Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Dumfries & Galloway Royal Infirmary

NHS Dumfries & Galloway

27 – 28 July 2026

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About our inspection

Background

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

From April 2023 our inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland Quality Assurance Framework. Further information about the methodology for 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

Dumfries & Galloway Royal Infirmary is the main hospital in Dumfries and serves the whole of Southwest of Scotland. The hospital has 278 staffed beds and has a full range of healthcare specialties including maternity services. NHS Dumfries & Galloway serves a population of over 148,000 within a large geographical area of around 2,400 square miles.

About this inspection

During the week of 27 July 2026, we carried out two unannounced safe delivery of care inspections within NHS Dumfries and Galloway. As part of this we carried out an unannounced maternity inspection to Dumfries & Galloway Royal Infirmary, using our safe delivery of care inspection methodology. We inspected the following areas:

- birthing suite, and
- maternity suite.

We also carried out an unannounced safe delivery of care inspection of mental health services at Midpark Hospital, on 27 and 28 July 2026. Two 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, birthing people, visitors and ward staff, and
- accessed women and birthing peoples' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Dumfries & Galloway 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 27 August 2026, we held a virtual discussion session with key members of NHS Dumfries & Galloway 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 Dumfries & Galloway, and in particular all staff at Dumfries & Galloway Royal Infirmary for their assistance during our inspection.

A summary of our findings

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

NHS Dumfries & Galloway provides maternity services for women and their families across the Southwest region of Scotland, serving a widely dispersed population across a large rural geographical area. The maternity unit provides both midwifery and consultant led care supporting approximately 1000 births per year.

The maternity unit was calm, clean and well organised, with a high standard of maintenance evident throughout. We observed the multidisciplinary team delivering timely, compassionate and person-centred care.

We observed a formal consultant led multidisciplinary ward round within the antenatal and postnatal ward areas of the maternity suite. Interactions between women and members of the multidisciplinary team were respectful and compassionate. Staff demonstrated a good understanding of quality improvement initiatives and a clear commitment to continuous service improvement.

Senior charge midwives reported feeling well supported by the senior leadership team. Interactions between colleagues, women and their families were consistently respectful, kind and professional. NHS Dumfries & Galloway are piloting the Dumfries Obstetric Triage System (DOTS), with the aim to support timely access to unscheduled care with consideration for the large geographical area supported by the service.

At the time of inspection there were no delays to the induction of labour service. We observed oversight of women undergoing induction of labour were discussed as part of daily safety huddles. However, within evidence and through discussion with senior managers it was unclear how delays were consistently identified, reported and monitored to support service learning and improvement.

During inspection we identified further areas for improvement. These included strengthening oversight and review processes to ensure clinical guidelines are consistent with evidenced based practice and remain relevant. We identified areas for improvement in oversight of incident reporting and the review of adverse events to ensure alignment with the national framework. Compliance with essential and role mandatory training is also variable across midwifery and medical staff groups.

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

This inspection resulted in eight areas of good practice, four recommendations and nine requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on women, birthing people and families using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

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

We expect NHS Dumfries & Galloway to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: http://www.healthcareimprovementscotland.org

Areas of good practice

The unannounced inspection to Dumfries & Galloway Royal Infirmary resulted in eight areas of good practice.

Domain 1	
1	NHS Dumfries & Galloway is piloting the Dumfries Obstetric Triage System (DOTS) with the aim to support timely access to unscheduled care (see page 12).
2	NHS Dumfries & Galloway has implemented a dedicated 'red phone' system within maternity triage to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff (see page 12).
3	We observed effective collaboration between midwifery and neonatal teams, with clear communication regarding care requirements and available support (see page 12).

Domain 2	
4	Respectful and effective multidisciplinary communication (see page 15).
5	Senior managers recognise the importance of staff experience in driving sustainable service improvement and are proactively engaging with staff to collate their views (see page 15).

Domain 4.1	
6	Staff demonstrated a good understanding of quality improvement initiatives and a clear commitment to continuous service improvement (see page 20).

Domain 6	
7	Interactions between colleagues, women and their families were consistently respectful, kind and professional (see page 25).
8	All patients we spoke with reported that they would recommend the maternity service to their family and friends. Feedback was consistently positive across all groups (see page 25).

Recommendations

The unannounced inspection to Dumfries & Galloway Royal Infirmary resulted in four recommendations.

Domain 1	
1	NHS Dumfries & Galloway should consider improving bereavement training compliance rates for all staff providing bereavement care to families and providing a dedicated clinical space for caring for bereaved families (see page 12).

Domain 2	
2	NHS Dumfries & Galloway should consider improving trauma informed training for all staff (see page 15).

Domain 4.1	
3	NHS Dumfries & Galloway should consider implementing a system for storage of expressed breastmilk in line with national guidance (see page 20).

Domain 6	
4	NHS Dumfries & Galloway should consider implementing Re:Birth language (see page 25).

Requirements

The unannounced inspection to Dumfries & Galloway Royal Infirmary resulted in nine requirements.

Domain 1	
1	NHS Dumfries & Galloway must ensure effective governance and oversight to inform improvement and mitigate risk when delays to care occur. This includes but is not limited to: Delays to Induction of Labour process (see page 12). This will support compliance with: Health and Social Care Standards (2017) criteria 1.19 and 1.24 and Quality Assurance Framework (2022) criteria 2.5 and 1.5.

Domain 4.1	
2	NHS Dumfries & Galloway must continue to ensure governance and oversight of unit data to support learning and improvement, including but not limited to: • Maternity early warning score (MEWS) chart • Postpartum haemorrhage (see page 20). This will support compliance with: Quality Assurance Framework (2022) Criterion 2.6.
3	NHS Dumfries & Galloway must continue to ensure clinical guidelines are up to date and reviewed within agreed timescales (see page 20). This will support compliance with: Quality Assurance Framework (2022) Criterion 5.4 and the Health and Social Care Standards (2017) Criterion 4.11.
4	NHS Dumfries & Galloway must ensure effective governance and oversight of adverse events to support and improve the quality and safety of care, including, but not limited to:

- Incident reporting.
- Reliable and timely reporting of all adverse events.
- Compliance with the Healthcare Improvement Scotland national adverse events framework (see page 20).

