Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Aberdeen Maternity Hospital

NHS Grampian

29 – 30 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

Aberdeen Maternity Hospital is a purpose-built maternity unit located on the Foresterhill site within NHS Grampian. The service provides maternity care to Grampian and surrounding areas, covering a large geographical area supporting approximately 4,000 births per year

through obstetric and midwifery led care. NHS Grampian also facilitates maternity care for women from Orkney and Shetland who require specialist obstetric care.

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 unannounced safe delivery of care inspections within NHS Grampian. As part of this we carried out an unannounced inspection to Aberdeen Maternity Hospital, on Wednesday 29 and Thursday 30 April 2026 using our safe delivery of care inspection methodology. We inspected the following areas:

- Ashgrove and Summerfield wards (combined antenatal and postnatal wards)
- labour ward
- maternity triage and induction of labour suite
- midwife led unit, and
- Rubislaw ward (early pregnancy and bereavement suite).

We also carried out an unannounced safe delivery of care inspection of maternity services at Dr Gray's Hospital, maternity ward 3 in conjunction with an acute hospital and mental health safe delivery of care inspection on 27 and 28 April 2026. 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 and birthing people'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 Aberdeen Maternity Hospital for their assistance during our inspection.

A summary of our findings

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

We observed staff working hard as a multidisciplinary team to deliver person-centred care. Staff were working together to maintain good communication and were accessible to women and their families. During onsite inspection we observed no delays to care. However, oversight of clinical activity within the maternity triage and induction of labour ward has been identified as an area for improvement. Recovery nurses are undertaking an extended role within maternity services which we raised with senior managers to ensure healthcare professionals are supported to work within their scope of practice.

We observed women and their families being treated with dignity, kindness and compassion. Women described positive experiences of staff promoting their dignity and felt respected. Women and their families were able to access specialised bereavement care.

All areas inspected were calm and organised with staff working hard to support the safe delivery of care. However, consultant obstetricians described obstetric staffing levels impacting daily consultant oversight of ward round activity especially within inpatient wards.

Timely estates repairs including faulty call bells and emergency buzzers within wards which may impact on the prompt escalation of an emergency were raised as an area for immediate action and were resolved by the second day of inspection.

Midwives working within the midwifery led unit spoke highly of the support and oversight received from labour ward staff including senior charge midwives. Staff described supportive and collaborative working within their teams. However, some staff described varying experiences of civility between departments.

We also observed oversight of data to support recognition of pregnant and postnatal women at risk of clinical deterioration, thromboprophylaxis risk assessment and audit compliance within the service as areas for improvement.

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.

During our corresponding inspections of Dr Gray's Hospital, we were aware of a recently concluded significant adverse event review carried out by NHS Grampian. The review identified the need to improve pathways to ensure women receive the right care, by the right

team in the right clinical setting. Concerns identified within the review about the safe delivery of level two high dependency care remained evident at the time of our inspection. These concerns related to the sustainability of the medical model required to safely deliver level two critical care. Whilst this was identified through our acute safe delivery of care inspection, this also impacted on maternity services within Dr Gray's Hospital.

In May 2026, Healthcare Improvement Scotland wrote to NHS Grampian to formally raise serious concerns relating to the sustainability of the High Dependency Unit (HDU) at Dr Gray's Hospital. This was in accordance with level 1 of our escalation process in line with the 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.

Further areas for improvement have been identified throughout this inspection including trauma informed training and bereavement care training for staff, improved fire safety training for staff and compliance with flushing of infrequently used water outlets.

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 eight areas of good practice, three recommendations and 20 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 Aberdeen Maternity Hospital resulted in eight areas of good practice.

Domain 1	
1	Staff were observed working hard as a multidisciplinary team to deliver person-centred care (see page 19).
2	During inspection we observed no delays to care (see page 19).

Domain 2	
3	Staff did not describe any barriers to submitting incident reports (see page 24).
4	NHS Grampian has introduced the Daisy Award programme to celebrate and recognise staff (see page 24).

Domain 4.1	
5	Women and their babies appeared well cared for with families speaking highly of the care they had received (see page 27).
6	The wards we inspected were calm, with good visibility of staff and senior managers (see page 27).

Domain 6	
7	NHS Grampian has undertaken a health needs assessment to identify and understand the needs of pregnant women experiencing, or at risk of, vulnerability across the region (see page 35).
8	Women and their families were able to access specialist bereavement care (see page 35).

Recommendations

The unannounced inspection to Aberdeen Maternity Hospital resulted in three recommendations.

Domain 4.3	
1	NHS Grampian should undertake a comprehensive workforce review of consultant obstetric staffing (see page 31).

Domain 6	
2	NHS Grampian should consider improving bereavement training compliance rates for all staff providing care to families (see page 35).
3	NHS Grampian should consider improving trauma informed practice training compliance rates for all staff providing care to families (see page 35).

Requirements

The unannounced inspection to Aberdeen Maternity Hospital resulted in 20 requirements.

Domain 1	
1	NHS Grampian must ensure effective governance and oversight of activity within the maternity service to support safe delivery of care for women, including, but not limited to: (i) maternity triage (ii) time to first assessment of women (iii) delays to care, including inductions (see page 19). This will support compliance with: Healthcare Improvement Scotland Quality Assurance Framework (2022) criteria 1.5, 2.5 and 2.6.
2	NHS Grampian must ensure a process is in place to ensure women receive timely access to midwifery telephone assessment (see page 19). This will support compliance with: Health & Social Care Standards (2017) criterion 3.21.
3	NHS Grampian must undertake regular review of staff skills and competency to ensure all nurses and midwives are supported to work within their scope of practice (see page 19). This will support compliance with: Nursing and Midwifery Council (NMC) The Code (2018)
4	NHS Grampian must ensure governance and oversight to monitor compliance with SBAR communication tool (see page 19). This will support compliance with: The Quality Assurance Framework (2022) criterion 2.6. and Healthcare Improvement Scotland Clinical governance standards (2026) criterion 7.1
5	NHS Grampian must ensure nurse call bells and emergency buzzers are functional and available at all times to support the safe delivery of care (see page 19).

	This will support with compliance: The Quality Assurance Framework (2022) criterion 5.3
6	NHS Grampian must ensure systems and processes are in place to monitor and support a consistent approach to the provision of transitional care within the postnatal ward (see page 19). This will support compliance with: Best start: A five year forward plan for Maternity and Neonatal care in Scotland, Healthcare Improvement Scotland Quality Assurance Framework (2022) Criterion 1.5 and Health and Social Care Standards (2017) Criteria 1.19, 1.20 and 4.11
7	NHS Grampian must ensure that women are provided with the right care, in the right place, at the right time by the right professional team (see page 19). This is to comply with Health & Social Care Standards (2017) criteria 1.19, 1.20, 3.14-3.19, 4.11,4.14,4.27.

Domain 2	
8	NHS Grampian must ensure the continued development of a culture which promotes and supports staff psychological safety for all staff groups (see page 24). This will support compliance with: Healthcare Improvement Scotland Quality Assurance Framework (2022) Criterion 2.1.
9	NHS Grampian must ensure staff receive time and resources to undertake training essential to their role with consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls (see pages 24). This includes, but is not limited to: (i) violence and aggression (ii) core mandatory training This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
10	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) and that feedback and lessons learned from incidents are shared with relevant staff and improvement actions are implemented (see page 24). 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).

Domain 4.1

11 NHS Grampian must ensure effective governance and oversight to ensure:

(i) monitor compliance with maternity early warning system
(ii) monitor completion and compliance with newborn early warning scoring system
(iii) venous thromboembolism risk assessment compliance (see page 28).

