this area.

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 Grampian uses the national review tool and includes the experiences of families involved. NHS Grampian submits all data in relation to perinatal deaths and uses the perinatal mortality review tool to support adverse events reviews.

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 Grampian ensures patients and families are informed, involved and supported throughout the review allocating a named contact. Women and families are offered the opportunity to contribute to the review 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 of the three adverse events detailed, none were compliant with the 140 days' timeframe, with the longest taking over 190 working days to be completed. In discussion with senior managers, they advised women and families are kept up to date through their named contact with timelines and actions from any significant adverse events monitored through the women's and children's clinical governance group, to support oversight and improvement.

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, we observed that the maternity service within Dr Gray's Hospital has a delay of up to four months in closing some level three incidents. This delay could impact timely improvement, feedback and learning. In discussion with senior managers, they highlighted the process for governance and oversight in this area, detailing delays to closure of incidents mainly occurred due to administrative errors rather than delay to review. Senior managers described a process for monitoring and escalating to responsible staff when incidents fell outside recommended review dates. A requirement has been given to support improvement in this area.

The National Framework for Reviewing and Learning from Adverse Events also outlines that NHS boards should ensure immediate access to support for staff involved in adverse events. Staff at Dr Gray's Hospital 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. Within evidence we observed published learning summaries and shared learning events posters detailing 2026 dates, where information related to the management of adverse events and service improvement are shared via teams for all staff.

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 quick response (QR) codes encouraging and welcoming feedback from service users. The service utilised a "what do you think" tree to ask service users for immediate feedback including what went well and what could be done better. In evidence provided by NHS Grampian we observed that of complaints

submitted through 2025/26, 2% related to maternity services within Dr Gray's Hospital. Oversight of complaints is monitored through the women's and children's clinical governance group.

Areas of good practice

Domain 2	
3	Staff described a positive culture where staff wellbeing was promoted.
4	NHS Grampian has introduced the Daisy Award programme to celebrate and recognise staff.
5	NHS Grampian uses the national PMRT tool as part of local review and includes the experiences of families.

Requirements

Domain 2	
6	NHS Grampian must ensure effective governance and oversight of adverse events to support and improve the quality and safety of care, including but not limited to: (i) reliable and timely reporting of all adverse events. (ii) thorough review is carried out to establish what happened, how it happened and why it happened. (iii) ensure compliance with the Healthcare Improvement Scotland national adverse events framework. (iv) feedback and lessons learned from incidents are shared with relevant staff and improvement actions are implemented.
7	NHS Grampian must ensure the safe and secure use of medicines at all times, including administration of medicines.

Domain 4.1 – Pathways, procedures and policies

Quality indicator 4.1 – Pathways, procedures and policies

NHS Grampian wide guidance is in use to support clinical practice and reduce the risk of unwarranted variation. However, compliance data for appropriate escalation of women requires 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.

NHS Grampian wide guidance is in use to support unwarranted variation in clinical practice. To support this approach a recent multidisciplinary guidance review group has been established. In discussion with senior leaders, they advised us a governance framework was in place which incorporates multidisciplinary oversight of all clinical guidelines within maternity services. From evidence, we observed of 178 guidelines, 79% were in date of the review period. Ensuring clinical guidelines are consistent with evidenced based practice requires oversight and a system

of review to ensure they remain relevant. A requirement has been given to support improvement in this area.

Quality improvement 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. Senior managers provided information on multi-workstream programmes to restore and expand the consultant-led maternity services at Dr Gray's Hospital incorporating the Scottish Patient Safety Programme aligned improvement methodology. Staff described being aware of ongoing quality improvement projects within maternity services. We observed an information board of improvements ongoing within the unit and the assigned improvement leader. This enables staff to become actively involved with quality improvements and advance a culture of continuous learning within their workplace.

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 we observed NHS Grampian's most recent progress and evaluation report detailing current and planned improvement focus for the next twelve months including maternal deterioration and variation in caesarean section rates within the service.