This will support compliance with: A national framework for reviewing and learning from adverse events in NHS Scotland (2025) and Quality Assurance Framework (2022) Criterion 2.5.

Domain 4.3	
5	NHS Dumfries & Galloway must ensure that there are processes in place to support consistent annual application of the common staffing method, demonstrating triangulation of all relevant service specific quality, safety and workforce data (see page 23). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
6	NHS Dumfries & Galloway must ensure that clear and robust systems and processes are in place, including guidance and support for staff, to allow consistent assessment and capture of real time staffing risk across all professional clinical groups (see page 23). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
7	NHS Dumfries & Galloway must ensure oversight of potential risks within maternity services are consistently captured within the wider hospital safety huddle (see page 23). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
8	NHS Dumfries & Galloway must ensure that effective systems and processes are in place to support clinical leaders within maternity services to undertake staff appraisals (see page 23). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
9	NHS Dumfries & Galloway must ensure they are complying with the duty imposed by section 12II, ensuring that its employees receive time and resources to undertake such training essential to their role (see page 23). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We observed members of the multidisciplinary team delivering timely, compassionate and person-centred care. NHS Dumfries & Galloway is piloting the Dumfries Obstetric Triage System (DOTS) with the aim to support timely access to unscheduled care for women. Oversight of delays to care such as delays to the induction of labour service is an area for improvement.

NHS Dumfries & Galloway provides maternity services for women and their families across the Southwest region of Scotland, serving a widely dispersed population across a large rural geographical area. The maternity unit provides both midwifery and consultant led care supporting approximately 1000 births per year.

The maternity suite and birthing suite are located on the first floor and are clearly signposted from the main entrance. There is secure buzzer entry to both areas which were answered promptly during inspection. The maternity suite and birthing suite are separated by double doors, providing a seamless continuation of the maternity environment. Staff work flexibly across the inpatient service depending on the clinical need of women providing antenatal, intrapartum and postnatal care. We observed members of the multidisciplinary team delivering timely, compassionate, and person-centred care. The maternity unit was calm, clean, and well organised, with a high standard of maintenance evident throughout.

Women have access to unscheduled maternity care 24 hours a day, seven days a week. Midwives provide the telephone triage service, responding to calls, and undertaking an initial assessment using a structured triage approach. A dedicated midwife is responsible for managing the triage telephone, informing the shift leader of incoming calls and supporting timely access to unscheduled maternity services for women, which supports women to access unscheduled maternity services. We observed that details of telephone calls were documented within the electronic patient record system and recorded on a whiteboard in the staff base. This enabled staff to identify women expected to attend the department and supported wider clinical oversight.

It is essential maternity triage arrangements are proportionate to local demand. The Royal College of Obstetricians and Gynaecologist's Maternity Triage: Good Practice Paper No. 17 highlights that staffing models should be informed by regular assessment of maternity triage workload and that services should ensure they can consistently meet triage recommendations, including prompt assessment and appropriate escalation processes. Within evidence, we observed arrangements to support the safe delivery of unscheduled maternity care, including defined processes, clinical guidance, regular audit activity, and senior oversight.

NHS Dumfries & Galloway serves a large geographical area and rural communities. We observed unscheduled care telephone assessments take account of these factors; such as the woman's distance from the hospital and any potential challenges in accessing services. Midwives use their clinical judgement to determine the most appropriate setting for women to receive this unscheduled care, which may include assessment and treatment by their local community midwife within a local health centre where this best meets the woman's needs. We were provided evidence of guidance and pathways to support this service. We also saw how community midwifery teams contributed to safety huddles, supporting discussion of availability and capacity to deliver the service.

While there is currently no national standardised maternity triage system to support unscheduled care in Scotland, NHS Dumfries & Galloway is piloting the Dumfries Obstetric Triage System (DOTS). This system has been adapted from the Birmingham Symptom-specific Obstetric Triage System (BSOTS), with the aim to support timely access to unscheduled care for the geographical area supported by NHS Dumfries & Galloway. DOTS supports an initial clinical assessment within 15 minutes of arrival to the service, followed by categorisation into one of

four urgencies of care levels. These are red for immediate review, orange within 15 minutes, yellow within one hour and green within four hours. This also aligns with Royal College of Obstetricians and Gynaecologists Maternity Triage: Good Practice Paper.

Comprehensive guidance is available to staff for each level of clinical urgency, including the escalation and management of women whose condition deteriorates. Staff demonstrated a clear understanding of the triage system, expected timescales of care provision and escalation pathways. Visual aids displayed throughout the department further supported consistent application of the process. These included a colour coded magnet system which identified women's assigned urgency of care level to the multidisciplinary team, a communication white board and concise escalation posters. The implementation and effectiveness of this approach are monitored through monthly audits by senior charge midwives. Findings are shared with all midwives through a monthly email that highlights areas for improvement to support better data collection. NHS Dumfries & Galloway supplied audit data from April to June 2026 which demonstrated in the three months prior to inspection 94.09% of women were seen within 15 minutes of arrival to the service, and 95.15% of women were seen by medical staff within the recommended time frame.

The birthing suite has a dedicated 'red phone' to enhance direct communication between the Scottish Ambulance Service and maternity staff. The introduction of this system followed a recommendation arising from a fatal accident inquiry undertaken within another NHS board area. The red phone supports the timely exchange of critical information, enabling clear, prioritised communication and promoting the safe coordination of care. Given the unit's small staffing model, the senior management team advised that the maternity phone is carried by a member of support staff who would alert a shift leader if it rang, ensuring continuous accessibility and uninterrupted communication.