This will support compliance with: The Quality Assurance Framework (2022) criterion 2.6. and Clinical governance standards (2026) criterion 7.1.

12 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 28).

This will support compliance with: Quality Assurance Framework (2022) criteria 2.5 and 2.6.

13 NHS Grampian must ensure effective systems and processes are in place to support assurance of a safe healthcare environment:

(i) that staff are aware of the process, and
(ii) that all essential maintenance works are completed (see page 28).

This will support with compliance of National Infection Prevention and Control Standards (2022) Criterion 8.1.

14 NHS Grampian must ensure infrequently used water outlets are flushed in line with current national guidance and support staff in understanding the process of assurance regarding water flushing (see page 28).

This will support with compliance with National Infection Prevention and Control Manual (2023) and Scottish Health Technical Memorandum SHTM 04- 01-part B (2014) 'Water safety for healthcare premises Part B: Operational management.'

15 NHS Grampian must ensure staff carry out mandatory fire safety training (see page 28).

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).

Domain 4.3

16 NHS Grampian must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real time staffing risk across all clinical professional groups within maternity services, to support consistent management of any identified staffing risks. This must include feedback to staff regarding decisions undertaken. This should include, but is not limited to:

(i) when staffing risks cannot be mitigated or when disagreement occurs
(ii) if increased care needs for women or babies are identified and staffing concerns are escalated

	(iii) when consultant obstetricians are unable to support ward rounds to enable oversight of workload. (see page 31). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
17	NHS Grampian must ensure that there are processes in place to support the consistent application of the common staffing method. This should include, but is not limited to: (i) the correct application of running the mandated staffing level and professional judgement tools (ii) a reporting template demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement (see page 32). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
18	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. This includes, but is not limited to: (i) staff appraisals (ii) clinical supervision (iii) protected teaching time for obstetric medical staff (see page 32). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
19	NHS Grampian must ensure that all newly qualified midwives are consistently provided with protected supernumerary time during their induction and orientation period (see page 32). This will support compliance with Health and Care (Staffing) (Scotland) Act 2019 and Clinical Governance Standards 5.2.

Domain 6	
20	NHS Grampian must ensure effective governance and oversight to ensure all women who require translation services have access to approved translation services (see page 35). This will support compliance with: Health and Social Care Standards (2017) criteria 1.19, 2.9, 2.10 and Quality Assurance Framework (2022) criteria 3.1, 6.1, 6.2.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We observed staff were accessible to women and their families and were working hard as a multidisciplinary team to deliver person-centred care. During the onsite inspection we observed no delays to care. However, oversight of clinical activity within the maternity triage and induction of labour ward is an area for improvement.

Aberdeen Maternity Hospital within NHS Grampian provides maternity services across Grampian, Moray and surrounding areas, covering a large geographical area supporting approximately 4,000 births per year through obstetric and midwifery led care. NHS Grampian also facilitates maternity care for women from Orkney and Shetland who require increased obstetric care.

Women are supported to make evidence-based decisions on their place of birth by their midwife and using information available on the Birth in NHS Grampian website. The website details services including available analgesia options, transfer times between maternity sites and information to support women following the birth of their baby. Aberdeen Maternity Hospital is a designated level three neonatal intensive care unit. A level three neonatal unit is designed to provide care for the smallest and sickest babies within an obstetric care setting.

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.

Aberdeen Maternity Hospital provides a full range of maternity services provided across the ground and first floors of the maternity hospital. Each area is well signposted from the maternity entrance which also supports a direct ambulance access to the service.

There is currently no national standardisation of maternity triage system available. However, the Royal College of Obstetricians and Gynaecologists good practice paper on maternity triage, and the National Institute for Health and Care guidance recommend each board develops their own guidance based on an evaluated system. Further information can be found here.

Maternity triage is a specialised assessment area which provides 24 hours a day, seven days a week unscheduled (emergency) care to women during pregnancy and within the postnatal period, for women from 24 weeks of pregnancy until birth, and from birth to six weeks postnatally. Women under 24 weeks gestation will be reviewed within the Rubislaw ward and will be discussed later in this domain.

The Royal College of Obstetricians and Gynaecologists recommend supporting the provision of focused unscheduled emergency care that only women requiring unscheduled care are seen within maternity triage. Within Aberdeen Maternity Hospital, triage and the induction of labour suite operate from the same clinical area and are located beside the labour ward. Triage is undertaken in a designated four bedded bay and side rooms which can be utilised if necessary to ensure patient dignity during physical examination or for private discussion.

We observed women who require unscheduled care access the service following a telephone assessment carried out by midwives. This provides maternity staff oversight of women attending the unit. Inspectors observed triage calls being undertaken by an allocated midwife on a four hour rotational basis. Outcomes of telephone triage can include signposting women

to other available care, such as their community midwife, general practitioner, telephone advice or admission to the maternity unit for review.

During inspection this clinical area was busy with competing priorities for staff such as inpatient care, scheduled care and preparation for planned caesarean birth. Midwives working within the department were assigned to different roles including triage, induction of labour, telephone assessment and providing care to women who had been admitted for further observation. Consultant obstetricians also described women being admitted to the maternity triage area to ensure that any clinical investigations could be carried out, a robust plan of care made, and further obstetric review could be promptly accommodated. However, due to the increased requirement to accommodate women for varying reasons, staff told inspectors that at times, this impacted on their ability to prioritise unscheduled care.

We raised this with senior managers during the inspection who advised as maternity care is provided across a large area within Aberdeen Maternity Hospital the consultant obstetricians can promptly attend maternity triage as it is situated close to labour ward. Senior leaders described this process as maintaining improved visibility for senior obstetric staff and to ensure that women have a robust plan of care in place prior to being transferred to the antenatal or postnatal wards. Ward rounds have been established in the area three times a day to maintain obstetric oversight for these women. We observed the use of a white board to maintain patient and system oversight and situational awareness for midwifery, obstetric and clinical support staff of the women within the service and those expected to attend.

Recommendations from the Royal College of Obstetricians and Gynaecologists state that clinical priority should be determined through face to face assessment rather than telephone assessment alone. Inspectors observed that following telephone triage, women were allocated a priority category and given an appointment time to attend the department. However, it was not clear how this appointment system ensured that women requiring unscheduled care were prioritised according to clinical need. Multiple staff reported this as normal practice to support flow within the department. Whilst some women were given an appointment time within a short period of time, following their initial telephone call we did observe one woman was given an appointment time slot two hours after her initial telephone call. During discussions with senior managers, they explained that appointment times are used to maintain patient flow and that women who required immediate assessment would be asked to attend the hospital without delay. Senior managers advised a recent trial had been carried out where women were asked to attend immediately after every phone call, however this resulted in delays to prompt assessment on arrival due to the volume of women attending. Therefore, the use of the appointment system was described as a safety mechanism to support women to access care promptly on arrival. Women who are asked to attend are added to an electronic patient appointment list to track attendance and arrival.

In discussion with staff, they described using clinical judgement to determine an appropriate time for women to attend. We observed guidance to support staff with the telephone triage process within the nurse's station, and we were also provided with the NHS Grampian Maternity Triage guidance. This detailed four categories of telephone prioritisation ranging from level one, requiring immediate attendance, to level four, attendance within four hours. However, the Royal College of Obstetricians and Gynaecologists recommend clinical priority or the use of an appointment system are not utilised based on telephone triage as clinical indicators required to determine level of priority cannot be undertaken such as maternal

observations or fetal assessment. NHS Grampian is currently working toward implementation of the Birmingham Symptom Specific Obstetric Triage System (BSOTS) which is an evaluated system that assesses and prioritises pregnant and recently postnatal women with unexpected problems or concerns. The aim of the system is to improve safety, efficiency and communication. Senior managers advised the aim is for the system to be implemented by October 2026. A requirement has been given to support improvement in this area.

