Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Queen Elizabeth University Hospital

NHS Greater Glasgow and Clyde

27 – 28 January 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 acute hospital 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

The Queen Elizabeth University Hospital maternity building is a standalone building that sits on the wider more recently established Queen Elizabeth University Hospital site which opened in 2015. The maternity building has been open in its current configuration for over 20 years. The maternity service supports around 4,800 births each year.

About this inspection

We carried out an unannounced inspection to Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde on Tuesday 27 and Wednesday 28 January 2026 using our safe delivery of care inspection methodology. We inspected the following areas:

- Antenatal ward
- Labour ward
- Maternity Assessment Unit
- Postnatal ward 47
- Postnatal ward 50

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with women such as during mealtimes
- spoke with women, visitors and ward staff and
- accessed women health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Greater Glasgow and Clyde 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 Monday 16 February 2026, we carried out an unannounced revisit to maternity services within Queen Elizabeth University Hospital to seek assurance in relation to a number of concerns we raised on the initial inspection.

Throughout February and March 2026, we held several virtual discussion sessions with key members of NHS Greater Glasgow and Clyde staff to discuss the evidence provided and the findings of the hospital 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 Greater Glasgow and Clyde, and particularly all staff at Queen Elizabeth University Hospital, for their assistance during our inspection.

A summary of our findings

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

Despite increased acuity, we observed staff working hard to provide kind and respectful care to women and their families. However, during our onsite inspection, women told us of varied experiences of maternity services within the Queen Elizabeth University Hospital.

We observed multidisciplinary teams working in most areas inspected, with staff describing positive working relations between midwifery, obstetric, anaesthetic and the health care support team within individual wards. However, some staff described concerns about a lack of civility between different teams within the service due to the consistent pressure for transfers of patients at times of high acuity. Staff also described a disconnect between staff delivering care and senior managers awareness and oversight of the reality of daily pressures within maternity services.

On the first day of our inspection, we identified concerns relating to poor general cleanliness of ward areas, poor compliance with some infection prevention control processes, fire safety regulations, medicines management and emergency equipment checks. These concerns were raised with senior managers and immediate actions were taken to address these concerns. We wrote to NHS Greater Glasgow and Clyde to highlight concerns relating to the healthcare environment, safe management of medicines assurance and oversight of concerns regarding staffing and culture on 10 February 2026. Further assurance was requested from NHS Greater Glasgow and Clyde executive team within a letter of serious concern.

In line with our inspection methodology we returned to carry out a return visit on 16 February 2026 to assess progress with concerns we had raised during our initial onsite inspection. During this return visit, we observed some improvements in the cleanliness of the environment and care equipment and emergency equipment checks. However, during the inspection, further areas for improvement were identified, including the management and oversight of incident reporting. Staff described barriers to submitting incident reports and a lack of assurance that submitted reports are sufficiently reviewed.

Staff raised concern regarding midwifery skill mix impacting on the ability to provide safe maternity care and maintain patient safety. Many staff told inspectors they were unable to have a break due to work pressures and acuity. As part of the inspection, we observed that staff being unable to have breaks appeared to become an accepted practice within the service.

Throughout the inspection NHS Greater Glasgow and Clyde responded and cooperated with the inspection process. However, as a result of a continued lack of assurance in relation to governance, oversight and the management of patient safety impacting on the safe delivery of care at the Queen Elizabeth University Hospital maternity services, on 19 March 2026 we

formally escalated these concerns at level 1 in line with Healthcare Improvement Scotland and Scottish Government Operating Framework.

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

This inspection resulted in six areas of good practice, four recommendations and 26 requirements.

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

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

We expect NHS Greater Glasgow and Clyde 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 Queen Elizabeth University Hospital resulted in six areas of good practice.

Domain 1	
1	NHS Greater Glasgow and Clyde utilise an evaluated system within maternity triage and has implemented a dedicated 'red phone' system (see page 21).
2	NHS Greater Glasgow and Clyde have a Black, Asian and Minority Ethnic (BAME) maternity group (see page 21).

Domain 2	
3	Student midwives described a friendly and supportive learning environment (see page 27).
4	We observed the use of positive birth language within the service (see page 27).

Domain 6	
5	We observed staff providing positive and kind care to women, babies and their families (see page 43).
6	NHS Greater Glasgow and Clyde have an established maternity voice partnership (see page 43).

Recommendations

The unannounced inspection to Queen Elizabeth University Hospital resulted in four recommendations.