The birthing suite has six labour rooms, all with ensuite facilities, including two rooms equipped with birthing pools; with two maternity assessment rooms used to provide unscheduled care through the unit's maternity triage service. All birthing rooms provided sufficient space to support women's mobility and freedom of movement during labour, whilst ensuring staff could readily access and respond in the event of an emergency. A range of birthing aids were available, including a birthing pool, ballet bars and birthing balls. Each room was equipped with a discreet wall mounted resuscitator, enabling any immediate neonatal resuscitation requirements to be managed promptly. This supported the provision of family-centred care by minimising the need for mother and baby to be separated in the immediate postnatal period. During inspection, the ward was calm with good visibility of staff and clinical leadership.

The induction of labour process is a procedure performed to artificially start labour. At the time of inspection there were no delays to the induction of labour service. However, staff reported this was a regular patient flow issue. Delays to the induction of labour process are associated with increased risk of adverse maternal and perinatal outcomes. Within evidence and through discussion with senior managers it was unclear how NHS Dumfries & Galloway consistently identified, reported and monitored delays to induction of labour, which would support organisational learning and improvement. Senior managers highlighted that there is currently no process to routinely collate this data and that this will be a focus of improvement going forward. A requirement has been given to support improvement in this area.

The National Bereavement Care Pathway Scotland is a project funded and developed by Scottish Government in partnership with SANDs, the stillbirth and neonatal death charity, with the aim of standardising and improving the quality of bereavement care for the families of Scotland. Further information can be found here. The National Bereavement Pathway recommends 'All units have access to a room where bereavement care can be provided in a suitable and sensitive environment.' NHS Dumfries & Galloway provides clinical bereavement care within the birthing rooms in labour ward. The service also has access to a dedicated non-clinical bereavement suite which offered a more homely and supportive setting for women and families. While this facility was available for clinically well women to spend time with their baby and family, it was not routinely used for intrapartum care. As a result, aspects of the clinical bereavement care, such as labour and birth, continued to be provided in a non-dedicated space within the labour ward. Although the dedicated space supported some of the principles of the bereavement care standards, the bereavement journey was not fully supported in this area.

The Best Start: A five-year forward plan for maternity and neonatal care in Scotland (2017) recommends where a family is bereaved, they should be offered access to appropriate bereavement support, and each maternity and neonatal unit should have access to staff members trained in bereavement care. NHS Dumfries & Galloway were unable to provide staff training compliance in bereavement care. Senior managers acknowledged bereavement training as a key area for improvement and described plans to expand training opportunities for all staff. In partnership with SANDs and ARC (Antenatal Results and Choices), work is underway to develop and deliver a training programme, with rollout anticipated by the end of 2026. A recommendation has been given to support improvement in this area.

Inpatient antenatal and postnatal care, including induction of labour and planned caesarean birth, is delivered within the maternity suite. Accommodation consists of 12 single ensuite rooms which are used flexibly depending on clinical need. Each room is equipped with recliner chairs to enable partners to stay overnight where appropriate. This supported a family-centred approach to care, encouraging partner involvement and helping families to remain together throughout the antenatal and postnatal journey.

Transitional care is provided to babies who require additional support above normal neonatal care with the aim of preventing separation of mum and baby and unnecessary admissions to the neonatal unit. This approach supports the principles of The Best Start initiative which emphasises keeping families together wherever safe and appropriate. NHS Dumfries & Galloway provides transitional care within the maternity ward and has guidance in place outlining admission criteria to the transitional care area, which was aligned with the British Association of Perinatal Medicine (BAPM) Transition Care Guidance.

Babies requiring transitional care or ongoing observations were routinely identified and discussed during daily multidisciplinary huddles. NHS Dumfries & Galloway provided evidence of a checklist to be completed before a baby is admitted to the maternity suite for transitional care. This ensures that the baby meets the eligibility criteria for transitional care within a ward setting, that parents have been fully informed and have agreed to the plan of care, and that an appropriate clinical management plan is in place. It also considers whether staffing levels and

staff competencies are sufficient to safely accommodate the additional workload associated with providing transitional care.

We observed effective collaboration between midwifery and neonatal teams, with clear communication regarding care requirements and available support. NHS Dumfries & Galloway provided evidence of actions and discussions relating to transitional care through a short life working group. This group aimed to identify and address barriers to providing transitional care within a ward setting, including staffing ratios, individualising care, and communication between departments.

Areas of good practice

Domain 1	
1	NHS Dumfries & Galloway is piloting the Dumfries Obstetric Triage System (DOTS) with the aim to support timely access to unscheduled care.
2	NHS Dumfries & Galloway has implemented a dedicated 'red phone' system within maternity triage to strengthen direct communication pathways between the Scottish Ambulance Service and hospital staff.
3	We observed effective collaboration between midwifery and neonatal teams, with clear communication regarding care requirements and available support.

Recommendation

Domain 1	
1	NHS Dumfries & Galloway should consider improving bereavement training compliance rates for all staff providing bereavement care to families and providing a dedicated clinical space for caring for bereaved families.

Requirement

Domain 1	
1	NHS Dumfries & Galloway must ensure effective governance and oversight to inform improvement and mitigate risk when delays to care occur. This includes but is not limited to: Delays to Induction of Labour process.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

We observed respectful and effective multidisciplinary communication. Midwifery and obstetric staff worked collaboratively within the maternity unit and demonstrated a clear understanding of escalation processes, including how to access support from anaesthetic staff, theatre teams and senior managers when required.

During the inspection, we observed a formal consultant led multidisciplinary ward round within the antenatal and postnatal ward areas of the maternity suite. Interactions between women and members of the multidisciplinary team were respectful and compassionate.