On admission to a maternity triage unit best practice guidance from the Royal College of Obstetricians and Gynaecologists, recommends a prompt and brief assessment is carried out to assess the level of further review required. During the onsite inspection we observed that triage was not always undertaken within 30 minutes of arrival with the longest observed wait being 60 minutes. Staff explained there was no formal guidance in place beyond the expectation of seeing patients ideally within 15 minutes of arrival, they described using professional judgement to prioritise the care of women. NHS Grampian management acuity tool does provide timescales for further review however not all staff we spoke with were aware of this.

Senior managers advised monthly audit information demonstrated in March and April 2026 that 58-60% of women had an initial assessment within 15 minutes and 88% of women were assessed within 30 minutes. Senior leaders described the ongoing improvement work within this area to support the implementation of the BSOTS model, support training and that monthly audit information will be presented through clinical governance.

Within requested patient incident forms submitted by staff for the six months prior to inspection there were no reported instances in relation to delays to accessing unscheduled care.

Concerns surrounding maternal wellbeing or the wellbeing of the unborn baby are time sensitive, requiring a systematic approach which identifies women of the highest clinical priority to improve outcomes. Whilst we recognise the ongoing improvement work a requirement has been given to support improvement in this area.

Prior to the inspection, it was recognised within the service that due to the volume of calls received, it was not always possible for registered midwifery staff to perform a telephone assessment and previously non-registered health care staff would answer triage calls. This was a recognised risk, sitting within the NHS Grampian's maternity services risk register. Senior managers described that when a shortfall in midwifery staff is identified a midwife from another ward will be moved to support the telephone triage process as an immediate mitigation to ensure timely access to telephone triage from a registered midwife. Non-registered health care staff no longer perform clinical calls. Senior managers also highlighted that service redesign is underway to support a centralised triage telephone service. A requirement has been given to support improvement in this area.

Induction of labour is a practice that is undertaken to artificially induce labour; this can be in response to concerns with the mothers or unborn baby's health or around the estimated date of birth. Women who are attending the service to be induced are given a scheduled appointment to avoid delays and to manage workload. Within incidents submitted we did not observe any delays in relation to the induction of labour process. Daily induction of labour activity is managed by midwives and obstetric staff with a risk assessment occurring for those who are inpatients awaiting induction and those who will attend from home.

Although there were no delays to care observed during onsite inspection, staff we spoke with explained delay to inductions can happen due to capacity within the unit. NHS Grampian provided the Standard Operating Procedure to support the escalation process for delays in induction of labour. This states that any new and ongoing induction of labour should be reviewed by the midwife and consultant obstetrician to risk assess and prioritise women should delays occur. This should include any follow up arrangements for women who experience a delay including any ongoing assessment to ensure safety.

Delays to the induction of labour process are associated with an increased risk of adverse maternal and perinatal outcomes. The current national average rate for induction of labour is 34.3%, NHS Grampian's rate is currently 39.2%. The service categorises a delay in the induction of labour process if a woman is unable to access labour ward within 24 hours to continue the process. We discussed this with senior managers who described a multidisciplinary team approach in assessing induction of labour activity including when priority was required for those women who were inpatients. Within evidence we observed one incident relating to a delay in the induction of labour process of 24 hours and 30 minutes due to the delay of transferring the woman to labour ward due to capacity. Further data provided demonstrated that 14 women were delayed in their transfer to labour ward over 24 hours in March and April which were not reflected in incident submissions. However, this data did not identify the length of delays experienced in commencing the induction of labour process or those less than 24 hours which may be a missed opportunity for learning. A requirement has been given to support improvement in this area.

NHS Grampian recently appointed a service development midwife with a focus on improving the induction of labour service and the experience of women using the service. To support board oversight a key performance indicator programme report will also be presented to the board Clinical Governance Committee on a six-monthly basis. A new data base has been designed to support collecting this information including ongoing daily and outstanding induction of labour, reasons for delays and when the woman is transferred to labour ward. However, we were not assured that the current system provides sufficient oversight of delays to the induction of labour process. A requirement has been given to support improvement in this area.

During our onsite inspection there were no delays in transferring women from triage to labour ward or the midwife led unit for intrapartum care. There are eight birth rooms available within the obstetric led unit which also supports an area for the provision of high-dependency care and theatre recovery beds. Although labour ward and the midwife led unit had increased activity, the ward was calm with good visibility of staff and clinical leadership. Birthing rooms provided space to support women's mobility and freedom of movement, whilst also allowing staff clear access in the event of an emergency. Within the midwife led unit there are a further three birthing rooms where women can be supported. Midwifery and obstetric teams work closely together to provide care and support the delivery of care within the midwife led unit. Staff we spoke with explained the recently published national Framework for maternity healthcare professionals is used to support individualised care for women who choose alternative birth choices. This guidance provides support for women, families and healthcare staff to promote a person centred care plan to promote safety and optimise birthing experiences.

The labour ward has an established ‘red phone’ system to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff. This system facilitates timely, clear and prioritised communication during critical information sharing, supporting safer and more effective coordination of patient care. Senior charge midwives described the use of this phone as essential during times of peak activity within the labour ward to ensure an uninterrupted communication line was available for emergency situations.

Women accessing intrapartum care within labour ward are supported by an obstetric, midwifery, anaesthetic and neonatal team. Labour ward, the midwifery led unit and Rubislaw ward all have access to the adjoining obstetric theatres which are situated in labour ward. Caesarean birth and assisted vaginal birth occur in the labour ward theatres with a dedicated theatre team available between the hours of 7am and 7pm, Monday to Friday. At all other times an on-call obstetric theatre team is available with support from teams across the wider hospital setting if necessary.

The Royal College of Midwives position statement welcomes multidisciplinary working, however, emphasises the importance of health professionals working within their limits of competency and that a midwife supported by maternity care workers should be the only registered professional to provide midwifery care. More information can be found here. Obstetric theatre teams and midwives we spoke with explained recovery nurses are undertaking an extended role within maternity services and midwives were undertaking recovery nurse duties out of hours. Whilst midwives will always be present in theatre for the birth and immediate care of the neonate, there may be occasions where the recovery nurse will have sole responsibility for the maternal and neonatal care in the recovery area in the immediate postnatal period. We highlighted this to senior leaders on the first day of inspection and noted that a midwife was assigned to provide postnatal care within recovery on the second day of inspection. Senior managers explained they had liaised with the Royal College of Midwives to ensure that their understanding of the position statement was accurate in supporting midwives and nurses within the recovery area.

We were provided with a learning package which is used within post anaesthetic care and includes obstetric competencies. This guidance is provided to support the skills development of recovery nurses who provide post operative care to ensure that they are equipped with the right skills including physical assessment, communication and an understanding of any complications which may arise to be able to provide the right care. A requirement has been given to support improvement in this area.

Included within this learning package is an assessment of the use of the Situation, Background, Assessment and Recommendation (SBAR) communication tool. Consultant obstetricians described an inconsistent use of the SBAR tool during the immediate postnatal period and that the lack of situational detail such as time of birth and estimated maternal blood loss can impact on the effective initiation of further treatment. 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 refer to a structured communication framework used widely in healthcare and the maternity services to improve clarity, efficiency and safety of the exchange of all relevant information between healthcare professionals, such as at shift handovers or when escalating concerns.