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 for the six months prior to inspection demonstrating varying compliance rates between 60-100% for accuracy and appropriate frequency of observations. However, compliance data for appropriate escalation of concern was not available. In discussion with senior managers, they advised oversight of MEWS compliance continues to be a service quality improvement priority. A requirement has been given to support improvement 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 2025 report demonstrates the leading cause for maternal death in the UK remains attributed to venous thromboembolism. Learning from the report highlighted a need for continuous evidence-based risk assessment throughout pregnancy and following birth. We observed guidance available to support staff risk assessment and management of venous thromboembolism in line with national recommendations. We were provided with audits undertaken within the service between January and March 2026. This demonstrated 93% compliance in the first trimester, 76% compliance in the second trimester and 36% compliance in the third trimester of pregnancy risk assessment. Postnatal risk assessment compliance was 70%. Of the incident reports submitted in relation to medicine management, two related to thromboprophylaxis being omitted. 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 Situation, Background, Assessment and

Recommendation (SBAR) tool refers to a structured communication framework used widely in healthcare and 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. We observed effective communication among staff, who were able to clearly describe the importance of communicating effectively when contacting other units to support the safe transfer of patients. We requested evidence of oversight and audit documentation regarding the use of the SBAR tool within the electronic patient record. Senior managers explained that structured communication training such as SBAR is embedded within core mandatory training. However, evidence reviewed as part of the inspection demonstrated a variation in escalation language and responsiveness has been identified through learning from adverse events by the service. A requirement has been given to support improvement in this area.

Staff told us that when required, women can access both online and face to face interpretation services. However, variation in access to interpreters can result in interpretation services not being immediately accessible and digital translation tools being used to support basic communication. We observed guidance available to support staff to access interpretation services. A staff survey was conducted by NHS Grampian to better understand the barriers and challenges faced which highlighted insufficient time during appointments when an interpreter is required and access to in-demand interpreters via telephone interpreting as current challenges. Senior managers advised actions in response to these findings are currently being developed. A requirement 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 (Royal College of Obstetricians and Gynaecologists 2019) have highlighted the essential safety feature of teams working and training together to improve outcomes for patients. Evidence received demonstrated varying rates of compliance were noted within the maternity services. Compliance rates for midwives undertaking core mandatory training ranged from 48 to 86%, whilst obstetric consultant compliance was 40% for all elements. We wrote to NHS Grampian on 23 July 2026 to raise concerns about low compliance with essential training. NHS Grampian acknowledged the variable compliance rates informing us of an improvement approach to increase midwifery and obstetric compliance with maternity specific training to 90% by March 2027. Progress will be monitored monthly by the director of midwifery through the women's and children's clinical governance meeting with oversight monitored through the acute sector governance structure. A requirement has been given to support improvement in this area.

During inspection the unit was well organised with immediate patient care equipment available, clean and in working order. The healthcare environment appeared to be well maintained, however, areas of improvement were noted; for example, in a patient shower where there appeared to be mould. This was highlighted to the senior charge midwife and was reported immediately for action. Staff describe that estates concerns can take long periods of time to be resolved and this was also noted within the acute ward inspections. Dr Gray's

Hospital building is part of an ageing estate and the board may face increased challenges with repairs due to this. No outstanding estates issues were noted whilst on site.

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 fire training within the maternity unit demonstrated 73% compliance. Senior managers acknowledged gaps in some areas of fire safety training and intend to increase monitoring of compliance. A requirement has been given to support improvement in this area.

Medicines were observed stored in locked cupboards. 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. Medication cupboards and fridges across all areas of care were noted to be secure and fridge temperatures were recorded daily. Emergency trolley checks were also in place using NHS Grampian standardised checklist booklets. The cardiac arrest trolley was clean and tagged to demonstrate it had been checked and ready for use.

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 Prevention and Control Manual. During the onsite inspection, we observed good compliance with hand hygiene.

Personal protective equipment such as gloves and aprons was readily available at the point of care and 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 and 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. Evidence submitted by NHS Grampian demonstrate omissions in water flushing regimes in the area inspected. A requirement has been given to support improvement in this area.

Requirements

Domain 4.1	
8	NHS Grampian must ensure effective and appropriate governance approval and oversight of guidelines, policies and procedures are in place to ensure the most up-to-date evidence-based guidance is available.
9	NHS Grampian must ensure effective governance and oversight to ensure:

	(i) venous thromboembolism risk assessment compliance (ii) compliance with Maternity Early Warning System (iii) compliance with SBAR communication tool.
10	NHS Grampian must ensure effective governance and oversight to ensure all women who require translation services have access to approved translation services.
11	NHS Grampian must ensure staff receive time and resources to undertake training essential to their role. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls.
12	NHS Grampian must ensure staff carry out mandatory fire safety training.
13	NHS Grampian must ensure infrequently used water outlets are flushed in line with current national guidance.

Domain 4.3 – Workforce planning

Quality indicator 4.3 – Workforce planning

Staff we spoke with described supportive midwifery senior leadership who were accessible with the ability to escalate any staffing or clinical concerns as required. We identified areas for improvement with the completion of staff appraisals and clinical supervision.

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 impacting on the health and safety of patients. As part of our inspection, we were able to attend the different safety huddles which support the safe delivery of care and occurred at different points throughout the day. The purpose of a safety huddle is to provide situational awareness, understand patient flow and raise issues such as patient safety concerns, review staffing and identify wards or areas at risk due to reduced staffing levels.

