Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Hospital inspection methodology

Maternity services within acute setting inspections; Safe Delivery of Care

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Contents

Introduction

Taking account of the changing risk considerations and sustained service pressures towards the end of 2021, the Cabinet Secretary for Health and Social Care approved adaptations to our previous COVID-19 focused hospital inspection programme. The Safe Delivery of Care inspection methodology continues to provide robust and proportionate public assurance that is reflective of and responsive to pressures within the system and remains focused on helping services identify and minimise risks within the current operating environment.

The maternity services within acute setting inspection methodology was developed as part of a range of actions to support, improve and provide assurance of the current maternity service provision across Scotland. Maternity services span community and hospital-based services with a significant proportion of care undertaken in the community setting. Utilising a staged approach and expanding the safe delivery of care inspection methodology will provide women, birthing people and families with an assessment of the quality of care provided by their local maternity service and an independent review of any required improvements. The first stage of maternity safe delivery of care inspections will be undertaken in maternity services within the acute setting i.e. an obstetric-led or consultant-led hospital or maternity unit. Community-based and midwife-led maternity care will not be inspected at this stage.

Our safe delivery of care inspections allow our inspectors to carry out as much of their inspection activities as possible through observation of care and virtual discussion sessions, whilst continuing to seek assurance on quality and safety of care provided.

The safe delivery of care approach, whilst mainly observational, may at times require access to documentation to ensure inspectors are able to robustly triangulate observations of care. Where this is required, inspectors will make every effort to avoid disruption to staff delivering care.

About this document

This document sets out the methodology that Healthcare Improvement Scotland will use to carry out maternity safe delivery of care inspections within the acute setting.

The purpose of this document is to inform the public and NHS boards of the process we will use to carry out safe delivery of care inspections; to measure NHS board compliance against a range of standards, best practice statements and other national documents.

We will seek feedback from the public, NHS staff and advice from Scottish Government, as a means of reviewing our methodology and ensuring our work is improving the standards of maternity care.

Our inspection methodology

Our inspection activity supports NHS boards to comply with national standards to improve outcomes, highlight areas of good practice and identify areas for improvement.

We have an inspection prioritisation procedure in place which helps us to determine the frequency of our inspections. This enables the targeting of inspection resources and contributes to a national drive for an overall risk based, proportionate and intelligence-led approach to scrutiny and assurance. The inspection prioritisation information is regularly refreshed and will include a range of available national data for maternity services.

To enable us to provide targeted assurance on the safe delivery of care in the context of current service pressures, our safe delivery of care inspections will focus on:

- Key indications of the delivery of care including open and equitable care, right care by the right team in the right environment, with evidence-based care driving informed choice. Services and care planning will hold women, birthing people and family's needs at the centre of care provided.
- Fundamentals of maternity care essential to improving experience and outcome such as accessible care, communication and respecting choice.
- Management of safety and risk through observation of care, attendance at hospital safety huddles and assessment of staffing data provided by the NHS board.
- Clinical Governance structures within the NHS board which gives oversight of current maternity performance.
- Leadership and culture.
- Standard infection control precautions and transmission-based precautions for infection prevention and control.

When carrying out inspections, our inspectors:

- Work to ensure that women, birthing people and families are at the heart of everything they do.
- Are consistent in their inspection approach and delivery.

- Adhere to current guidelines and practices outlined in Appendix I.
- Communicate with colleagues within the NHS boards undergoing the inspection in a considerate and respectful manner and explain the purpose and remit of the inspection, to support the safe delivery of care for women, birthing people and staff.
- Treat everyone fairly and equally, respecting their rights.
- Taking account of women, birthing people and staff privacy and dignity.
- Act when there are serious risks to those using the hospitals we inspect.
- Ensure the focus of inspection is aligned to our maternity Safe Delivery of Care inspection methodology and is focused on improving the quality of care.
- Represent the values and behaviours of our organisation.

Our inspections will:

- Remain independent of Scottish Government and the NHS boards that are being inspected.
- Publish a report of our findings on our website to ensure they are available to the public.
- Publish the improvement action plan produced by the NHS board on our website to ensure they are available to the public.
- Where required return to inspect hospitals after we have reported our findings, through a follow-up inspection.

Our inspections will not:

- assess the fitness to practice or performance of individual members of staff.
- assess clinical decision-making
- investigate the cause of outbreaks of infection or
- investigate complaints.

The footprint of the inspection is expected to last 12 weeks, this entails:

- the initial onsite observational inspection visit
- review of evidence and discussion sessions with the NHS board
- any return visits where required
- production of the inspection report
- factual accuracy process, and

publication of the inspection report and improvement action plan.

In the event that this timeframe cannot be achieved, this information will be shared with the NHS board as soon as possible.