During inspection staff were observed using the SBAR communication tool. We were also provided with evidence which described ongoing quality improvement work within maternity services relating to SBAR communication. However, evidence provided by NHS Grampian identified variation in escalation language and responsiveness between professional groups, highlighted through learning from adverse events. Structured communication tools are embedded within core mandatory training and emergency scenario training to strengthen escalation, situation awareness and multidisciplinary team communication. A requirement has been given to support improvement in this area.

Antenatal and postnatal care are provided within Ashgrove and Summerfield wards which are based on the ground and first floor of the maternity hospital which accommodate 44 standard care beds. This can be increased to 50 beds during times of increased activity. Although extra beds can be provided these would be in standard bed spaces with access to buzzers and bedside tables. Women are accommodated within four bedded bays and single side rooms. Women who were being cared for who require infection prevention control precautions, or women whose babies were admitted to the neonatal unit would be cared for within side rooms. Women had access to ensuite facilities in each bay area and side rooms. The vision for maternity services across Scotland is set within 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 that birthing partners could be accommodated within the ward overnight with the use of fold out beds in side rooms. However, due to age and design of the building, it is not possible to provide full facilities such as toilets, showers and meals for birthing partners across the maternity unit.

The nurse call bell system within any ward plays a critical safety role for the escalation of clinical concern and to request assistance. We observed that some bedside patient buzzers within the Ashgrove and Summerfield wards were faulty. Staff explained that this had been escalated to the facilities teams, however, had not yet been resolved. Senior charge midwives attributed this to a perceived lack of investment in repair, citing the age of the system, difficulties sourcing replacement parts, financial constraints and the potential transition to the new hospital site. Due to the fault causing a continuous sound, staff had taped cotton wool over the open buzzer panel to silence this. Ashgrove and Summerfield wards did not have emergency buzzers within their bedspaces. Within incident reports we observed that an emergency buzzer in labour ward had also been faulty and reported multiple times, with staff requiring to call out of the room for help. We also observed a non-working buzzer within the triage department and nonfunctioning light bulbs in the midwifery led unit patient toilet. Due to the potential impact on the safe delivery of care, we raised this as a matter of urgency with senior managers who responded promptly to ensure the system was fully functional and this was rectified by the second day of inspection. A requirement has been given to support improvement in this area.

Transitional care offers additional support to babies above normal neonatal care with the aim of preventing separation of mum and baby and unnecessary admissions to the neonatal unit. British Association of Perinatal Medicine (BAPM) 2017 guidance states that keeping mothers and babies together should be the cornerstone of newborn care. More information can be found here. Alongside routine postnatal care, transitional care enables mothers to remain with their baby and be supported as a primary care giver when the baby's needs exceeds those expected within routine newborn care. NHS Grampian previously piloted a transitional care

model in 2021 however this was suspended due to neonatal staffing pressures and the limited neonatal staff availability to support the transitional care area. Senior charge midwives described providing elements of transitional care including, for example, babies born at approximately 34 weeks' gestation, babies requiring feeding support and those requiring management under hypoglycaemia protocols or the use of heated cots. Staff told inspectors that due to high activity levels on the ward, competing priorities of care and staffing pressures that they felt they were not always able to provide the level of care required for these babies and their families. Senior leaders described that a daily ward round for any babies requiring elements of transitional care support was in place and escalation guidance was available for staff to raise concerns. However specific transitional care guidance is not currently available for staff to support the safe delivery of this increased level of neonatal care. A requirement has been given to support improvement in this area.

Consultant obstetricians shared concerns with inspectors regarding the ability for one consultant to consistently provide daily oversight of ward activity for women in all inpatient wards. Inspectors were told competing priorities for labour ward and triage reviews impacted daily senior obstetric led ward rounds in antenatal and postnatal areas, despite the complexity of some women's care needs.

The Royal College of Obstetricians and Gynaecologists outline roles and responsibilities of consultant obstetricians highlighting the importance of the role as key professional decision makers, reducing variation in patient care and role modelling professional behaviours. Further information can be found here. Ward rounds are an important part of patient care supporting the multidisciplinary team to share information and gain an oversight of the clinical condition of all women within their care. This enables staff to monitor, anticipate and respond in a timely way to emerging health concerns and deterioration. They also offer women the chance to ask questions and participate in their care. Within NHS Grampian guidance we observed a daily review and plan of care on the consultant led ward round should be carried out. We observed ward rounds across all areas and found variance in the approach to these. For example, within maternity triage, consultant ward rounds had been established three times per day however the inpatient ward rounds were carried out by speciality trainee obstetricians. Specialist trainee obstetric medical staff reported feeling well supported by senior colleagues and described clear and robust clinical escalation processes, with no barriers to contacting consultants. However, both consultants and trainee obstetric staff noted that competing priorities, despite strong consultant support, may impact the timeliness of care planning and reduce opportunities for trainee learning and teaching. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 1	
1	Staff were observed working hard as a multidisciplinary team to deliver person-centred care.
2	During inspection we observed no delays to care.

Requirements

Domain 1
1 NHS Grampian must ensure effective governance and oversight of activity within the maternity service to support safe delivery of care for women, including, but not limited to: (i) maternity triage (ii) time to first assessment of women (iii) delays to care, including inductions.
2 NHS Grampian must ensure an effective process is in place to ensure women receive timely access to midwifery telephone assessment.
3 NHS Grampian must undertake regular review of staff skills and competency to ensure all nurses and midwives are supported to work within their scope of practice.
4 NHS Grampian must ensure governance and oversight to monitor compliance with SBAR communication tool.
5 NHS Grampian must ensure nurse call bells and emergency buzzers are functional and available at all times to support the safe delivery of care.
6 NHS Grampian must ensure systems and processes are in place to monitor and support a consistent approach to the provision of transitional care within the postnatal ward.
7 NHS Grampian must ensure that women are provided with the right care, in the right place, at the right time by the right professional team.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

We observed good local teamwork, respectful interactions and positive conversations between staff, women and their families. Areas for improvement are required to support service culture and to improve timelines of reviews when adverse events occur.

We observed positive interactions between midwifery and obstetric staff and senior managers. Senior clinical leaders appeared approachable and engaging with all team members and multidisciplinary team communication was respectful and inclusive. 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.

Staff described a sense of pride in the service they deliver, despite experiencing periods of workforce shortages and increased demand. They described the unit as welcoming, inclusive, and a positive working environment and students reported feeling well supported within their placements. Midwives working within the midwifery led unit spoke highly of the support and oversight received from labour ward staff including senior charge midwives. Staff described supportive and collaborative working within their teams.

Clinical governance standards were published by Healthcare Improvement Scotland in February 2026. More information can be found here. These standards set out the importance of a healthy and supportive working environment which can optimise staff and team wellbeing and performance. During our onsite inspection, consultant obstetricians told inspectors they felt well supported by maternity teams and senior leaders. However, they described feeling

disempowered and unheard at a wider organisational level. For example, they were not aware of recent papers submitted to the board to support oversight of the maternity services, despite these papers identifying workforce constraints as the most significant risk to maternity service resilience in NHS Grampian. We were also told that consultant obstetricians were not always involved in daily strategic decisions which would affect their workload. This included decisions to delay or cancel elective procedures due to unit capacity. Effective and respectful communication across the multidisciplinary team is essential for the safe delivery of patient care and to ensure staff wellbeing.