We had the opportunity to observe maternity services within the site wide safety and capacity huddle during which staffing was discussed and collective solutions found where required. We observed maternity services engagement, leadership and senior managers had oversight of real-time staffing, acuity and safety concerns. We observed the use of safe care data to achieve this oversight and any mitigations required to maintain safe staffing. The system uses a Red (staffing considered unsafe, requiring immediate escalation and intervention), Amber (staffing pressures identified, with mitigations in place and ongoing monitoring), Green (staffing is safe and appropriate) and Grey (no issue identified and no risk escalated) RAGG status to indicate staffing risk and compliance with safe staffing requirements. Senior managers informed us this enables informed decision making when deploying staff to help mitigate risk. On both days of the onsite inspection maternity services within Dr Gray's Hospital reported a grey safe to start position.

Dr Gray's Hospital remote and rural setting of maternity service provision requires staff who are willing to work in more generalised roles and on out of hours on call rotas with greater frequency of work. Over the last two years, Dr Gray's Hospital has progressed with the recruitment drive to secure the multidisciplinary team required to support a fully integrated obstetric led unit. The most recent update on their progress, published in February 2026, describes the challenges in recruitment around roles such as anaesthetist and obstetrics/gynaecologist which are the most difficult to recruit to and is demonstrated at a national level. The recruitment campaign "wish you worked here" intends to continue scoping

the key medical roles required throughout 2026. Review of obstetric workforce data for Dr Gray's Hospital demonstrated a vacancy rate of 36.9% for obstetric consultant level. We consider a vacancy rate of over 10% to be high.

Senior midwives spoke positively about their continued ability to recruit and retain midwives within the service. Workforce data provided demonstrated a stable midwifery and healthcare support workforce over 2025/2026. Preceptorship and flying start programmes are utilised within the service to support new members of the midwifery team and include four dedicated study days. Resources include a welcome booklet which outlines the senior charge midwife's role in supporting new staff and ensuring clinical learning is achieved.

The Health and Care (Staffing) (Scotland) Act 2019 stipulates that NHS boards have a duty to apply the Common Staffing Method (CSM), which includes a staffing level tool run and requires this to be applied rigorously and consistently. The application of the CSM and staffing level tools supports NHS boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care. As part of evidence, we observed staffing level tool runs had been undertaken in 2025 and 2026 for all areas inspected however were non-compliant due to omitted professional judgement data. We raised this in discussion with senior managers who described the omission as a systematic issue which was currently under review. Senior managers also described staff training and engagement as a priority. A requirement has been given to support improvement in this area.

Midwives within the unit provide scheduled, unscheduled and intrapartum care working flexibly across the unit to build and maintain skills within each area. The senior charge midwives did not describe any concerns regarding their available time to lead. Each charge midwife within the service is responsible for a team of midwives to manage their training; performance, including absence; conduct; and appraisal. We observed oversight of protected time to lead and how this was monitored for assurance within submitted evidence.

In evidence received, we observed that 100% of consultant obstetricians had their appraisals undertaken within the last 12 months. In the same timeframe, 45% of midwives had received an appraisal by their line manager. Staff appraisals are essential to support and enable staff to feel valued and support their individual development. In response to our letter highlighting poor completion of staff annual appraisals, NHS Grampian acknowledged appraisal compliance reported during inspection was below expected organisational standard. NHS Grampian has put a formal appraisal improvement plan in place with an aim of 70% of appraisals signed off by 31 March 2027. This will be monitored through NHS Grampian established governance routes for oversight. A requirement has been given to support improvement in this area.

NHS Education for Scotland (NES) created the national clinical supervision nursing and midwifery frameworks which supports a 'Once for Scotland' approach to implementation, practice and governance of clinical supervision. Clinical supervision is a proactive process to support staff's development and professional growth by offering dedicated time, feedback and guidance in a psychologically safe space to critically reflect practice. The aim is to enable and empower staff to provide high-quality, safe, person-centred care. Within evidence, NHS Grampian was unable to provide overall compliance rates recognising this as an area for improvement within the service. A requirement has been given to support improvement in this area.

Area of good practice

Domain 4.3	
6	Staff we spoke with described supportive senior leadership.

Requirements

Domain 4.3	
14	NHS Grampian must ensure that there are processes in place to support the consistent application of the common staffing method. This should include but not limited to: (i) the correct application of running the mandated staffing level and professional judgement tools (ii) a reporting template demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement.
15	NHS Grampian must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and management responsibilities including but not limited to: (i) staff appraisals (ii) clinical supervision.