Domain 2	
1	NHS Greater Glasgow and Clyde should consider improving trauma informed training for all staff (see page 27).

Domain 4.3	
2	NHS Greater Glasgow and Clyde should continue to take steps to enable midwifery staff to undertake examination of the newborn as per Best Start recommendation number 23 (see page 40).

Domain 6	
3	NHS Greater Glasgow and Clyde should consider a flexible approach to the presence of partners, to ensure that families can stay together, with suitable accommodation and facilities being provided when babies are unwell in the neonatal unit (see page 44).
4	NHS Greater Glasgow and Clyde should consider improving staff bereavement training compliance and providing dedicated space for caring for bereaved families (see page 44).

Requirements

The unannounced inspection to Queen Elizabeth University Hospital resulted in 26 requirements.

Domain 1	
1	NHS Greater Glasgow and Clyde must ensure timely review for women presenting to maternity assessment to support the safe delivery of care (see page 21). This will support compliance with: Health and Social Care Standards (2017) 4.11, 4.4 and Quality Assurance Framework (2023) criteria 1.3 and 1.5
2	NHS Greater Glasgow and Clyde must ensure effective governance and oversight to inform improvement and mitigate risk when delays to care occur (see page 21). This will support compliance with: Health and Social Care Standards (2017) 1.19, 1.24 and Quality Assurance Framework (2023) criteria 2.5 and 1.5
3	NHS Greater Glasgow and Clyde must ensure all women who require interpreter services have access to approved interpretation services (see page 21). This will support compliance with: Health and Social Care Standards (2017) and 1.19, 2.9, 2.10 and Quality Assurance Framework (2023) criteria 3.1 and 6.1 and 6.2
4	NHS Greater Glasgow and Clyde must ensure that patients are provided with the right care, in the right place, at the right time by the right professional team. This includes but is not limited to: (i) Scheduled care within maternity assessment unit (ii) Non-obstetric unscheduled presentation and admissions (iii) Appropriate level of clinician review (see page 21). This is to comply with Health & Social Care Standards (2017) Standard 1, criteria 1.19, 1.20 and Standard 3, criteria 3.14-3.19 and Standard 4, criteria 4.11,4.14,4.27.
5	NHS Greater Glasgow and Clyde must ensure effective oversight to ensure essential patient equipment is available and ready for use. This includes, but is not limited to: (i) Fetal monitoring equipment (ii) Obstetric emergency equipment including medication (see page 21). This will support compliance with: Health and Social Care Standards (2017) criteria 4.14 and Healthcare Improvement Scotland Quality Assurance Framework (2023) criteria 2.6.

6	NHS Greater Glasgow and Clyde must ensure effective senior management oversight and support, to ensure the fundamentals of care are provided and reduce the risks for women, their babies and staff at times of extreme pressure within maternity services, including but not limited to: (i) Preserving dignity (ii) Providing adequate analgesia (iii) Ensuring appropriate level of care provision for clinical situation for women and babies including monitoring (see page 21). This will support compliance with: Health and Social Care Standards (2017) criterion 1.2, 1,4, 1.19, 1.20, 1.24, 4.11 and Healthcare Improvement Scotland Quality Assurance Framework (2023) criteria 4.1 and 7.1.
7	NHS Greater Glasgow and Clyde must ensure systems and processes are in place to monitor and support a consistent approach to the provision of transitional care within the postnatal wards (see page 21). This will support compliance with: Best Start: A five-year forward plan for Maternity and Neonatal care in Scotland, Healthcare Improvement Scotland Quality Assurance Framework (2023) Criterion 1.5 and Health and Social Care Standards (2017) Criteria 1.19, 1.20 and 4.11.

Domain 2	
8	NHS Greater Glasgow and Clyde must ensure the continued development of a culture which promotes and supports staff psychological safety (see page 27). This will support compliance with: Healthcare Improvement Scotland Quality Assurance Framework (2023) Criteria 2.1.
9	NHS Greater Glasgow and Clyde must ensure effective governance and oversight of adverse events to support and improve the quality and safety of care, including but not limited to: (i) Reliable and timely reporting of all adverse events (ii) Compliance with the Healthcare Improvement Scotland national adverse events framework (iii) Compliance with statutory duty of candour (iv) Actions from adverse events reviews are implemented timely into practice and monitored to ensure improvement is embedded (see page 27). This will support compliance with: Healthcare Improvement Scotland A national framework for reviewing and learning from Adverse events in NHS Scotland and Healthcare Improvement Scotland Quality Framework (2018) criteria 2.5