In 2024 senior leadership within NHS Grampian maternity services recognised the need to better understand civility and working relationships between staff and the impact this may have on patient safety and staff wellbeing. Evidence was provided of ongoing work to strengthen culture and psychological safety. This work was being co-led by senior clinical leaders and involves members of the multidisciplinary team and is informed by staff experiences. It focuses on improving communication, supporting staff to speak up and encourages respectful challenges between teams. Initiatives include developing workplace champions, delivering multidisciplinary workshops on incivility and co-creating a "Values and Behaviour Agreement" with staff to set clear expectations for team behaviour. Practical tools were also developed including scenario-based training and the PAUSE tool to support respectful relationships and to help staff at all levels manage difficult conversations.

We were provided with evidence to highlight the outcomes of two recent staff surveys which demonstrate signs of cultural improvement. However, it was not possible for us to gain assurance of an embedded cultural change due to the difference in survey response rates. Inspectors spoke with some staff who reported that incivility persists between teams, describing undermining and disrespectful behaviours. Whilst we acknowledge a change in culture will take significant time before a true improvement is felt by staff, continued engagement of staff, visibility and commitment of senior leaders is essential to support meaningful improvement. A requirement has been given to support improvement in this area.

The NHS iMatter survey is an annual staff experience tool designed to help teams and health boards understand and enhance staff wellbeing and engagement. 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 able to work 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 this is needed.

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), Each baby counts (Royal College of Obstetrics and Gynaecologists 2019) and Kirkup (2015) have highlighted the essential safety feature of teams working and training together to improve outcomes for families. Evidence received from NHS Grampian demonstrated variable compliance rates for midwives of between 60-83% and 78% of the obstetric team having undertaken the Practical Obstetric Multi-Professional Training (PROMPT) course. The 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 the antenatal and labour period. It is an important tool used in conjunction with clinical assessment to be able to determine fetal wellbeing. NHS Grampian provided training compliance evidence for all maternity wards, which demonstrated variation in compliance across the service. The area with lowest compliance of this two-yearly fetal heart monitoring requirement was Rubislaw ward with 17% of midwives having completed this training and highest noted at 80% within maternity theatres. The yearly element of fetal heart rate monitoring training is delivered with the core mandatory maternity update training day which also includes neonatal resuscitation and obstetric emergencies. Compliance rates for midwives varied across all maternity wards, ranging from 40% in the midwife led unit to 67% in the maternity triage and induction of labour ward. Obstetric consultants' compliance rates were 56-65% for both elements. Whilst we acknowledge some areas have better training compliance than others, low compliance rates with core mandatory training and essential two yearly updates that include fetal monitoring are concerning. Low compliance with this essential element of core mandatory training may affect the ability to recognise and escalate any concerns regarding fetal wellbeing promptly.

Regular and up to date neonatal resuscitation training is essential to ensure staff are competent and confident in responding effectively to neonatal emergencies, thereby supporting safe outcomes for newborns and maintaining high standards of clinical care within the maternity setting. Scottish Neonatal Resuscitation Course rates of compliance for midwives were demonstrated between 70-100% for the four yearly neonatal resuscitation requirements. The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives emphasises the importance of maintaining knowledge and skills by taking part in the appropriate learning and professional development activities.

Staff described barriers to completing mandatory training due to staffing shortages. Senior charge midwives described challenges in being able to provide adequate time for training for staff. NHS Grampian provided evidence to describe ongoing work to support the improvement of training compliance across maternity services including coordinating training days, clearer communication with staff and proactive support within the clinical area by practice educators to support managers to release staff where service pressures allow. To increase visibility and assurance of this essential element of safety, NHS Grampian have added core mandatory training within their key performance indicators. 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.

Some staff we spoke with described frequent exposure to violence and aggression from women's family members, which they described as having a significant adverse impact on staff wellbeing. Visitors were reported to commonly express frustration regarding visiting arrangements and delays to discharge, which staff identified as contributory factors to incidents of aggression. The senior charge midwife advised that they routinely act as the first point of contact for de-escalation and escalate concerns to the on-call bleep holder as required. Hospital security support is available; however, this service is based at the main hospital site, and police involvement was described as reserved for exceptional circumstances. NHS Grampian provided the escalation policy available to all staff when encountering episodes of violence and aggression. This guidance provides emergency contact numbers and encourages early escalation to senior staff for support and recommends an incident submission is created for each episode. However, we did not observe any incidents submitted due to violence and aggression in the six months prior to our inspection. Staff training and support when managing violence is an essential element of a safety culture. Training compliance for maternity staff in Aberdeen Maternity Hospital is 68% across all staff groups. A requirement has been given to support improvement in this area.

Inspectors observed a "trigger list" which provided guidance to staff on the types of events that should be reported through the electronic incident reporting system. Staff reported a positive attitude to the submission of patient incident forms and did not report any barriers to this. However, some staff reported mixed views on the level of feedback received following submission of patient incident forms including any learning or areas of good practice.

Consistent reporting and learning from adverse events are essential in assuring learning, quality improvement and patient safety within a service. The National Framework for Reviewing and Learning from Adverse Events in NHS Scotland highlights all adverse events 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 (SAER). More information on the adverse event framework can be found here. 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. The adverse events framework recommends level 1 SAER's are completed within 140 working days from the date of incident submission. Within evidence we observed 25 events were commissioned for serious adverse event review in the past 12 months with 15 fully approved and 10 in progress. Of the remaining 10 none are out with 140 days. During discussion with senior managers at our virtual discussion session, we asked how oversight of timescales for incident review was maintained. Senior leaders described a process of monthly oversight which reports back into clinical governance structures to ensure timescales are reviewed. Although no level 1 events were out with the review date of 140 days, we observed that some level 2 events, which require review within 70 days, were over their review date. NHS Grampian provided evidence to support that these timescales are reviewed through clinical governance structures and there is currently work ongoing to understand why these reviews are out with their review date. A requirement has been given to support improvement.

NHS Grampian has a Quality, Risk and Governance team who oversee quality, patient safety and governance across maternity based services. Evidence included daily review of events to support incident reporting, multidisciplinary review, implementation of immediate safety actions and the reporting of incident themes through governance structures. This includes a

structured use of review tools including the national perinatal mortality review tool. This tool is designed to standardise reviews and learning following the death of a baby. NHS Grampian engages families in the significant adverse events and perinatal mortality review process by assigning a key contact to the family. Where appropriate, this role is undertaken by the bereavement specialist midwives, or another family liaison contact to ensure the family's experience forms part of the review process and learning.

We observed learning is shared with staff through the use of "Maternity Mail" which is issued monthly including learning from adverse events, topical maternity unit information and any safety news. Opportunities for learning from serious adverse events are also shared at the Quality, Risk and Governance meeting every month. Staff described a varying awareness of feedback from adverse events and learning. Within evidence we observed published 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 to engage with.

Staff described using hot debriefs to support and promote psychological safety following adverse events. Healthcare Improvement Scotland National Framework for Reviewing and Learning from Adverse events states that NHS boards should ensure immediate access to support for staff involved in adverse events. A hot debrief or discussion immediately following an event is an important element of staff support. This is an opportunity to ensure there are no immediate patient safety risks, acknowledge what has happened and support staff wellbeing. Staff spoke of hot and cold debriefs following an adverse event and being supported with wellbeing check ins with senior charge midwives. However, some staff reported that support in relation to workplace pressures including stress and morale was limited. Within evidence we observed wellbeing support within the newly qualified midwives induction pack to highlight the importance of feeling supported and signposting to services within the We Care in Distress service which utilises various NHS and third sector services including mental health support. Psychological and occupational health wellbeing services are offered to support all staff including spiritual care.

