

NHS Greater Glasgow and Clyde	Paper No. 26/76
Meeting:	NHSGGC Board Meeting
Meeting Date:	25 June 2026
Title:	NHSGGC Response to HIS Unannounced Inspection Report – Maternity Services Safe Delivery of Care Inspection, QEUH
Sponsoring Director:	Professor Angela Wallace, Director of Nursing
Report Author:	Miss Freya Gillies, Business Manager - Corporate

1. Purpose

The purpose of the attached paper is to provide Board members with an overview of the findings, requirements and recommendations arising from the Healthcare Improvement Scotland (HIS) Unannounced Inspection of Maternity Services and the QEUH. Additionally, the paper will highlight to Board members the ongoing improvement work and governance structures in place to ensure successful and timely implementation of the recommendations and requirements.

2. Executive Summary

The paper can be summarised as follows:

- The HIS unannounced inspection of maternity services at QEUH (January–February 2026) identified 6 areas of good practice, alongside 4 recommendations and 26 requirements for improvement, across culture, professional practice and workforce.
- Key improvement areas relate to timeliness of care and patient flow, governance and oversight, environment and equipment, medicines management, workforce capacity, and organisational culture.
- NHSGGC had undertaken extensive assurance and improvement work since 2022, aligned to national reviews (Kirkup, Ockenden, NHS Lothian), including strengthening governance, workforce planning, and service redesign.
- A £4 million workforce investment has been agreed, supporting increased midwifery staffing, strengthened leadership roles, and recruitment of newly qualified midwives to address capacity and safety risks.

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- Actions to improve culture and leadership include a Board-wide staff survey, organisational development support, multidisciplinary training, and enhanced engagement through safety huddles and team-based initiatives.
- Professional practice and governance arrangements have been strengthened through increased senior oversight, MDT walkabouts, improved audit and clinical guidance processes, and clearer communication systems.
- A Maternity and Neonatal Improvement Programme has been established, co-chaired at Executive level, with direct reporting through the Transforming Together Executive Oversight Group and integration into Board governance structures.
- Progress is underway, with 7 requirements completed and 72% of actions delivered, and all requirements and recommendations targeted for completion by December 2026.
- Next steps include continued delivery of improvements, strengthened governance and reporting, and enhanced engagement with service users.

3. Recommendations

The Board is asked to note the:

1. findings of the HIS unannounced inspection and the associated 26 requirements and 4 recommendations.
2. significant programme of improvement work in progress to address the requirements and recommendations, including the £4 million incremental workforce investment and strengthened governance arrangements.
3. proposed governance and oversight arrangements, including direct reporting through the Transforming Together Executive Oversight Group and integration with Board governance.
4. scale and immediacy of the required response, and the importance of sustained organisational focus to deliver improvement and rebuild public confidence.

4. Response Required

This paper is presented for **assurance.**

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

• Better Health	<u>Positive</u> impact
• Better Care	<u>Positive</u> impact
• Better Value	<u>Positive</u> impact
• Better Workplace	<u>Positive</u> impact
• Equality & Diversity	<u>Positive</u> impact
• Environment	<u>Positive</u> impact

6. Engagement & Communications

- Ongoing communication at Directors Group 1
- Continued engagement with Maternity Services and leads
- Board Briefing on 17th June 2026

7. Governance Route

Proposed governance and oversight arrangements through the Transforming Together Executive Oversight Group

8. Date Prepared & Issued

Prepared: 11 June 2026

Issued: 19 June 2026

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1. Introduction

The purpose of this paper is to provide NHSGGC Board Members with an overview of the findings, requirements and recommendations arising from the Healthcare Improvement Scotland (HIS) Unannounced Inspection Report on Maternity Services Safe Delivery of Care at Queen Elizabeth University Hospital (QEUH), published on 4th June 2026.

Additionally, the paper outlines the preparatory and remedial work undertaken by NHSGGC and highlights the governance and oversight processes in place to deliver sustained improvement across maternity services. NHSGGC acknowledges the requirements and recommendations made by Healthcare Improvement Scotland and is committed to completing these in a timely manner.

2. Background: Previous Assurance Activity

Since 2022, NHSGGC has undertaken significant maternity assurance work to strengthen the service which remains ongoing. A summary is provided:

In November 2022 & June 2023: The Executive Nurse Director commissioned the Director of Midwifery to lead internal reviews identifying gaps within leadership, culture, professional practise and workforce. Resulting in the introduction of monthly senior walkabouts, a Behaviours Charter, expanded service improvement projects and incremental staffing increases.

In December 2022: Benchmarking against the Kirkup report on East Kent prompted the establishment of the Maternity Voice Partnership and third-sector engagement. As well as, strengthened bereavement and public protection roles and governance restricting (including aligned Terms of References for local Safety Groups).