We attended the multidisciplinary team handover, which was attended by the midwife in charge and staff from across the obstetric team. The handover was comprehensive and

included discussion of women in labour, expected triage attendances, inductions of labour, elective procedures, and antenatal and postnatal inpatients. We observed effective communication throughout the handover, with staff introducing themselves and providing clear and detailed updates.

Multidisciplinary discussions were respectful and compassionate, particularly when considering women with complex obstetric histories and babies receiving care in the neonatal unit following a preterm birth. This demonstrated a person-centred, trauma-informed approach. Trauma can significantly affect a person's emotional and psychological wellbeing, and it is therefore essential for services to be sensitive to the experiences of trauma survivors. NHS Dumfries & Galloway are introducing a programme of trauma-informed education sessions for staff. While staff have been signposted to relevant online learning modules and webinars, there has been no formal or consistent process in place. NHS Dumfries & Galloway was unable to provide attendance rates for staff within maternity services undertaking trauma informed practice training. A recommendation has been given to support improvement in this area.

A recent publication from the Nursing and Midwifery Council (NMC) in collaboration with the General Medical Council (GMC) highlighted the positive impact of effective communication within the multidisciplinary team on the safe delivery of maternity care. More information can be found here. The obstetric team spoke positively about their experiences within NHS Dumfries & Galloway maternity services. They described the model of care as providing a level of continuity and highlighted a positive and inclusive working culture. They reported that all members of the multidisciplinary team were encouraged to contribute and raise concerns, with no evident hierarchical barriers. This was reflected in the multidisciplinary handover we observed, where junior staff participated confidently in discussions and contributed to decision making.

The Ockenden Review (2022) highlighted the need for timely senior clinical oversight and effective multidisciplinary decision making in maternity services, reinforcing the importance of regular consultant led ward rounds to identify deteriorating women early, support safe care planning, and improve outcomes for mothers and babies. We observed a formal consultant led multidisciplinary ward round within the antenatal and postnatal ward areas of the maternity suite. Interactions between women and members of the multidisciplinary team were respectful and compassionate. Discussions demonstrated that women were well known to the obstetric team, reflecting continuity of care and familiarity with individual circumstances. Staff advised that these ward rounds take place daily and reported no barriers to accessing medical support or seeking obstetric review at any point throughout the day.

The NHS iMatter survey is an annual staff experience tool designed to support teams and NHS boards in understanding and improving staff experience. The survey provides valuable insight into areas of strength and opportunities for improvement, helping organisations to focus their efforts on enhancing staff wellbeing, engagement and, ultimately, the quality of care provided. More information can be found here.

Feedback from staff highlighted a desire for more formal feedback mechanisms following clinical incident review groups, and greater visibility and engagement from senior leaders. Staff also expressed a wish to be more involved in decision making processes, which aligns with findings reported at a national level. Senior managers highlighted the use of previous iMatter

action plans to drive service improvement and support change initiatives including measures to strengthen staff engagement, improve communication, and increase opportunities for staff participation in service development and decision making. The service has introduced initiatives including a recognition scheme and the display of staff photographs to promote team cohesion and support within the clinical environment.

Senior managers have recently commenced a programme of staff engagement inviting maternity and neonatal staff to share their views on service strengths, areas for improvement, and factors influencing the delivery of safe care. Recognising the importance of staff experience in driving sustainable service improvement.

This includes a variety of initiatives aimed at promoting staff wellbeing, several of which were introduced in response to findings from the iMatter survey. These included a 'Share the Joy' board, which recognised both individual and team achievements, celebrated successes in clinical practice, and promoted opportunities for professional development such as forthcoming training events.

Staff consistently described a positive working culture, supported by strong team relationships and effective support mechanisms. Anonymous staff feedback is collected via quick response (QR) code surveys and discussed at team meetings, providing opportunities for shared reflection and continuous improvement. We also observed an 'affirmation station' within the unit, comprising of a whiteboard where both staff and women could leave positive feedback and messages using post it notes, helping to promote a supportive and appreciative team environment.

NHS Education for Scotland created the national clinical supervision nursing and midwifery frameworks which supports a 'Once for Scotland' approach to implementation, practice and governance of clinical supervision. Clinical supervision is a proactive process to support staff development and professional growth by offering dedicated time, feedback and guidance in a psychologically safe space to critically reflect practice. The aim is to enable and empower staff to provide high quality, safe, and person-centred care. Within evidence, we observed that NHS Dumfries & Galloway offered both group clinical supervision and one-to-one sessions. Overall compliance was 77% for midwives in 2025 and is currently 63% in 2026.

Areas of good practice

Domain 2	
4	Respectful and effective multidisciplinary communication.
5	Senior managers recognise the importance of staff experience in driving sustainable service improvement and are proactively engaging with staff to collate their views.

Recommendation

Domain 2	
2	NHS Dumfries & Galloway should consider improving trauma informed training for all staff.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

Staff demonstrated a good understanding of quality improvement initiatives and a clear commitment to continuous service improvement. Oversight of incident reporting and review of adverse events in line with the national framework are areas for improvement.

Quality improvement boards were visible within the unit and provided accessible information on key performance measures, including maternity early warning score (MEWS) compliance. The Scottish maternity early warning score (MEWS) is a bedside screening tool which supports observation of physiological parameters such as blood pressure and heart rate in an aim to improve the recognition of pregnant and postnatal women at risk of clinical deterioration. This facilitates early intervention to improve outcomes. We noted positive levels of compliance with both the completion of observations and the escalation of clinical concerns in line with local procedures. NHS Dumfries & Galloway provided evidence of MEWs completion and escalation audits which demonstrated improvement in completion of MEWs from 65% in April 2025 to above 90% between January to March 2026. Additionally, compliance with the MEWs chart escalation pathway in April 2025 was 48% and has been around 80% since October 2025. Through evidence we saw that NHS Dumfries and Galloway continues to use quality improvement methodology to test changes and is actively seeking opportunities to further improve compliance.