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.

Areas of good practice

Domain 2	
3	Staff did not describe any barriers to submitting incident reports.
4	NHS Grampian has introduced the Daisy Award programme to celebrate and recognise staff.

Requirements

Domain 2	
8	NHS Grampian must ensure the continued development of a culture which promotes and supports staff psychological safety for all staff groups.
9	NHS Grampian must ensure staff receive time and resources to undertake training essential to their role with consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls. This includes, but is not limited to: (i) violence and aggression (ii) core mandatory training.
10	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. (ii) ensure compliance with the Healthcare Improvement Scotland national adverse events framework (iv) and that feedback and lessons learned from incidents are shared with relevant staff and improvement actions are implemented.

Domain 4.1 – Pathways, procedures and policies

Quality indicator 4.1 – Pathways, procedures and policies

Women and their babies appeared well cared for with families speaking highly of the care they had received. All areas inspected were calm and organised with staff working hard to support the safe delivery of care. We observed areas of improvement in relation to venous thromboembolism risk assessment and MEWS audits.

Quality improvement initiatives can improve safety, effectiveness and experience of care. 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 supports early intervention to improve outcomes. NHS Grampian provided evidence including findings from MEWS audits. However, no data was available for triage or the Rubislaw ward, which was identified through oversight of internal audit processes.

Evidence provided showed that the maternity service has undertaken audits of their MEWS chart compliance. These demonstrated variation in compliance rates and identified areas for

improvements, including the accurate frequency of MEWS recordings. Between December 2025 and April 2026, audits showed that 94% of women in the labour ward had the appropriate frequency of observations. However, in Ashgrove and Summerfield wards only 58% of women had the appropriate frequency of observations undertaken.

An essential element of MEWS observation is the appropriate escalation of concerns to ensure timely medical review and treatment. This relies on observations being accurately recorded at the appropriate frequency. The completion and escalation of MEWS is discussed during daily staff briefings using “tea trolley talks” to promote awareness, answer questions and remind staff of the policy. Whilst we recognise the plans in place to improve MEWS compliance rates and to demonstrate sustained improvements over time, a requirement has been given to support improvement in this area.

NHS Grampian provided evidence of quality improvement work being undertaken to understand the unplanned admissions of term babies to the neonatal unit. Babies who are admitted to the neonatal unit following birth require increased levels of observation and care and are separated from their parents. Within all incidents submitted over a six-month period, 23% related to the unplanned admission of term babies born within Aberdeen Maternity Hospital to the neonatal unit. To support efforts to reduce the separation of women and their babies’, senior leaders advised that an audit of these admissions since January 2025 identified respiratory disease (49.7%) as the leading cause of escalation, followed by short observation (16.46%) and hypoglycaemia (7.93%). Evidence showed quality improvement work to address this, such as identifying babies with risk factors for hypoglycaemia to help prevent admission to the neonatal unit. However, NHS Grampian does not routinely audit compliance of the newborn early warning screening tool. As a result, no data is available in relation to this. The newborn early warning score is a bedside screening tool which is used to record physiological parameters for the newborn such as heart rate, temperature and respiration rate. It is used to support early detection of deterioration in the clinical condition of the baby which may require treatment. The lack of data surrounding this important element of newborn observation may present a missed opportunity for reducing rates of unnecessary separation of mothers and babies and potentially delay necessary clinical interventions. 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 2024 report demonstrated the leading cause for maternal death in the UK being attributed to venous thromboembolism. Learning from the report highlighted a need for continuous evidence-based risk assessment throughout pregnancy and following birth.
NHS Grampian provided their Reducing the risk of venous thromboembolism (VTE) during pregnancy and the puerperium guidance in use to support the risk assessment of all pregnant women including those who are admitted to hospital. Recent audits provided by NHS Grampian of thromboprophylaxis assessment showed incomplete compliance data and due to the limited sample size of notes reviewed we could not be assured regarding the reliability of the data. It was also not possible to determine if this compliance included assessments during the antenatal period and any unplanned admissions. A requirement has been given to support improvement in this area.

The Scottish Patient Safety Programme (SPSP) is a national quality improvement programme which aims to improve the safety and reliability of care and reduce harm. Through its perinatal

programme, boards submit quarterly progress updates which form the basis of coaching conversations between teams and Healthcare Improvement Scotland. This identifies any improvement support required to meet the aims and objectives set. Through its perinatal programme they, amongst other measures, request data for all postpartum haemorrhages which occur from 1500 ml and above in an aim to reduce morbidity and mortality related to maternal haemorrhage following childbirth. Improving quality requires a robust and methodical approach. Following review of NHS Grampian's incident reports, we observed the service has oversight of postpartum haemorrhage which accounts for 25% of all submitted incidents. NHS Grampian has established a Post-Partum Haemorrhage (PPH) Review Group, which meets on a monthly basis to provide oversight of quality assurance systems and processes. The group reviews relevant cases to identify learning opportunities and ensure that appropriate actions are implemented. NHS Grampian provided evidence to support ongoing improvement work including implementing new haemorrhage management treatments and improving documentation.

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. Clinical guidelines within maternity services which should be available to support and guide staff in clinical practice were available to staff on an internal directory. Whilst onsite, we observed that some guidance was overdue review. We asked senior managers about processes in place to support the oversight of policies and procedures. We were advised a structured system for the governance and oversight of clinical guidelines has recently been established through a multidisciplinary clinical guidelines group. Through evidence we observed that 79% of all maternity services guidelines were currently in date with the remainder of 21% awaiting review and update. A requirement has been given to support the ongoing improvement in this area.

The appropriate equipment to manage obstetric and neonatal emergency situations was readily available. Emergency trolleys provide immediate access to critical equipment and medications during an obstetric emergency. Emergency trolley checks were also in place using NHS Grampian standardised checklist booklets. The cardiac arrest trolley was tagged securely, ensuring it was ready for use and had not had any essential equipment removed. Emergency trolleys and neonatal resuscitaires were placed appropriately and accessible to all staff for prompt use.

The maternity unit was calm and well organised during inspection with immediate patient care equipment available, clean and in working order. Aberdeen Maternity Hospital is approximately 80 years old and has undergone maintenance and upgrades during this time. However, within wards there were various outstanding estates issues including faulty shower room flooring. Within the wards inspectors observed peeling paint, stained tiles and shower areas which had a buildup of what appeared to be mould around the tiled flooring. These issues were highlighted to the senior charge midwives who reported delays in response for maintenance. Staff were unclear who had general oversight of repair issues within the department to ensure these were reported, escalated and resolved in a timely manner. A requirement has been given to support improvement in this area.

Medicines were observed stored in locked cupboards inside a locked 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. Temperatures were recorded daily.

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 access restricted domestic service rooms. Chlorine-based cleaning products were not noted to be left unattended on any domestic service trolleys or in areas where patients or staff could come into contact with these.

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

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 and that no opportunities to perform hand hygiene were missed.

We 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 provided by NHS Grampian demonstrated inconsistent water flushing in some areas which were inspected that is not in line with guidance. A requirement has been given to support improvement in this area.

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 Grampian demonstrated that 63% of maternity staff had completed mandatory fire safety training in the last 12 months. NHS Grampian explained that there had been some gaps within fire safety tabletop exercises across some clinical areas. Further evidence of tabletop exercises across all areas was provided to support ongoing monitoring and compliance in this area. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 4.1

5	Women and their babies appeared well cared for with families speaking highly of the care they had received.
6	The wards we inspected were calm, with good visibility of staff and senior managers.