Our focus

All inspections will reflect the existing context of operating environments and service pressures within NHS Scotland acute hospitals and other health settings. Intelligence may highlight concerns that would suggest a maternity safe delivery of care inspection would be beneficial to support improvement.

Our maternity safe delivery of care inspections will be unannounced and the hospitals to be inspected will be based on all available intelligence (see section: Data gathering and intelligence).

The inspections will:

- Ensure that the care of women, birthing people and the environment supports safe and effective care and is in line with current standards and best practice.
- Report our findings during our inspection and ensure the NHS board produces an improvement action plan to address any areas for improvement identified.
- Engage with staff and managers if there is evidence, they are not following the NHS board policies and procedures, best practice statements or national standards, to provide assurance on the safety and quality of care.

We will inspect using existing Health and Social Care Standards (2017) Infection Prevention and Control Standards (2022) and our Quality Assurance Framework (2022) and any other standards that become relevant during the inspection. Our inspections align with the following Quality Assurance System.

We will also consider the delivery of care in accordance with the Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019).

Inspection tools have been updated and will continue to be reviewed to ensure that they reflect current national guidance and any impact this may have on the safe delivery of care. A list of national guidance is available in Appendix I.

Data gathering and intelligence

The decision on which hospitals we inspect is risk-based and intelligence-led, derived from information and intelligence from our data measurement and business intelligence (DMBI) team. Where available previous inspection findings are included in this data.

In the week leading up to any inspection, members of the inspection and DMBI teams will meet and review available data and intelligence relevant to healthcare associated outbreaks and services pressures within the NHS boards. We will seek to balance the benefits of public assurance against any risk to the delivery of care caused by the presence of an inspection team.

In the planning stages of inspection and to support site selection, regular meetings will take place between the senior inspector, the chief inspector and representatives from Scottish Government to understand service pressures across NHS Scotland.

The lead inspector will review progress against previous improvement action plans to seek assurance that previous actions have been addressed.

Onsite Inspection

The inspection team will comprise of:

- a lead inspector
- inspectors (number dependent on size of hospital)
- programme support staff (these members will not attend the onsite inspection but will support the inspection remotely)
- staff from our healthcare staffing team or other clinical experts to support the inspection team either onsite or remotely, when required, and
- each inspection will be supported by a senior inspector, who may be onsite or provide support remotely.

The size of the inspection team will be determined by the size of the hospital site being inspected and the number of areas being inspected.

All onsite members of the inspection team are enrolled in the Protecting Vulnerable Groups (PVG) scheme.

To reduce the burden of inspection on the NHS board, public partners will **not** be part of the onsite inspection.

As public partners cannot be involved in the onsite inspections at this time and to ensure a level of public involvement, we sought input and advice from our Community Engagement colleagues and public partners on questions that the inspection team will ask people receiving care as part of the inspection.

Roles and responsibilities – Inspection team

The inspection team will carry a Healthcare Improvement Scotland photo ID card.

The onsite inspection is expected to take place over 1 to 3 days (depending on the size of the hospital site). Offsite discussion with representatives of the NHS board using Microsoft Teams will also form part of the inspection. When inspectors are onsite for the inspection, this will generally be between 8.00am – 6.00pm. However, these times may vary and inspections may take place out of hours. We will endeavour to ensure there is minimal disruption to the provision of care by our inspection team.

Inspectors will endeavour to minimise the burden on staff delivering care when we visit wards and departments and will aim to conduct the main part of the

inspection as observations of care. However, where possible and necessary, we will speak with members of staff and inspectors will, if approached, be happy to listen to the views or concerns of staff.

On arrival at the hospital site, the lead inspector will attend the hospital main reception and announce the inspection. The lead inspector will ask reception staff to contact the NHS board senior managers onsite, requesting they meet with the lead inspector to make the NHS board aware of the inspection process, the time the inspection team are expected to be on site and the remit of the inspection.

An inspection programme (including timings but excluding details of the wards and departments to be inspected) will be shared with the hospital management team. At this point, we will also request any information that will be required to undertake the inspection. This will include a template for the collation of necessary staffing information.

During our inspection, the inspectors will:

- Use digital inspection tools to document findings whilst observing the ward and hospital environment.
- Observe the care environment, staff practice of standard infection control precautions such as hand hygiene and use of personal protective equipment, including during mealtimes and the general delivery of care such as staff interactions with women, birthing people and their family.
- If highlighted and required this may also include review of escalation management, placement of women and birthing people, medicines management or other immediate patient safety risks or concerns identified during the inspection.
- Observe hospital safety huddles and speak with the multidisciplinary team staff where appropriate.
- Access health records, monitoring reports, policies and procedures where appropriate.
- Talk with women, birthing people and their families where appropriate to triangulate observations of care.
- Ask the NHS board to provide relevant evidence appropriate to the inspection including information and data on workforce.
- Apply their professional judgement, in relation to all aspects of the inspection.