Domain 4.1	
10	NHS Greater Glasgow and Clyde must ensure governance and oversight of unit data and ensure a robust documentation audit to support learning and improvement, including but not limited to: (i) Venous thromboembolism risk assessment (ii) Maternity early warning score (MEWS) chart (iii) Postpartum haemorrhage (iv) Obstetric anal sphincter injury (v) Data completeness (vi) Cardiotocography interpretation (see page 34). This will support compliance with Quality Assurance Framework (2023) criteria 2.6.
11	NHS Greater Glasgow and Clyde must continue to ensure clinical guidelines are up to date and reviewed within agreed timescales (see page 34). This will support compliance with: Quality Assurance Framework (2023) criteria 5.4 and the Health and Social Care Standards (2017) criteria 4.11.
12	NHS Greater Glasgow and Clyde must ensure the healthcare built environment is effectively maintained to allow decontamination and ensure potential risks to patients and staff safety are effectively identified and mitigated (see page 34). This will support compliance with: National Infection Prevention and Control Standards (2022) and Infection Prevention and Control Standards.
13	NHS Greater Glasgow and Clyde must ensure that all women have access to a call bell (see page 34). This will support compliance with: Health and Social Care Standards (2017) Criterion 3.17.
14	NHS Greater Glasgow and Clyde must ensure compliance with national guidance. This includes but is not limited to: (i) Hand hygiene (ii) Linen management (iii) Sharps management (iv) Uniform policy (v) Transmission based precautions (vi) Correct bed spacing (vii) Environmental and equipment cleanliness (see page 34). This will support compliance with National Infection Prevention and Control Standards (2022).

15	NHS Greater Glasgow and Clyde must ensure infrequently used water outlets are flushed in line with current national guidance and support staff in understanding the process of assurance regarding water flushing (see page 34). This will support with compliance with National Infection Prevention and Control Manual (2023) and Scottish Health Technical Memorandum SHTM 04-01 part B (2014) 'Water safety for healthcare premises Part B:Operational management.'
16	NHS Greater Glasgow and Clyde must ensure the safe and secure use of medicines at all times, including the governance and oversight of compliance with safe storage and administration of medicines (see page 34). This will support compliance with: The Royal Pharmaceutical Society Professional guidance on the safe and secure handling of medicines (2024) and relevant codes of practice of regulated healthcare professions.
17	NHS Greater Glasgow and Clyde must ensure all hazardous cleaning products are securely stored and labelled appropriately, as per manufacturers' guidelines (see page 34). This will support with compliance of Control of Substances Hazardous to Health (COSHH) Regulations (2002).
18	NHS Greater Glasgow and Clyde must ensure fire risk assessments are up to date and fire actions and improvements identified within fire safety risk assessments are addressed. This includes, but is not limited to: (i) Staff training compliance (ii) Safe storage of medical gases and appropriate signage (see page 34). This will support compliance with: Fire Safety (Scotland) Regulations 2006.

Domain 4.3	
19	NHS Greater Glasgow and Clyde must ensure that there are clear, consistent systems and processes in place to support management of any potential identified staffing risks within maternity services. This includes accurate recording of any clinical risk, escalation, mitigation/inability to mitigate, communication of outcomes with all relevant clinical teams and any disagreements with decisions made (see page 41). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
20	NHS Greater Glasgow and Clyde 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. Assessments should consider skill mix of available

	staff, dependency and complexity of patients to support staff to confidently apply and record professional judgement in relation to required staffing when declaring “safe to start” (see page 41). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
21	NHS Greater Glasow and Clyde must ensure oversight of potential risks within maternity services are consistently captured and discussed where appropriate within the wider hospital safety huddle (see page 41). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
22	NHS Greater Glasgow and Clyde must ensure a supportive and inclusive working environment for staff which supports staff to raise concerns, with systems and processes in place to ensure that these concerns are responded to and appropriately addressed (see page 41). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019, guiding principles 12IA.
23	NHS Greater Glasgow and Clyde must ensure that there are systems and processes in place to safeguard all clinical leaders within maternity services being able to access appropriate protected leadership time in order to fulfil their leadership and management responsibilities such as oversight of quality of care and provision of support for staff. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls and/or increased service demand (see page 41). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Health and Social Care Standards (2017) criteria 3.14, 3.15 and 3.19.
24	NHS Greater Glasgow and Clyde must have robust systems and processes in place to ensure that all staff are appropriately trained to carry out their role. This includes protected learning time and monitoring of training completion (see page 41). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Health and Social Care Standards (2017) criteria 3.14, 3.15 and 3.19.
25	NHS Greater Glasgow and Clyde must ensure that maternity services are appropriately and effectively staffed in order to reduce delays to care, preserve patient safety and support wellbeing by enabling staff to take statutory rest breaks on shift (see page 41). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