By May 2023: Self-assessment against the Ockenden report rated amber overall. The actions from this self-assessment resulted in an uplift in Practice

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Development and Clinical Risk resource, the commissioning of clinical skills midwife roles and new retention and preceptorship programmes.

During November 2025: An internal review against NHS Lothian HIS Inspection findings was completed. Key risks were highlighted in; senior management oversight, delays in care, staffing and estates. As a result, investment included additional midwives and a new Lead Midwife for Quality, Risk and Governance. Additionally, as various Maternity Inspection Reports were published, NHSGGC continued to benchmark against these.

In addition, ward-level readiness was strengthened through routine quality and safety processes, the introduction of safe-care checklists and bi-weekly meetings with Estates, IPC and Midwifery colleagues. The Maternity Care and Compassion Assurance Team Tool (MCCATT) was developed in 2024 to support peer and external review across environment, documentation and patient experience measures.

It is acknowledged that whilst significant preparatory work was undertaken in advance of the inspection, the inspectors found many areas for improvement.

3. HIS Inspection Findings

Following the unannounced inspection on 27 and 28 January 2026, the report highlighted six areas of good practise, four recommendations and twenty-six requirements for improvement.

3.1 Areas of Good Practise:

Within the areas of good practice, the inspection noted the effective use of an evaluated maternity triage system with a dedicated 'Red Phone' for escalation, an established BAME maternity group, a supportive learning environment for student midwives, a well-functioning Maternity Voice Partnership, the use of positive birth language and, positive and kind care to women, babies and their families.

3.2 Recommendations for Improvement:

In the report, HIS made four recommendations which involved, enabling midwifery staff to undertake newborn examinations, adopting a more flexible approach to partner presence when babies are unwell in the neonatal unit, improving trauma-informed training for all staff and lastly, to improve bereavement training compliance alongside the establishment of a dedicated space for bereaved families.

3.3 Requirements for improvement:

The twenty-six requirements cover a variety of themes including; governance, clinical pathways, environment, workforce and culture.

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- **Timely care and flow** - Requirements address the need for timely review of women in maternity assessment, delivery of care in the right place at the right time, effective governance when delays occur, and consistent transitional care on postnatal wards.
- **Governance and oversight** - Clinical guidelines must be current; documentation audits must cover VTE risk assessment, MEWS, postpartum haemorrhage, obstetric anal sphincter injury, data completeness and CTG interpretation. Adverse event governance must ensure reliable reporting, HIS framework and duty of candour compliance, and embedded learning from SAERs and complaints.
- **Environment and equipment** - Requirements cover maintenance enabling decontamination, ensuring the availability of fetal monitoring and emergency equipment, call bell access, IPC compliance (hand hygiene, linen, sharps, uniform, bed spacing, cleanliness), water outlet flushing, secure storage of hazardous products, and fire safety.
- **Medicines management** - Safe storage and administration with robust governance oversight.
- **Workforce** - Appropriate staffing to reduce delays and support safety and wellbeing; clear systems for managing staffing risks; protected leadership time; and robust training systems.
- **Culture** - Development of psychological safety; a supportive environment for raising concerns; and consistent capture of maternity risks in hospital safety huddles.

From the twenty-six requirements and four recommendations, currently 165 actions have been identified to support the achievement of these. All actions are being monitored closely via the action plan.

As of June 2026, seven requirements have been completed with 72% of supporting actions achieved additionally, a further eight requirements are on track to be completed through July and August 2026. All requirements and recommendations are scheduled to be achieved by December 2026.

4. Work Undertaken – Post Inspection

Within the key themes identified from the report requirements and recommendations, as well as areas of improvement already identified within the maternity service prior to inspection, significant improvement has been made.

4.1 Workforce Investment:

NHSGGC has agreed £4 million investment in maternity staffing, including:

- £1.5 million recurring investment for 2 WTE Clinical Safety Midwives, 2 WTE Unit Coordinators, and 18 WTE newly qualified midwives (all posts offered).
- 19 WTE posts for BSOTS & Triage (agreed February 2025, in post February 2026)
- 15 WTE posts for Labour Ward (agreed November 2025, in post April 2026)

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- In total, 62 WTE newly qualified midwives have received confirmed job offers, covering 100% of maternity leave in labour wards, all vacancies, and anticipated attrition for six months.

4.2 Culture and Leadership:

A five-week culture survey launched in April 2026 received 520 responses, with results currently being analysed and team-based coaching and Civility Saves Lives session for staff have been arranged via Organisation Development support. Also, a joint NMC/GMC session for the multidisciplinary team on Professional Behaviours and Team working as been arranged and external safety training with Baby Lifeline is commissioned for Autumn 2026. In addition, medical attendance at cross-site huddles has been implemented.