Requirements

Domain 4.1	
11	NHS Grampian must ensure effective governance and oversight to ensure: (i) monitor compliance with maternity early warning system (ii) monitor completion and compliance with newborn early warning scoring system (iii) venous thromboembolism risk assessment compliance.
12	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.
13	NHS Grampian must ensure effective systems and processes are in place to support assurance of a safe healthcare environment: • that staff are aware of the process and • that all essential maintenance works are completed.
14	NHS Grampian must ensure infrequently used water outlets are flushed in line with current national guidance and support staff in understanding the process of assurance regarding water flushing.
15	NHS Grampian must ensure staff carry out mandatory fire safety training.

Domain 4.3 – Workforce planning

Quality indicator 4.3 – Workforce planning

Safety huddles were attended by members of the multidisciplinary team. Staff described feeling supported to escalate staffing issues. Consultant obstetricians raised concern regarding obstetric staffing levels impacting daily consultant oversight of ward round activity especially within inpatient wards.

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 that occurred at different points throughout the day. The purpose of a safety huddle is to provide situational awareness, understand patient flow and raise issues such as patient safety concerns, review staffing and identify wards or areas at risk due to reduced staffing levels.

We were able to observe how maternity services fed into the site safety and capacity huddle during which staffing was discussed and collective solutions found where required. We observed maternity services engagement and leadership evident within these huddles ensuring senior managers had oversight of real-time staffing, acuity and safety concerns within maternity services. 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 told us this enables informed decision making when deploying staff to help mitigate risk. We observed the huddle captured oversight of midwifery, obstetric, theatre and healthcare support. During inspection maternity services reported a green safe to start position on day one and amber position on day two. In response to this we observed staff movement within the service to support the safe-to-start position.

Workforce pressures including recruitment and retention of both obstetricians and midwives continue to be experienced throughout NHS Scotland. Consultant obstetricians provided an opportunity for discussion with inspectors whilst on site. They described concern regarding obstetric staffing levels which have been escalated within a paper to the board. This resulted in the obstetric workforce concern being added to NHS Grampian's risk register. Available workforce data demonstrates a consultant obstetrician vacancy rate of 5.7 %. Senior leaders told inspectors that the obstetric led service has accommodated an increase of approximately 600-700 births per year since 2018 due to the redesign of maternity care provision at Dr Gray's Hospital. No increase in available workforce resource has been implemented to support this rise in both patient numbers and complexity. Despite this increase in activity the last obstetric staffing review was undertaken in 2019.

During our virtual discussion, senior managers told us that scoping work is underway to assess the consultant obstetric role. This includes consideration of additional daily duties, such as early pregnancy scanning, which have not been reflected in job planning to date. Consultant obstetricians discussed their concerns regarding the ability of one consultant to consistently provide daily oversight for all ward round activity for women in inpatient wards. There is currently no real-time staffing tool for other professional groups such as obstetricians and anaesthetists. Within incident reports reviewed for the six months prior to the inspection, we did not see any evidence of incidents reported in relation to lack of availability of consultants within the service. A recommendation has been given to support improvement in this area.

Review of workforce data demonstrated a vacancy rate between band 5 and band 6 midwives of 21.6% we consider above 10% high. The Health Care (Staffing) (Scotland) Act 2019 requires a process for risk escalation to be in place which should include the ability to record any disagreement with any decisions made following the initial daily report. We were provided with NHS Grampian Staffing Risk Assessment Guidance. We were unable to determine from this guidance where any staffing escalations or unmitigated risks would be recorded. Staffing issues are included within the incident submission trigger list. Over the last six months only one incident was submitted in relation to staffing. We discussed the capture of staffing risk information with senior leaders during the virtual discussion. They confirmed that, in addition to recording staffing concerns within the relevant tools, staff are encouraged to report concerns through the incident submission process. Senior leaders also described a weekly review process to identify themes from staffing concerns and provide support where required. A requirement has been given to support improvement in this area.

Within the midwife led unit lone working arrangements were in place, with midwives carrying handheld phones to reduce the need to leave women when summoning assistance. Emergency buzzers were also linked to the labour suite to enable immediate support and ensure staff oversight through access to patient information. A daily bleep holder operates within maternity services throughout day and night shifts. We observed that this role is supported by the senior

charge midwife team, who maintain oversight of staffing levels and activity and act as the first point of contact for escalation. NHS Grampian provided the escalation policy for staff which outlined processes for out of hours support via the on-call duty manager.

NHS Grampian provides guidance for staff to use the embedded staffing tool to capture staffing activity. However, some senior charge midwives reported that the use of the staffing tool to capture real-time staffing and acuity was inaccurate in relation to babies being cared for in the postnatal areas, as babies requiring additional care needs were allocated a standard postnatal bed. In discussion with senior managers, they request women and babies with any increased observation or support needs should be highlighted for discussion at staffing huddles. A requirement has been given to support improvement in this area.

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. NHS Grampian provided their CSM analysis for maternity services undertaken between July and September 2025 which demonstrated that due to the changing complexity and extending role of the midwife that each area within Aberdeen Maternity Hospital requires more midwifery staff to provide safe, quality patient care. Staffing level tool runs had been undertaken in all areas inspected and demonstrated that only one of the six inpatient rosters were compliant due to missing data regarding professional judgement. We raised this 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.

Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This enables clinical leaders to have protected time and resources to fulfil their professional duties, including supporting appropriate staffing and leading the delivery of safe, high quality and person-centred healthcare. NHS Grampian provided evidence that when senior charge midwife's time to lead and carry out management responsibilities is compromised, this would be captured within the real time staffing tool and common staffing method reports. There is a risk that reduced time to lead impacts on time for senior charge midwives to perform management roles including staff appraisals.

Staff annual appraisals are essential to assessing and supporting staff performance including identifying training needs, resulting in a positive work culture. Evidence provided by NHS Grampian demonstrated that 100% of obstetric staff appraisals were complete. However, we wrote to NHS Grampian to raise concerns relating to low appraisal rates across all inpatient midwifery and healthcare support staff. We observed only 26.9% of staff in Rubislaw ward, 27.5% in Ashgrove and Summerfield wards, 34.3% in maternity triage and the induction of labour suite, 41.4% of staff in labour ward, 46.3% in maternity theatres and 66.6% in the midwife led unit had received an appraisal in the last 12 months. Low appraisal compliance reduces assurance that staff have regular opportunities to discuss their support, development and training needs, including any barriers to completing mandatory training. This is relevant given the low rates of mandatory training compliance highlighted throughout this report, including training essential to supporting the safe delivery of patient care. NHS Grampian acknowledged that appraisal compliance reported during inspection was below the expected

organisational standard. In response to this, NHS Grampian has put a formal appraisal improvement plan in place with the 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 framework 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. We observed NHS Grampian have 25 trained clinical supervisors who have undertaken a specialised course provided by NES. However, opportunities to attend supervision sessions are challenging due to the lack of protected learning time and engagement is varied across all areas of midwifery. NHS Grampian was unable to provide overall compliance rates therefore a requirement has been given to support improvement in this area.

Flying Start NHS is a national development programme for all newly qualified nurses, midwives and allied health professionals in Scotland to be undertaken in the first year of practice. The programme supports early career midwives to develop their practice within four pillars of competence including clinical practice, facilitating learning, leadership and evidence, research and development. NHS Grampian has adopted the Flying Start programme for all newly qualified midwives which incorporates clinical supervision in protected study days. Within evidence provided we observed that this runs in conjunction with a preceptorship and development programme which supports midwives to develop and undertake self-assessments throughout their post registration year with the involvement of a designated preceptor, practice educators and development teachers. Most early career midwives that inspectors spoke with described feeling well supported within their induction period and being able to undertake supernumerary shifts to familiarise themselves within their work environment. However, some staff described not having this time protected for orientation due to staffing constraints and being required to work within ward staffing which compromised their ability to complete their orientation. This was recorded in staffing tools provided by NHS Grampian. A requirement has been given to support improvement in this area.