Domain 6	
26	NHS Greater Glasgow and Clyde must ensure learning and improvement from themes highlighted from patient complaints. (see page 44). This will support compliance with Quality Assurance Framework (2023) Criteria 7.1.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We observed staff working hard to provide care to women and their families. However, we raised concern with senior managers regarding assurance and oversight of the safe delivery of care within maternity services.

Queen Elizabeth University Hospital includes one of Scotland's biggest maternity units. As a specialised centre for cardiology and the countries only facility for performing fetal medicine surgeries, the unit receives urgent referrals and transfers from across the country for specialised care. It is one of five maternity units within NHS Greater Glasgow and Clyde and operates a cross-site approach to providing care in times of high acuity. At the time of inspection, maternity services within Queen Elizabeth University Hospital were experiencing pressures, like many of NHS Scotland services, such as reduced staff availability and increased patient acuity. Despite this, staff were working hard to provide care to women and their families.

During the onsite inspection, we identified concerns with the quality of ward assurance checks and readiness to support the safe delivery of care within all areas inspected. Concerns included cleanliness of the healthcare environment, poor compliance with some infection prevention control processes, fire safety regulations, medicines management and emergency equipment checks which will be discussed in further detail throughout this report. These concerns were raised with senior managers at the time of inspection for immediate action and we wrote to NHS Greater Glasgow and Clyde on 10 February 2026, to highlight concerns regarding the safe delivery of care. In line with our inspection methodology, we returned to carry out a return visit on 16 February 2026, to assess progress with concerns we had raised during our initial onsite inspection. NHS Greater Glasgow and Clyde responded and cooperated with the inspection process. However, as a result of a continued lack of assurance in relation to governance, oversight and management of patient safety impacting the safe delivery of care at the Queen Elizabeth University Hospital maternity services, on 19 March 2026 the chief executive for Healthcare Improvement Scotland formally escalated these concerns at level 1 in line with Healthcare Improvement Scotland and Scottish Government Operating Framework to the chief executive of NHS Greater Glasgow and Clyde.

The maternity assessment unit within Queen Elizabeth University Hospital is a specialised triage assessment area which provides 24 hours a day, seven days a week unscheduled (emergency) care from 12 weeks of pregnancy until birth and from birth to six weeks postnatal. The unit adopted the Birmingham Symptom Specific Obstetric Triage System (BSOTS) in 2022. BSOTS is an evaluated system that assesses and prioritises pregnant and recently postnatal women with unexpected problems or concerns. The aim of the system is to improve safety, efficiency and communication.

The maternity assessment unit is accessed by women following telephone consultation or self-presentation. Best practice described by the Royal College of Obstetricians and Gynaecologists recommends telephone triage is undertaken by a midwife dedicated to triaging calls for all or part of their shift. Further information can be found here. During the inspection telephone triage was carried out at the nurses' station, however, it was not assigned to a dedicated member of staff. In discussion with senior managers, they advised of a plan to introduce a central telephone triage hub for all maternity services within NHS Greater Glasgow and Clyde, based within the Princess Royal maternity unit. This will commence in March 2026, which will align with recommendations from the Royal College of Obstetricians and Gynaecologists good practice paper.

Senior managers told us about a structured programme of staff engagement undertaken prior to the introduction of the telephone triage hub. This included a programme of communication and engagement, face to face training and a triage improvement short life working group established on25 August 2025 and meeting fortnightly. Online staff engagement sessions were offered throughout the programme to support consultation and feedback from staff. However, staff reported being apprehensive around this change to practice describing a lack of communication on the change from the senior management team and concern regarding the impact on staffing levels. They described concerns that the introduction of the triage hub will result in a reduction of the current midwifery staffing complement within the maternity assessment unit. Senior managers confirmed that following the implementation the staffing establishment would increase by 0.5 midwifery whole time equivalent staff.