The Scottish Patient Safety Programme (SPSP) Perinatal Programme recommend oversight of all postpartum haemorrhage which occurs from 1.5 litres and above in an aim to reduce morbidity and mortality related to maternal haemorrhage following childbirth.

NHS Dumfries & Galloway record within their incident reporting system any postpartum haemorrhage over 1.5 litres to ensure learning from events can be achieved. We observed evidence of the management and escalation of postpartum haemorrhage discussed with the obstetric management group to highlight areas of service improvement. Whilst onsite we observed Scottish Patient Safety Perinatal Programme participation details were displayed within the ward areas for staff awareness of ongoing improvement work.

The Maximum Allowable Blood Loss (MABL) is a critical concept in obstetric practice, particularly in the context of postpartum haemorrhage (PPH). It is used to determine the maximum allowable blood loss before a blood transfusion may be required by a woman, ensuring patient safety during surgical and trauma procedures. MABL is calculated based on the patient's initial and final haemoglobin level, and weight, and is crucial for guiding transfusion decisions and managing blood loss during childbirth.

MABL formed an integral part of the service's approach to managing blood loss. We observed an individualised approach to assessing and actively managing blood loss, with MABL calculated for all women to support ongoing monitoring and timely clinical decision making. NHS Dumfries & Galloway has an ongoing quality improvement project to improve postpartum haemorrhage (PPH) risk assessment and management. Inspectors observed a dedicated area within all birthing rooms for the assessment of blood loss measurement. This included visible guidance and relevant equipment such as scales to accurately assess blood loss. Between January and June 2026, compliance improved consistently across several key measures, including cumulative blood loss recording from less than 30% to 70%. Completion of at least two fundal height assessments from 25% to 60%. Completion and appropriate escalation of

postnatal observations from 30% to 45%, and completion of PPH risk assessments. Whilst we recognise improvement work already underway, a requirement has been given to support ongoing improvement in this area.

The provision of antenatal colostrum harvesting reflects UNICEF UK Baby Friendly Initiative standards by supporting breastfeeding preparation, enhancing maternal confidence, and reducing the likelihood of formula supplementation for babies requiring additional nutritional support after birth. NHS Dumfries & Galloway undertook a quality improvement project to increase antenatal colostrum collection and postnatal breastmilk expression among eligible women. Early outcomes indicate improved maternal breastfeeding experience. Within evidence reviewed we can see the Neonatal unit breastfeeding rates at discharge increased from 34% in May - June 2025 to 47% in May - June 2026.

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 most recent publication in September 2026 continues to demonstrate the leading cause for maternal death in the UK is attributed to venous thromboembolism.

NHS Dumfries & Galloway has undertaken audits to identify barriers and support improvement in this area. Audit results demonstrate 83% of antenatal booking and 99% of inpatient or postnatal venous thromboembolism risk assessments were completed appropriately between February and July 2026. We were provided with NHS Dumfries and Galloways 'Thromboprophylaxis in Pregnancy, Labour and the Puerperium' used to support clinical practice contained up to date best practice guidance.

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. We observed that NHS Dumfries & Galloway added a risk to the risk register in January 2023 relating to practitioners providing care with outdated clinical guidelines. However, this risk has not yet been reduced. Ensuring clinical guidelines are consistent with evidenced based practice requires oversight and a system of review to ensure they remain relevant. Senior managers advised that they were aware of the outdated guidelines and had made progress in prioritising the review of those most frequently used. However, progress has been impacted by vacancies within the consultant obstetrician rota. In evidence we observed 45% (11) clinical guidelines were currently under review and 55% (13) within date of review. Senior managers were unable to provide assurance regarding the length of time that the most overdue guideline had remained out of date. A requirement has been given to support ongoing improvement in this area.

Staff demonstrated a good understanding of the incident reporting system. We were provided with an incident trigger list designed to promote the submission of incident reports following adverse events, ensuring that appropriate review, learning and improvement activities are undertaken. Staff reported no barriers to incident reporting and described a positive reporting culture. They advised that feedback was routinely provided following incident submission, and that additional feedback could be requested where desired. We asked for all incident reports submitted by staff for the six months prior to our inspection.

Review of the supporting evidence identified events that met the criteria for incident reporting. However, while these events had been discussed at multidisciplinary huddles, they were not evident in the incident reports submitted. Senior managers acknowledged that there is currently no formal process to provide oversight or assurance that all reportable incidents are recorded and submitted. The patient safety lead midwife advised that this will be taken forward.

The consistent reporting and learning from adverse events are essential in assuring learning, quality improvement and patient safety within a service. The learning from adverse events national framework highlights all adverse incidents should be reviewed. The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review (SAER). More information on the adverse event framework can be found here. The adverse events framework recommends level 1 SAER's are completed within 140 working days from the date of incident submission. We were provided with evidence of four serious adverse event reviews commissioned in the past 12 months. These were all being reviewed within the recommended timeframes. However, some level 2 events, which require review within 70 working days and level 3 events, which require review within 10 working days were not being achieved, with some several months overdue.

NHS Dumfries & Galloway added a risk to the risk register in March 2024 as perinatal adverse events are not being reviewed in line with national guidance. We asked senior managers how they ensure all incidents are reviewed and learning achieved. Senior managers described a renewed focus on oversight of clinical incidents being led by the patient safety lead midwife. We observed the development of a clinical incident and adverse event roadmap within evidence aimed at supporting structured review planning to support improvement. Evidence also demonstrated an associated improvement action plan, with a focus on strengthening adverse event processes and aligning practice with the Healthcare Improvement Scotland adverse event framework. A requirement has been given to support improvement in this area.

