

NHS Greater Glasgow and Clyde	Paper No. 26/15
Meeting:	NHSGGC Board Meeting
Meeting Date:	26 February 2026
Title:	HIS Safe Delivery of Care Inspection – Queen Elizabeth University Hospital (QEUH) Maternity Unit
Sponsoring Director/Manager:	Prof Angela Wallace, Executive Director of Nursing Mr William Edwards, Deputy Chief Executive, NHSGGC
Report Author:	Ms Mary Ross-Davie, Director of Midwifery

1. Purpose

To provide the Board with an update on the initial informal feedback of the recent unannounced inspection of QEUH Maternity Unit by Healthcare Improvement Scotland. The paper also outlines the actions taken in response, and progress against identified risks.

2. Executive Summary

The paper can be summarised as follows:

- An unannounced inspection of QEUH Maternity Unit by Healthcare Improvement Scotland on 27 and 28 January 2026 identified both positive care delivery and areas for improvement. A follow up inspection took place on the 16 February 2026.
- Immediate actions were taken to address areas for improvement that were identified.
- As was previously highlighted to the Board, significant progress has been made in regard to recruitment, retention, culture and early-career support. We continue to identify staffing requirements in line with the Nursing and Midwifery Workforce and workload planning tools.
- As anticipated, delays in care have been highlighted in the initial feedback by the inspectors which be subject to further review.

3. Recommendations

The NHS Board is asked to consider the following recommendations:

- Note the recent HIS inspection
- Note the ongoing actions undertaken by maternity leadership, Acute Services, Estates, IPC and Facilities.
- Endorse the preparatory work underway in advance of further HIS visits to QEUH, PRM and RAH. Cross-site learning and proactive walkarounds are taking place.
- Recognise the significant response from teams in responding to initial feedback.
- Note continued focus on the safe delivery of care across our maternity services.

4. Response Required

This paper is presented for awareness.

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

This paper is presented as an update to an ongoing inspection.

7. Governance Route

This paper is presented as an update to an ongoing inspection.

8. Date Prepared & Issued

Date prepared: 16 February 2026

Date issued: 19 February 2026

1. Purpose of Paper

This paper provides the Board with visibility on the unannounced inspection of the QEUH Maternity Unit undertaken by Healthcare Improvement Scotland (HIS) on 27 and 28 January 2026.

It also provides awareness of the follow-up inspection visit conducted on 16th February 2026, alongside an assessment of the key risks identified and the proposed next steps to ensure sustained improvement and assurance.

The Board is asked to note ongoing improvement work.

2. Key Issues

The service has submitted two evidence dossiers (on 2 February and 10 February) and will provide further evidence by 17 February.

Immediate actions were taken to address areas for improvement that were identified.

Our focus remains on reducing Maternity activity related pressures, reducing Induction of Labour (IOL) delays and reviewing Midwifery staffing.

We continue to identify staffing requirements in line with the Nursing and Midwifery Workforce and workload planning tools.

In addition to the above, cultural improvement support, organisational development (OD) involvement, and strengthened governance arrangements are required to continue our improvement journey.

3. Background

During the inspection activity undertaken on 27 and 28 January, HIS inspected all maternity inpatient areas, observed care delivery, and attended four operational huddles across the unit. HIS provided positive feedback that staff were welcoming, compassionate, and delivering good-quality care, with effective multidisciplinary team working observed.

A number of concerns were identified as part of the initial feedback, including infection prevention and control practice and the environment. Additional concerns related to inappropriate equipment storage in corridors and non-clinical spaces.

On 10th February, a further follow-up letter was received which sought further information. In line with the inspection process, the service is continuing to respond systematically to each area of concern raised, providing supporting evidence and a clear statement of actions underway within its formal submission.

4. Assessment

4.1 Immediate Response following Inspection on 27 and 28 January (Actions Completed 29 January – 3 February)

All initial areas of feedback were addressed

A communication pack and daily checklists were issued for shift leaders to support consistent oversight, and deep dive walkarounds were undertaken across **all maternity sites** with Estates, Facilities, Infection Prevention and Control (IPC), and Acute Division leadership.

4.2 Follow-up Visit – 16 February

The follow-up visit on 16 February confirms:

- Improvement in several areas made
- Interviews with staff were carried out as part of the visit
- Discussions with the maternity leadership team requested as part of the normal inspection methodology.

5. Recommendation

The Board is asked to:

1. Note the recent/ongoing HIS Safe Delivery of Care Inspection within QEUH Maternity
2. Note the Immediate response to initial feedback by maternity leadership, Acute Services, Estates, IPC and Facilities.
3. Note the ongoing preparatory work in advance of further HIS visits to QEUH, PRM and RAH. Cross-site learning and proactive walkarounds have and are taking place
4. Awareness of the continued focus on workforce, culture and governance improvements.