We observed NHS Greater Glasgow and Clyde has implemented a 'red phone' system within the maternity assessment unit to support direct, prioritised communication between the Scottish Ambulance Service and hospital staff. This system facilitates timely, clear and prioritised communication during critical information sharing, supporting safer and more effective coordination of patient care.

Staff understood the principles of the BSOTS in place and the expected clinical care timeframe for presentations and we did not observe any delays to care. However, advice displayed to women attending the unit implied waiting times for review may vary depending on the capacity and acuity of the unit which is in contrary to the aim of the system.

Time to first assessment under the Birmingham Symptom Specific Obstetric Triage System should occur within 15 minutes from women's presentation to the service. We were provided with the triage performance activity data relating to the first day of the inspection. From this we observed the time from admission to the service and initial triage assessment of women varied between 17 to 21 minutes. When required, most women received medical review within 42 minutes. We requested data oversight for the triage department for the six months prior to our inspection. This demonstrated the initial assessment of women attending the unit was undertaken within 15 minutes for 61.6% of attendees which falls below the expected 80% target for units utilising BSOTS. Further analysis of ongoing midwifery and medical care assurance and compliance was limited due to areas of incomplete documentation at the time of women's attendance which impacts available data essential to audit. Only 17% of the 5,400 attendances had appropriate documentation to support review of available data and of these 17%, 45% of the women received care in line with BSOTS recommendations. We raised the lack of assurance regarding timely unscheduled care with the executive team who acknowledged delays within the maternity assessment unit. They advised us that the introduction of the centralised telephone hub commenced on the 2 March 2026 and since this introduction they are continuing to monitor data to assess performance. A requirement has been given to support improvement in this area.

The Royal College of Obstetricians and Gynaecologists recommend only women requiring unscheduled care are seen within maternity triage to prevent competing priorities and allow for the provision of focused unscheduled care. However, we observed scheduled care such as reviews of women following ultrasound assessment are also undertaken within the maternity assessment unit. Staff told inspectors this impacted on their ability to prioritise unscheduled care. A requirement has been given to support improvement in this area.

MBRRACE 2025 report Saving Lives, Improving Mothers' Care details the maternal deaths across the UK between 2021-2023. Over half of the women who died (56%) were known to have a pre-existing medical condition. Best practice described by the Royal College of Obstetricians and Gynaecologists recommends a system is in place to ensure women are directed to the correct department. The standards set within the Nursing and Midwifery Code to preserving safety stipulate nurses and midwives work within limits of their competency. Further information can be found here.

Staff we spoke with described instances of pregnant women attending the maternity assessment unit with chest pain and other non-obstetric complaints. This was also highlighted as a concern from staff within the maternity inpatient wards who told inspectors that at times, pregnant women with cardiac and neurological complications are admitted to maternity wards. Although staff discussed good collaborative working between the obstetricians and the wider acute multidisciplinary teams, they expressed concerns around their own lack of professional knowledge and competency of providing care for women with these complex care needs, unrelated to maternity or obstetric care.

Staff described a lack of guidance in place to support them to care for women with non-obstetric related complex care needs and the oversight of these women boarding within maternity services was not clear. We requested evidence of any guidance to support staff with appropriate admission to maternity services with non-obstetric issues and the maternity assessment unit criteria. Senior managers provided, “Chest pain and breathlessness in pregnancy” guidance that had been implemented in December 2025. However, there remains a lack of formalised criteria or care pathways for non-obstetric complications in place to support staff in this area. In discussion with senior managers, they acknowledged the need for complex antenatal inpatient care and the need for multidisciplinary input from acute services for these women. To ensure the safe delivery of care, women should be in the right place, at the right time and cared for by the right professional team, supported by evidence-based clinical guidance to meet their clinical needs. A requirement has been given to support improvement in this area.

Labour ward is located on the ground floor and can be accessed via the main maternity entrance or dedicated ambulance bay. The ward has access to 11 birth rooms and provides high dependency level care within a two bedded bay and increased observation area within the three bedded bay for women in the antenatal and postnatal period who have increased care needs. This may include women who have a pre-existing health complication or who have experienced complications during birth. Two maternity theatres are available within the labour ward; one assigned for planned caesarean births Monday to Friday during the day and the other is assigned for unplanned births. Overnight, both theatres may be used to facilitate unplanned caesarean birth or assisted vaginal birth. Obstetric and obstetric anaesthetic and theatre teams are available for unplanned labour ward activity 24 hours a day, 7 days a week. Planned caesarean births are staffed by a separate midwifery, obstetric and theatre team, led by a band 7 midwife responsible for overseeing this activity. During the onsite inspection the labour ward was operating at full capacity and we observed good visibility of staff and clinical leadership in the area.