Recommendation

Domain 4.3	
1	NHS Grampian should undertake a comprehensive workforce review of consultant obstetric staffing.

Requirements

Domain 4.3	
16	NHS Grampian must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real time staffing risk across all clinical professional groups within maternity services, to support consistent management of

	any identified staffing risks. This must include feedback to staff regarding decisions undertaken. This should include, but is not limited to: (i) when staffing risks cannot be mitigated or when disagreement occurs (ii) if increased care needs for women or babies are identified and staffing concerns are escalated. (iii) when consultant obstetricians are unable to support ward rounds to enable oversight of workload
17	NHS Grampian must ensure that there are processes in place to support the consistent application of the Common Staffing Method. This should include, but is not limited to: (i) the correct application of running the mandated staffing level and professional judgement tools (ii) a reporting template demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement.
18	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 (iii) protected teaching time for obstetric medical staff
19	NHS Grampian must ensure that all newly qualified midwives are consistently provided with protected supernumerary time during their induction and orientation period.

Domain 6 – Dignity and respect

Quality indicator 6.2 – Dignity and respect

We observed women and their families being treated with dignity, kindness and compassion. Women described positive experiences of staff promoting their dignity and felt respected. Women and their families were able to access specialised bereavement care. However, bereavement and trauma informed training are areas for recommended improvement.

Women we spoke with felt they were able to access care without delay through maternity triage and were made to feel welcome on their arrival. Women and families were consistently positive regarding their birth experiences with some reporting that even when their preferred birth options could not be achieved, they had felt fully informed and central to decision making. Clear communication and working with the multidisciplinary team contributed to their experiences.

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. Café areas were also located close to the maternity unit to ensure facilities were available for families and visitors.

Within labour ward only one room has access to ensuite facilities with other shared toilet and shower facilities available throughout the ward. Although this has the potential to impact on

the dignity of the woman during the labour and postnatal period, we did not observe any incidences of this during inspection and observed midwives working hard to provide private and respectful care. Curtains were used appropriately during personal cares in all wards to respect the privacy and dignity of women. We observed staff working hard to maintain privacy and dignity, utilising side rooms and privacy screens when necessary.

NHS Grampian use the Care Opinion platform to collect feedback on the care women and their families receive. Care Opinion is a feedback mechanism used by the NHS that is available to the public to submit and receive feedback from their care providers. Within evidence it was observed that NHS Grampian monitor all complaints and compliments which are discussed within the women's and children's clinical governance group to support service improvements.

Women and families who submitted compliments to the maternity service highlighted their feelings of appreciation for all staff who participated in care including administration, domestic, support and clinical staff. Inspectors spoke with staff who demonstrated an understanding of the social and financial impact that families from outlying areas and island boards experience and try to minimise disruption to families. Accommodation can be provided on site and will be sustained when care is transferred to The Baird and Anchor hospital. Consultant obstetricians described a good working relationship with obstetric teams in NHS Orkney and NHS Shetland when women require to receive care due to complexity in Aberdeen Maternity Hospital including the support of the bereavement service.

During our inspection we observed the Rubislaw ward where care is provided to enable the full in-hospital bereavement journey to be undertaken. Bereavement services within NHS Grampian are dedicated to the provision of care to women and families experiencing the loss of their baby. All aspects of care can be managed here including ultrasound scanning, counselling, inpatient care and follow up support after discharge home. Women have access to care provided in five single rooms, a triage room, a bereavement suite with two ensuite bedrooms and an area for families to spend time with their babies. We observed supportive multidisciplinary working relationships between the Rubislaw ward, labour ward, bereavement specialist staff, obstetric theatres and anaesthetics.

NHS Grampian uses the National Bereavement Care Pathway to support care for women and families. 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.

Bereavement specialist staff spoke passionately regarding the ongoing service NHS Grampian provides to support families and be present with them throughout challenging experiences including during any adverse event review process. Bereavement specialist midwives work collaboratively across Aberdeenshire and Moray to support women, continuing contact through subsequent pregnancies. They work closely with bereavement specialist support organisations such as SANDS Moray and Sands Aberdeenshire. Staff bereavement training is a recognised standard recommended by the National Bereavement Care Pathway. Evidence demonstrated that 23% of midwifery staff and 4% of obstetric staff have completed bereavement training. In addition, we observed that biannual bereavement training days have been available for all members of the multidisciplinary team since 2023. Whilst we recognise

the ongoing work in this area, a recommendation has been given to support continued improvement.

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 developing study days. A recommendation has been given to support improvement in this area.

The impact of inequalities within maternity services has been highlighted through national reports such as saving mother's lives, improving care (MBRRACE-UK 2025). All women and their families deserve safe, kind and accessible care throughout their pregnancy journey. Ethnicity data is vital information in pregnancy as it helps to identify and address inequalities in maternal and perinatal adverse outcomes. Ethnicity data reviewed through NHS Grampian's latest perinatal mortality review report demonstrated compliance of 90.9% data completeness in relation to maternal ethnicity with the national average for completeness at 97.7% within the report.

Staff recognised that the maternity unit serves a large ethnically diverse population, which increases the demand for timely and effective access to interpretation services. 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. Digital devices, such as Interpreters on Wheels are available within the service to support communication. However, staff reported occasional difficulties in accessing interpretation for certain languages. NHS Grampian provided a guideline to support the use of interpretation phone services and in person interpretation including provision for sign language services. NHS Grampian conducted a staff survey to better understand the barriers and challenges staff faced. This highlighted insufficient time during appointments when an interpreter is required, and difficulties accessing in-demand interpreters through telephone interpreting. Within evidence we did not observe any incidents relating to interpretation services, however, senior managers advised that actions in response to the report findings are currently being developed. A requirement has been given to support ongoing improvement in this area.

NHS Grampian undertook a comprehensive Health Needs Assessment using data from January 2020 to December 2025 to identify and understand the needs of pregnant women experiencing, or at risk of, vulnerability across the region. This work reflects the changing demographic profile of Grampian, particularly in Aberdeen City, where increasing ethnic diversity demonstrates approximately one third of babies are born to mothers born outside the UK.

The Health Needs Assessment highlights that women from minority ethnic backgrounds are more likely to experience intersecting vulnerabilities, including socioeconomic deprivation. This included six focus groups representing diverse ethnic communities and a staff survey exploring

experiences of caring for women from ethnic minority groups. Findings will inform targeted improvement activity, supported by a multidisciplinary approach involving public health teams. The Health Needs Assessment has enabled NHS Grampian to identify key areas of need and implement focused improvement initiatives to enhance maternity care outcomes.

Areas of good practice

Domain 6	
7	NHS Grampian has undertaken a health needs assessment to identify and understand the needs of pregnant women experiencing, or at risk of, vulnerability across the region.
8	Women and their families were able to access specialist bereavement care.

Recommendation

Domain 6	
2	NHS Grampian should consider improving bereavement training compliance rates for all staff providing care to families.
3	NHS Grampian should consider improving trauma informed practice training compliance rates for all staff providing care to families.

Requirement

Domain 6	
20	NHS Grampian must ensure effective governance and oversight to ensure all women who require translation services have access to approved translation services.

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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