Families are included within the significant adverse events and perinatal mortality review process by assigning a key contact to the family. The contact acts as a spokesperson for the family and where possible is independent from the review team to ensure the families' experience forms part of the review process and learning. NHS Dumfries & Galloway uses the national Perinatal Mortality Review Tool (PMRT) to support a standardised review of all stillbirths and neonatal deaths, ensuring that learning is identified consistently. The PMRT is designed to include families' experiences and questions within a robust, objective and standardised local review of care following the death of a baby. The tool's primary purpose is to provide bereaved parents and families with clear answers about whether care was safe, personalised and appropriate and whether different care may have altered the outcome. Review of NHS Dumfries & Galloway's most recent PMRT report demonstrated that the recommended reporting timescale of within seven days was achieved for only 29% of stillbirth and 33% of neonatal deaths. In discussion with senior managers, review of the report had identified this as an area for improvement, which will be monitored by the patient safety lead midwife going forward. A requirement has been given to support improvement in this area.

Duty of candour is a statutory requirement within Scotland. Further information can be found here. The duty requires organisations providing health, social work or care services in Scotland to be open, honest and inclusive with anyone who experiences unintended or unexpected harm or death. We asked senior managers what mitigations were in place to ensure duty of candour were recognised and actioned appropriately given the highlighted delays to adverse events reviews within the service. We were advised all incidents are considered on a weekly basis and any incident which triggered duty of candour would be considered by the patient safety group for action and oversight.

During the inspection, we observed patient use equipment was clean, appropriately stored, and ready for use. Storage areas were well organised, tidy, and maintained in a manner that supported safe and efficient access to equipment. The clinical environment appeared clean and well maintained, with no significant evidence of wear and tear observed within the maternity ward. Shower and toilet facilities were of a good standard and were visibly clean. Ward corridors were free from obstruction, with equipment stored appropriately to support safe movement throughout the department.

Call bells were available and within reach at each bed space, enabling women to summon assistance when required. We observed a mealtime, which appeared to be well organised, and staff reported no concerns with obtaining dietary preferences and requirements from catering.

Medicines were stored securely in locked cupboards within a restricted accessed preparation room. Medications required for the management of obstetric emergencies were readily available and accessible to authorised staff when needed. Medication refrigerators were appropriately secured, with access restricted to relevant maternity staff. We also observed allergies being highlighted and discussed during multidisciplinary team huddles, supporting staff awareness, risk mitigation, and effective oversight of patient care.

National guidance from National Neonatal Network Scotland (2025) emphasises the importance of quality assurance and traceability throughout the handling, storage, transportation and administration of expressed breast milk. Expressed breast milk was stored in a dedicated refrigerator, and fridge temperatures were monitored as part of daily ward assurance checks. All breast milk observed was appropriately labelled. While there was no formal sign-in/sign-out process for the storage and retrieval of expressed breast milk, the ward manager advised that arrangements had previously been considered following an adverse event. The service described a focus on strengthening bedside identification checks and communication with mothers prior to administration, which staff described as the key control measure for reducing the risk of breast milk administration errors. While expressed breast milk was appropriately labelled and stored, there was no formal system to track removal from, and return to, storage. A recommendation has been given to support improvement in this area.

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 require chlorine-based cleaning products to be stored securely within a locked storage area. During the inspection, we observed chlorine-based cleaning products being stored appropriately in a locked cabinet within the maternity ward sluice room.

Hand hygiene is a key component of standard infection prevention and control precautions and is essential in reducing the risk of healthcare associated infection. Throughout the inspection,

we observed good compliance with hand hygiene practices, with no missed opportunities for hand decontamination identified.

Personal protective equipment (PPE), including gloves and aprons, was readily available at the point of care. We observed safe sharps management practices, with sharps containers appropriately labelled in accordance with local guidance and temporary closure mechanisms in use. The use of temporary closures reduces the risk of sharps protruding from, or falling out of, the container if moved or accidentally dropped. Sharps containers not in active use were observed to be stored safely and appropriately.

Linen trolleys were placed and stored appropriately with the correct covering. Used linen, which was potentially contaminated with blood or suspected to be infectious was managed and disposed of correctly in line with the National Infection Prevention and Control Manual.

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. During the inspection, we observed that NHS Dumfries & Galloway uses an electronic monitoring system to manage, and record required water flushing activities. Domestic staff working within the ward demonstrated a clear understanding of the flushing schedule and associated requirements. NHS Dumfries & Galloway also provided evidence of water flushing compliance between 95 - 100% for the three months prior to inspection.

NHS Scotland Fire code SHTM 86: 'Fire Risk Assessment' states that hospitals and other healthcare premises with sleeping accommodation should have a yearly fire safety review. A fire risk assessment within the maternity unit was noted from April 2026. Fire escape routes and exits were clear, well signposted and unobstructed. Medical gases were seen to be stored correctly with appropriate signage within ward areas.

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 Dumfries & Galloway demonstrated that 93% of midwifery staff and 100% of medical staff had completed mandatory fire safety training in the last 12 months.

Area of good practice

Domain 4.1	
6	Staff demonstrated a good understanding of quality improvement initiatives and a clear commitment to continuous service improvement.

Recommendation

Domain 4.1	
3	NHS Dumfries & Galloway should consider implementing a system for storage of expressed breastmilk in line with national guidance.

Requirements

Domain 4.1

2	NHS Dumfries & Galloway must continue to ensure governance and oversight of unit data to support learning and improvement, including but not limited to: • Maternity early warning score (MEWS) chart • Postpartum haemorrhage.
3	NHS Dumfries & Galloway must continue to ensure clinical guidelines are up to date and reviewed within agreed timescales.
4	NHS Dumfries & Galloway must ensure effective governance and oversight of adverse events to support and improve the quality and safety of care, including, but not limited to: • Incident reporting • Reliable and timely reporting of all adverse events • Compliance with the Healthcare Improvement Scotland national adverse events framework.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Senior charge midwives reported feeling well supported by the senior leadership team. Compliance with essential and role mandatory training is variable across midwifery and medical staff groups and identified as an area for improvement.