Induction of labour is a practice that is undertaken to artificially induce labour. This can be in response to concerns with the mothers or unborn baby’s health. Delays to the induction of labour process are associated with increased risk of adverse maternal and perinatal outcomes. At the time of inspection, we observed delays to the induction of labour process of up to 21 hours due to staffing and capacity pressures. During our inspection we observed oversight of ongoing delays and planned inductions being discussed by the lead midwifery team at the cross-site huddle which occurred at 09:15am on the second day of inspection. In discussion with staff and within evidence provided by NHS Greater Glasgow and Clyde, we observed delays to the induction of labour process occurred frequently during the six months prior to inspection. There was evidence of women experiencing delays which exceeded 100 hours, potentially up to 190 hours, due to staffing and capacity within the unit. In discussion with senior managers and within evidence provided we were made aware of improvement work undertaken by NHS Greater Glasgow and Clyde regarding induction of labour. This included the recruitment of a project midwife, development of patient information leaflets and new care pathways to support outpatient induction. We

also observed that a scoping exercise had been undertaken by senior managers to understand the delays faced by women during the induction of labour process. This included time from commencing the induction of labour process to birth of the baby but did not allow for identification of any delays during the process. A requirement has been given to support improvement in this area.

Timely access to labour ward and one-to-one midwifery care is a fundamental part of maternity care. Research consistently demonstrates this improves outcomes for women and their babies, reducing intervention and adverse outcomes. During our inspection most staff we spoke with raised concern regarding timely access to labour ward for women. NHS Greater Glasgow and Clyde provided incident reports submitted by staff for the six months prior to this inspection in relation to patient safety. These reports demonstrated delays occurred in accessing labour ward for women in established labour, delays in the provision of one-to-one midwifery care and delays to transfer to labour ward for women during the induction of labour process. Some incident reports contained details of delays which involved multiple women and some reports did not include the number of women affected, making it difficult to identify fully how many women are affected by these delays. However, 6% (23) of all available incident reports documented a delay in accessing labour ward, one-to-one care or induction of labour. From available data these delays were experienced by at least 128 women in this six month period. Of the 128 women, 76 women were delayed in transfer to labour ward and 24 women were delayed or experienced pausing of the induction of labour process.

Delays can impact women’s dignity, choice of analgesia and can prevent a basic level of maternal and fetal monitoring being offered which could delay timely recognition of deterioration and need for intervention. The psychological impact of delayed maternity care, including delayed analgesia, on women’s long term mental health and birth experience is well documented, not only for the current pregnancy, but subsequent pregnancies as well. We raised concerns with senior managers regarding the emerging volume of women who were experiencing delays to accessing intrapartum care within the labour ward evident within patient incident reports. However limited oversight and assurance of mitigations put in place was provided in response. A requirement has been given to support improvement in this area.

Electronic fetal monitoring is a tool to assist in the assessment of fetal wellbeing. Staff we spoke with explained that in times of high acuity, it was difficult to source equipment to complete fetal monitoring. We found this also corresponded to two incident reports received within evidence. We raised this with senior managers who provided evidence of a scoping exercise which determined there was enough cardiotocography equipment available in all but one ward. They determined the antenatal ward would benefit from an addition that would double the equipment that was available during the time of inspection. Women who are delayed being transferred to the labour ward during the induction of labour process are inpatients within the antenatal ward therefore lack of equipment

availability may impact timely assessment of fetal wellbeing. A requirement has been given to support improvement in this area.

Transitional care units offer additional support to babies above normal neonatal care with the aim of preventing separation of mum and baby and unnecessary admissions to the neonatal unit. During our initial onsite and return visit we observed a disconnect between ward staff and senior managers understanding of the available transitional care provision within the postnatal ward. From evidence we received and in discussion with senior managers, we were provided guidance to support staff caring for babies with transitional care needs. The guideline contains two pathways of care available within the service; 1. Admission to a Transitional Care Unit and 2. Babies with additional care requirements who can remain on the postnatal ward. Senior managers informed us both pathways of care were provided within the postnatal wards. However, ward staff working in these areas highlighted to inspectors they were caring for neonates who were not in the appropriate pathway for care within the postnatal ward. Staff also described feeling pressured to accept care for these babies to support flow within the neonatal unit and not exclusively on the clinical presentation of the baby. Additionally, the acuity of the babies receiving transitional care did not appear to be considered in staffing ratio and skill mix. During our return visit we observed a baby being cared for within the postnatal ward who did not meet the criteria within the transitional care guidance provided as part of our inspection. We raised this as a concern with senior managers. In response we were told an audit will be undertaken of babies transferred to the postnatal ward for transitional care support to ensure compliance with guidance. A requirement has been given to support improvement in this area.