On arrival at the ward or clinical area, the inspector will introduce themselves and explain the inspection process to the midwife in charge.

High level verbal feedback will be provided in the ward and to senior managers throughout the inspection, and we will seek to understand from the NHS board how best to provide this during the inspection. If the ward pressures are such that the senior charge midwife cannot attend the feedback, then this will be offered to the designated lead for that area. This will be decided by the NHS board.

In the event of serious concerns being identified, verbal feedback will be provided to senior managers as soon as practically possible during the period of the inspection.

A virtual staff discussion session with representatives from the NHS board will take place (using Microsoft Teams) at an agreed time following the onsite inspection activity. This is to enable the inspection team to obtain further evidence or information. This is also an opportunity for further discussion of any points raised during the inspection. Arrangements for this will be made by the project officer (offsite) and a designated member of the hospital staff.

Should the NHS board require clarification of any points made in the high-level findings, they should contact the hospital inspection team via the dedicated mailbox: his.nhsinspections@nhs.scot. Arrangements can then be made for the lead inspector, senior inspector or chief inspector for the inspection programme to contact a named person within the NHS board.

The inspectors have no involvement in crisis or incident management. In the event of a situation that significantly affects the day-to-day operation of a ward or hospital, the inspector will review the arrangements for the inspection with the lead Inspector, NHS board and hospital staff.

Follow-up inspections

Where concerns are identified, a follow-up inspection can be carried out. We can carry out two types, a return visit or follow-up inspection, which can be announced or unannounced.

A return visit can take place within 1-3 weeks of the initial onsite inspection. This is to check progress against any concerns raised by the inspection team. Findings from this return visit will be included in the original inspection report.

We can also return for a follow-up inspection to any hospital to check the NHS board has acted on our requirements and made sustained improvements. Timescales to execute any follow-up inspections will be proportionate to the nature of the interventions required resulting from the initial onsite inspection. Findings from this type of follow-up inspection will be published using our follow-up inspection report template and will be published separately from the original inspection report.

Escalation

If we have serious concerns during the inspection, we will inform the NHS board while the inspection team is still onsite, or as soon as possible. This will allow the NHS board to take immediate steps to address the issues, and protect the safety and welfare of women, birthing people, staff and the wider public.

In some instances, it will be necessary for us to implement our escalation process. This will be done in line with our Operating Framework: Healthcare Improvement Scotland and Scottish Government. During any stage of escalation, there will be ongoing dialogue with the NHS board.

If necessary, we may also refer our concern(s) to other relevant bodies to ensure NHS board compliance with a range of standards, best practice statements, legislation and national guidance and any impact this may have on the safe delivery of care.

Reporting

We publish inspection reports for women, birthing people, the public and care services, based on what we find during inspections.

We will report our findings on the following key areas:

- People's experience of safe accessible care and support that meets their needs and is based on relevant evidence, guidance and current best practice
- staffing arrangements are sufficient to ensure people receiving care are provided with the care and support that meets their needs
- leadership and culture, and
- infection control practices support a safe environment for both people experiencing care and staff.

The NHS board chief executive and key contacts will receive a draft version of the inspection report following the onsite inspection, this should be within nine weeks. However, this timeframe may be adjusted dependent on inspection findings and time required to review additional evidence. The NHS board will then have five working days from receipt of the draft report to agree the factual accuracy of the report and 10 working days to draft an improvement action plan. Following finalisation of the report by Healthcare Improvement Scotland, an embargoed report will go to Scottish Government approximately one week before publication.

The final inspection report and improvement action plan will be published on the Healthcare Improvement Scotland website approximately 12 weeks after the inspection.

Our Inspection Process Flowchart can be found in Appendix II.

Areas of good practice

When the inspection team gather strong evidence that an NHS board is delivering areas of good practice, ways of working or good outcomes for women, birthing people and families, this is reported as an area of good practice in the inspection report. This can then be used to share learning across NHS Scotland and to give recognition to the NHS boards involved.

Requirements and recommendations

A requirement sets out what action is required from an NHS board to comply with the standards published by Healthcare Improvement Scotland and the Scottish Government or other relevant agencies. These are standards which every woman, birthing person and families have the right to expect.

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.

Improvement action plans

The NHS board producing the improvement action plan is the owner of the action plan and holds responsibility for the necessary improvements to meet the requirements. The inspection team will review the content and timeframes of the actions outlined in the improvement action plan and may provide comments back to the NHS board and hospital with suggested amendments

The inspection team may also request to meet with colleagues from the NHS board or carry out another onsite visit to discuss and assess their implementation of improvement actions or to request evidence of completion.