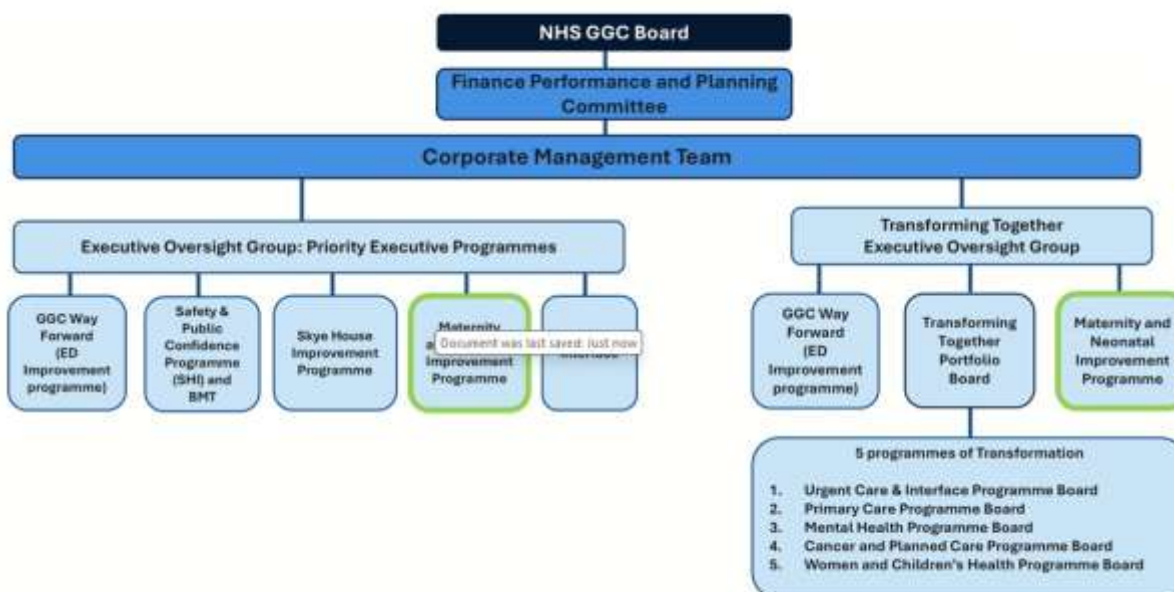
4.3 Professional Practise:

In relation to the recommendations within Professional Practise, MDT walkabouts have increased and now include Pharmacy, IPC, Facilities and Estates colleagues. Senior oversight of the weekly Senior Charge Midwife checklist completion has been strengthened and there are now monthly walkabouts in each unit with the Associate Chief Midwife. As well as this, key SOPs and guidance have been re-shared, medicines management audits have been reviewed, and new guidance has been issued for daily emergency trolley checks.

5. Governance and Oversight Arrangements:

In response to the inspection report, NHSGGC is progressing work via a locally led improvement programme which is embedded within both the Board and Transforming Together governance structures.

Figure 1: Maternity Improvement Programme Governance



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The Maternity and Neonatal Improvement Programme will be co-chaired by the Chief Operating Officer / Deputy Chief Executive and the Director of Nursing. Direct reporting through the Transforming Together Executive Oversight Group ensures there is clear Executive visibility. Additionally, because the programme is fully integrated into existing organisational governance, there is a consistent escalation route to the NHSGGC Board, via both CMT and FP&P. Direct clinical and executive dialogue ensures that both operational and clinical issues are addressed at the appropriate level.

Within this governance structure, monthly domain-based status reporting will be used to track progress, risks and escalation points aligned with the HIS requirements and recommendations. Also, an indicative delivery timeline (to December 2026) phases immediate, medium-term and longer-term improvement actions.

Overall, this governance model ensures clear organisational accountability and transparency and increases public confidence.

6. Conclusion

The establishment of the Improvement Programme ensures that the delivery of the HIS requirements and recommendations continues to progress, with all anticipated to be achieved by December 2026. Also, the improvement programme ensures that a robust organisational infrastructure for oversight, governance and visibility is maintained at all levels.

As work continues to progress, routine updates will be provided through executive and board governance as well as structured reporting to HIS.

To ensure successful progression within the programme, consistent dialogue with patients and clinical teams via the established structures will be enforced whilst additionally, a specific exercise will be undertaken to seek the views of 300 users of maternity services – ensuring patient and family members voices are properly understood.

7. Recommendations

The Board is asked to note the:

1. Findings of the HIS unannounced inspection and the associated 26 requirements and 4 recommendations.
2. Significant programme of improvement work in progress to address the requirements and recommendations.
3. Proposed governance and oversight arrangements, including direct reporting through the Transforming Together Executive Oversight Group and integration with Board governance.

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4. Scale and immediacy of the required response, and the importance of sustained organisational focus to deliver improvement and rebuild public confidence.