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

Workforce data reviewed demonstrates a shortfall in band 7 midwifery staffing establishment of 15.8%, band 6 midwifery establishment of 13.7% with a high proportion (65%) of the midwifery establishment part time. Consultant obstetricians have a 24.8% shortfall. We consider a rate of over 10% as high. We were informed of escalation processes that are in place in relation to staffing risk, and how staffing risks are routinely reviewed within and across the hospital. A risk relating to staffing within obstetrics and gynaecology has been added to the maternity services risk register.

Senior managers and the senior medical team openly discussed challenges to recruit to obstetric vacancies which had been initially difficult to fill and had resulted in gaps in the obstetric rota. Senior managers acknowledged the vulnerabilities associated with current workforce arrangements. They advised that these had been mitigated through the use of a regular and consistent group of locum consultants, supporting greater continuity of care and consistency in practice. Recruitment had recently been successful with a substantive consultant starting September 2026. They also recognised the essential role of training opportunities in supporting recruitment and retention. In response, the team described innovative approaches including working closely with NHS Greater Glasgow and Clyde to enhance access to shared learning and training.

Senior managers demonstrated a clear understanding of workforce demographics, recognising that a relatively young midwifery workforce, combined with maternity leave requirements and a high proportion of part-time staff, can present recruitment and staffing challenges. Despite this, managers outlined a proactive approach to succession planning, focused on nurturing talent, developing skills, and creating opportunities for staff to progress into enhanced and leadership roles.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024 and requires all NHS boards ensure appropriate staffing for the provision of safe and high-quality care. NHS boards have a duty to apply the Common Staffing Method (CSM). The CSM triangulates and analyses all relevant service specific data, evidence and intelligence to support clinical leaders to understand staffing requirements for a given area. As part of common staffing methodology, it is mandated that the given areas undertake a staffing level tool and professional judgement tool run concurrently over a two-week period once a year. NHS Dumfries & Galloway advised that a staffing tool run was undertaken in 2025. However, the organisation recognised that insufficient application of professional judgement limited the interpretation and usefulness of the findings. In response, targeted staff training was implemented to strengthen understanding and application of the tool. A subsequent assessment was completed, although the results had not yet been fully analysed at the time of inspection. A requirement has been given to support ongoing improvement in this area.

During inspection we attended maternity services staffing huddles led by senior charge midwives. The huddle included midwifery workforce planning for both onsite and offsite maternity services within NHS Dumfries & Galloway. We observed open and transparent discussions regarding potential staffing issues. However maternity services do not routinely contribute to, or attend, the wider acute hospital safety huddles. As a result, opportunities to share maternity specific staffing, activity and risk information across the wider hospital system may be limited. A requirement has been given to support improvement in this area.

NHS Dumfries & Galloway introduced the SafeCare maternity staffing tool in May 2026. Although the tool remains in the early stages of implementation and there have been some initial challenges in embedding its use, it has become an established component of everyday practice. During the site visit, we observed the completion of real time staffing assessments and the reporting of staffing levels using the SafeCare maternity staffing tool. However, we noted that the information generated was not consistently used or referenced during subsequent staffing and activity safety briefs, resulting in a process that appeared fragmented and lacking continuity. This was discussed with the senior managers on site, who were receptive to the feedback and recognised the opportunities for improvement. They expressed a commitment to strengthening the use of shared language and developing a more integrated approach to assessing and communicating service pressures and activity levels as part of the ongoing embedding of the SafeCare system. A requirement has been given to support improvement in this area.

Staff described opportunities for career development through succession planning arrangements that enabled clinical midwives to broaden their roles and participate in quality improvement initiatives. These opportunities were reported to be well supported across the service.

Senior charge midwives reported feeling well supported by the senior leadership team and reported sufficient time to lead. Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019) to ensure clinical leaders have protected time and adequate resource to facilitate appropriate staffing alongside other professional duties to lead the delivery of safe, high quality and person-centred healthcare. Band 7 midwives reported that they had adequate protected time to fulfil their leadership responsibilities and identified no concerns in this area. Staff described a supportive working environment where training is valued and accommodated. However, through evidence received, only 63% of midwives and maternity care assistants, and 67% of medical staff had received an appraisal by their line manager in the last 12 months. Staff appraisals are essential to support and enable staff to feel valued and support their individual development. A requirement has been given to support improvement in this area.

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.

Cardiotocograph training is critical to safeguarding fetal wellbeing, supporting consistent interpretation of fetal monitoring, and ensuring adherence to clinical governance standards. NHS Dumfries & Galloway provided us with compliance rates for its cardiotocograph (CTG) training which demonstrated a compliance of 44% completion for midwifery staff, and 28.5% for medical staff.

Emergency scenario training, for example Scottish Core Obstetric Teaching and Training in Emergencies (SCOTTIE), is vital in the maternity setting to ensure staff can respond promptly and effectively to obstetric emergencies, promoting teamwork, preparedness and the delivery of safe, high-quality care. Regular, scenario-based training in the management of shoulder dystocia is essential to ensure that maternity staff can recognise, respond to and resolve this time critical obstetric emergency effectively. Overall, compliance with this training varied between 93% for midwifery staff and 57% for medical staff.

Senior managers provided up to date compliance rates for training, which showed variable compliance of role mandatory training rates of between 55% and 86%. The inspection has identified several areas where compliance with essential and role mandatory training is variable across midwifery and medical staff groups. Neonatal resuscitation compliance rates for midwives were 84% within the yearly requirement and 100% compliance rate for the four yearly neonatal resuscitation requirements. A requirement has been given to support improvement in overall training compliance.