Where appropriate, the inspection team may liaise with other teams within Healthcare Improvement Scotland for support, information and guidance.

Where appropriate, the inspection team may contact other agencies such as the Health and Safety Executive, to share serious concerns through a memorandum of understanding.

We will follow-up on the progress made by the NHS board and hospital in relation to the actions outlined in the improvement action plan. This will take place at approximately 18 weeks after the publication of the inspection report; although

the exact timing will depend on the severity of the issues highlighted by the inspection team and the impact on patient care.

Improvement action plans will remain published on our website with the inspection report. In the instance where a follow-up inspection has been carried out as a result of concerns, the improvement action plan will remain in addition to any further improvement action plans subsequent to the follow up inspection.

During future inspections to a hospital, we may review progress against previous improvement action plans in order to seek assurance that all actions were completed or have been progressed.

Additional follow-up inspections

During future inspections to a hospital, we may review progress against previous improvement action plans in order to seek assurance that all actions were completed or have been progressed. The nature of any additional follow-up activity will be determined by the level of risk presented to patients and may involve one or more of the following additional elements:

- a future announced or unannounced inspection (please see section: Follow-up inspections)
- a future targeted announced or unannounced inspection looking at specific areas of concern
- a meeting with key members of staff from the NHS board and hospital
- a written submission by the NHS board outlining progress made, along with supporting evidence, or
- another intervention deemed appropriate by the inspection team based on the findings of the initial inspection.

This process may continue until the inspection team is satisfied the necessary improvement actions have been completed and the requirement is met.

Where we have returned for a follow-up inspection, we will require the NHS board to produce a further improvement action plan. The NHS board will remain the owner of the action plan and holds responsibility for the necessary improvements to meet the requirements. We will publish and review any follow-up actions plans as detailed in the section: Improvement action plans.

Further information

Inspection information, can be found on the 'Inspecting and regulating care' section of the Healthcare Improvement Scotland website: Inspections, reviews and regulation - Healthcare Improvement Scotland

To raise any concerns you have about a hospital or NHS board you should raise this through the NHS board directly in the first instance or Healthcare Improvement Scotland's responding to concerns team: his.respondingtoconcerns@nhs.scot

Appendix I – List of national guidance

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

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Antenatal care (NICE, August 2021)
- CMO(2018)18 - Core mandatory update training for midwives and obstetricians (Scottish Government, December 2018)
- Food Fluid and Nutritional Care Standards (Healthcare Improvement Scotland, November 2014)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- gpp17-final-publication-proof.pdf (RCOG Maternity Triage good practice paper, December 2023)
- 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)
- 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: November 2022 (Healthcare Improvement Scotland, November 2022)
- Overview | Intrapartum care | Guidance | NICE (NICE, September2023)
- Person-centred care - The Nursing and Midwifery Council (NMC, December 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- Recommendations | Postnatal care | Guidance | NICE (NICE, April 2021)
- The best start: five-year plan for maternity and neonatal care - gov.scot (Scottish Government, January 2017)
- The Quality Assurance System (healthcareimprovementscotland.org) (Healthcare Improvement Scotland, September 2022)
- Scottish Patient Safety Programme (SPSP) | ihub | Health and social care improvement in Scotland - Scottish Patient Safety Programme (SPSP)
- Staff governance covid-19 guidance for staff and managers (NHS Scotland, January 2022)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018).

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Appendix II - Inspection process flowchart

Before

Before the inspection, we review a range of information provided by our Data Measurement and Business Intelligence team, and the NHS board's previous inspection reports and action plans, where these are available. We also meet with representatives from Scottish Government to discuss data and intelligence relevant to healthcare associated outbreaks and services pressures within the NHS boards.

During

We arrive at the hospital and inspect a selection of wards and departments and communal areas. We assess compliance with; key indicators of the delivery of care; leadership and culture and the management of safety and risk.

We carry out as much of our inspection activities as possible through observation of care and via discussion sessions, to avoid disruption to staff delivering care. We use a range of inspection tools to record findings to assist with gathering evidence.

Following the onsite inspection, we review evidence submitted by the NHS board and hold discussion sessions with key members of staff from the NHS board. If significant concerns are identified, we will implement our escalation procedure and consider carrying out a follow-up inspection of the hospital.

After

We publish reports for women, birthing people and families based on what we find during inspections. NHS staff can use our reports to find out what other hospitals or services do well and use this information to help make improvements. Our reports are available on our website at https://www.healthcareimprovementscotland.scot

We require NHS boards to develop, and then update, an improvement action plan to address the requirements we make. We check progress against the improvement action plan.