Domain 6 – Dignity and respect

Quality indicator 6.2 – Dignity and respect

We observed respectful and caring interactions between women, their families and members of the multidisciplinary team. Trauma-informed training and bereavement care training for staff are recommended areas for improvement.

Women and their families spoke highly of the care they received whilst attending maternity services within Dr Gray's Hospital. Women described being well informed, given time to process information and discuss any concerns they had. Women felt they were able to access care without delay and felt comfortable attending the unit.

Each woman we spoke with described a feeling of relief of not needing to travel to Aberdeen Maternity Hospital to receive their care due to the length of travel and impact on family life. We observed women being cared for with respect and attention to detail to maintain privacy and dignity. Women we spoke with told us they had access to regular analgesia and felt informed of their available options prior to the birth of their baby.

We observed no restrictions to visiting and the service supported a family-centred approach, recognising the importance of and encouraging fathers, co-parents, partners and family members to be, partners in care. Partners are supported to stay overnight within an environment which could support this and the provision of available pull-out beds were observed. Food, fluid and nutrition were available to women and their families. Women were able to have snacks such as tea, toast and sandwiches as they wished.

The National Bereavement Care Pathway (NBCP) 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. Dr Gray's Hospital was an early adopter of the NBCP implementation and continues to develop the care packages available across the service. There are two dedicated bereavement rooms within the service. The Forget me Not suite is a bespoke bereavement room dedicated to providing bereavement care, designed to support the full in-hospital bereavement journey. The space offered a private and quiet environment where care options could be discussed sensitively, the birth could be supported and families could spend time together following the death of a baby. Evidence reviewed demonstrate that bereavement learning and development sessions are offered to all staff. This is in line with Key Action 32 of the National Bereavement Care Pathway Scotland and Recommendation 41 of The Best Start, A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland, which highlights that all staff who are caring for bereaved families should be supported to access learning opportunities. Since 2023, biannual Sands Bereavement Training has been available to NHS Grampian staff. However, evidence demonstrated only 23% of midwives and 4% of obstetricians are currently trained. A recommendation has been given to support improvement in this area.

Trauma-informed training equips maternity staff to recognise and understand the impact of trauma on emotional and psychological wellbeing. The training enables services to respond sensitively and effectively in ways that prevent further harm, support recovery and address inequalities for trauma survivors. Within evidence NHS Grampian explained the current challenges including low staff engagement and incomplete attendance data demonstrated low assurance in this area of staff training. Despite this, NHS Grampian maintain trauma-informed training as a service priority and are intending to utilise innovative ways of embedding the contents in to newly developed study days. A recommendation has been given to support improvement in this area.

The Moray collaborative newsletter is published quarterly as an update for the Grampian community on the progression of maternity services within Dr Gray's Hospital. The most recent publication available in February 2026 included celebrating professional successes, introducing new members of staff and an update of the progression of the service. This included being open and honest regarding the challenges faced by the collaborative, particularly in relation to recruitment of the multidisciplinary team required to support the service.

Community engagement highlighted within the newsletter outlines NHS Grampian's maternity voices partnership and close working with Aberdeen ethnic minority women's group, supporting a maternity health needs survey. Using data from January 2020 to December 2025, the assessment identifies and explains the needs of pregnant women experiencing, or at risk of, vulnerability across Grampian, informing targeted improvement in response to population needs. Six focus groups representing diverse ethnic communities and a staff survey exploring experiences of caring for women from ethnic minority groups were established. Findings will inform targeted improvement activity, supported by a multidisciplinary approach involving public health teams.

Areas of good practice

Domain 6	
7	Women and their families spoke highly of the care they received.
8	We observed no restrictions to visiting and the service supported a family-centred approach to care.
9	NHS Grampian's maternity voices partnership work closely with Aberdeen ethnic minority women's group.

Recommendations

Domain 6	
1	NHS Grampian should consider improving bereavement training compliance rates for all staff.
2	NHS Grampian 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)
- A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland Healthcare Improvement Scotland, February 2025
- Clinical Governance Standards (Healthcare Improvement Scotland 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 (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 2024)
- Recommendations | Postnatal care | Guidance | NICE (NICE, April 2021)
- Scottish Patient Safety Programme (SPSP) (Healthcare Improvement Scotland)

- The best start: five-year plan for maternity and neonatal care - gov.scot (Scottish Government, January 2017)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)
- The UNCRC Act - UNCRC (Incorporation) (Scotland) Act 2024 (Scottish Government, September 2024)
- The Quality Assurance System (healthcareimprovementscotland.org) (Healthcare Improvement Scotland, September 2022)

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