Requirements

Domain 4.3	
5	NHS Dumfries & Galloway must ensure that there are processes in place to support consistent annual application of the common staffing method, demonstrating triangulation of all relevant service specific quality, safety and workforce data.
6	NHS Dumfries & Galloway must ensure that clear and robust systems and processes are in place, including guidance and support for staff, to allow consistent assessment and capture of real time staffing risk across all professional clinical groups.

7	NHS Dumfries & Galloway must ensure oversight of potential risks within maternity services are consistently captured within the wider hospital safety huddle
8	NHS Dumfries & Galloway must ensure that effective systems and processes are in place to support clinical leaders within maternity services to undertake staff appraisals.
9	NHS Dumfries & Galloway must ensure they are complying with the duty imposed by section 12II, ensuring that its employees receive time and resources to undertake such training essential to their role.

Domain 6 – Dignity and respect

Quality 6.2 – Dignity and respect

Interactions between colleagues, women and their families were consistently respectful, kind and professional. Breastfeeding information is available in more than 75 languages, supporting equitable access to infant feeding advice.

The maternity service within NHS Dumfries & Galloway supports the continuity of care model described in the Scottish Government's *The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland* (2017), which promotes truly family-centred and compassionate care for parents and babies. During our inspection, we observed no restrictions on visiting with the service actively supporting a family-centred approach. Staff recognised the importance of involving fathers, coparents, partners and other family members as partners in care.

The Women Individually Nurtured Grow Strength (WINGS) team was established in line with the Scottish Government's *Best Start* implementation programme and aims to support women experiencing complex social circumstances during pregnancy. The service seeks to provide streamlined, coordinated and consistent care, with women allocated a named midwife wherever possible. This approach is intended to promote continuity of carer, reducing the need for women to repeatedly recount their circumstances and supporting the development of trusting and sustained relationships. The team provides consistent health and wellbeing advice and facilitates early referral and signposting to relevant statutory, partner and third sector services. The service aims to improve outcomes for women, babies and families through enhanced coordination of care and support for those with additional vulnerabilities.

The Racialised Health Inequalities in Maternity Care workstream was established to address the poorer outcomes and experiences reported by some minority ethnic women and babies. In 2023, the Scottish Government established a short life working group which developed three key deliverables to support NHS boards in reducing these inequalities: an action plan, an interpretation toolkit, and an evidence and data resource. NHS Dumfries & Galloway provided evidence of work undertaken in response to the action plan and demonstrated how relevant actions have been incorporated into local service planning. Examples included the availability of nationally translated information resources, the WINGS service, collection and use of ethnicity data, and arrangements to support access to and appropriate use of interpreting services.

NHS Dumfries & Galloway provided evidence demonstrating clear pathways for staff to access interpretation services for women who do not speak English and for women who communicate using British Sign Language (BSL). Staff reported no barriers to accessing telephone, video, or

face to face interpreting services and were confident that these services could be arranged to meet the communication needs of women receiving care. In addition, through its work with the Scottish Breastfeeding Collaborative, breastfeeding information is available in more than 75 languages, supporting equitable access to infant feeding advice.

All patients we spoke with reported that they would recommend the maternity service to their family and friends. Inspectors spoke with women receiving care across a range of maternity pathways, including antenatal inpatients, women undergoing induction of labour, postnatal women whose babies were receiving care in the special care baby unit, and postnatal women receiving care alongside their babies on the ward.

Feedback was consistently positive across all groups. Patients told us they felt listened to and actively involved in decisions about their care. They described being treated with dignity and respect and reported receiving compassionate, person-centred care from staff. Many women spoke positively about the support and reassurance provided throughout their maternity journey.

Interactions between colleagues, women and their families were consistently respectful, kind and professional. Current national guidance, including the Royal College of Midwives' Re:Birth Shared Language for Pregnancy, Labour and Birth recommendations, emphasises the importance of using language that is respectful, inclusive, person-centred and supportive of informed choice. Consistent use of this language helps promote positive experiences, effective communication and a shared understanding between women, families and healthcare professionals.

During the inspection, we observed clear and effective communication between staff and women. However, some of the terminology used by staff when communicating with colleagues was not fully aligned with current professional guidance. For example, the term 'emergency caesarean section' was observed, whereas Re:Birth guidance advocates the use of terms such as 'unplanned caesarean birth'. Similarly, the term 'delivered' was used in place of 'gave birth' or 'birthed'. A recommendation has been given to support improvement in this area.

Areas of good practice

Domain 6	
7	Interactions between colleagues, women and their families were consistently respectful, kind and professional.
8	All patients we spoke with reported that they would recommend the maternity service to their family and friends. Feedback was consistently positive across all groups.

Recommendation

Domain 6	
4	NHS Dumfries & Galloway should consider implementing Re:Birth language.

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)
- A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (Healthcare Improvement Scotland, February 2025)
- Antenatal care (NICE, August 2021)
- Clinical Governance Standards (Healthcare Improvement Scotland, February 2026)
- CMO(2018)18 - Core mandatory update training for midwives and obstetricians (Scottish Government, December 2018)
- Delivering Together for a Stronger Nursing & Midwifery Workforce (Scottish Government, March 2025)
- Fire (Scotland) Act 2005 (Fire Scotland Act, Acts of the Scottish Parliament, 2005)
- Food Fluid and Nutritional Care Standards (Healthcare Improvement Scotland, November 2014)
- Generic Medical Records Keeping Standards (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 Report 2026 (Maternal, Newborn and Infant Clinical Outcome Review Programme, 2026)
- 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 and Framework (Healthcare Improvement Scotland, September 2022)

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or email contactpublicinvolvement.his@nhs.scot

Healthcare Improvement Scotland

Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

0131 623 4300

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.healthcareimprovementscotland.scot