Obstetric emergencies are time sensitive and the appropriate equipment to manage these situations should be readily available. An emergency trolley provides immediate access to critical equipment and medications during an obstetric emergency. Lack of quality assurance impacts on the ability to access essential equipment in an emergency leading to a delay. We observed emergency trolleys within most wards were non-compliant with expected daily assurance checks. They also contained expired equipment, expired emergency medication and were visibly dusty. We raised this immediately with ward staff and with senior managers. On the second day of our inspection, we observed actions had been taken to rectify concerns. Emergency trolleys had been checked, organised and expired equipment replaced, however they had not been effectively cleaned. During our return visit, we observed further ongoing gaps in the daily assurance checks. A requirement has been given to support improvement in this area.

The Royal College of Obstetricians and Gynaecologists outline roles and responsibilities of consultant obstetricians highlighting the importance of the role as key professional decision makers, reducing variation in patient care and role modelling professional behaviours. Further information can be found here. Ward rounds are an important part of patient care supporting the multidisciplinary team to share information and gain an oversight of the clinical condition of all women within their care. This enables staff to monitor, anticipate

and respond in a timely way to emerging health concerns and deterioration. They also offer women the chance to ask questions and participate in their care.

We observed ward rounds across all areas and found variance in the approach to these. For example, there was no standard consultant led ward round for the postnatal ward despite the complex care needs of some women within the service. This contrasted with the antenatal ward where consultant presence had been established. Both midwifery and medical staff we spoke with raised concerns regarding the process for review of postnatal patients within the inpatient wards. NHS Greater Glasgow and Clyde have guidance in place to support staff to understand the appropriate level of obstetric review of postnatal patients. However, this was published in 2021 and predated recommendations from maternity reviews such as Ockenden 2022, which highlighted the need for consultant obstetric review of unwell postnatal women and re-admissions to the postnatal ward.

Evidence provided included patient safety incidents highlighted and discussed within NHS Greater Glasgow and Clyde maternity services clinical safety meetings. Improvement actions in response to patient safety incidents had been identified and reported through the clinical safety meetings. This included an improvement action from September 2025 relating to lack of a consultant on the postnatal ward round. The action highlighted a need for maternity services to review and strengthen the consultant postnatal review processes, specifically for high-risk women with a timescale of implementation of three months. We raised concerns regarding the unclear process and gaps in multidisciplinary review of patients with senior managers and the lack of embedded ward round practice within the postnatal area which could impact on safe delivery of care. During our return visit, we observed improved process within the postnatal ward where a multidisciplinary team ward rounds had commenced.

Within evidence received we observed recurring actions from adverse events relating to clinical situations such as fourth degree tear repair and unplanned caesarean birth at full dilatation. We raised this in discussion with senior managers, who provided assurance a consultant obstetrician would attend these clinical situations when requested. However, due to repeated need to circulate the criteria there continued to be a lack of assurance regarding the implementation and oversight of learning from these adverse events and adherence to best practice for appropriate level of clinician review to support the safe delivery of care. A requirement has been given to support improvement in this area

The impact of inequalities within maternity services has been highlighted through national reports such as saving mother's lives, improving care (MBRRACE-UK 2025). All women and their families deserve safe, kind and accessible care throughout their pregnancy journey. Ethnicity data is vital information in pregnancy as it helps to identify and address inequalities in maternal and perinatal adverse outcomes. Ethnicity data reviewed through NHS Greater Glasgow and Clyde's Queen Elizabeth University Hospital latest perinatal mortality review report demonstrated 96% compliance with recording of ethnicity data for stillbirths and neonatal deaths which occurred within the board.

As part of our inspection, senior managers shared improvement work within maternity services to proactively target racialised inequalities over the last three years. This includes a Black, Asian and Minority Ethnic (BAME) maternity group, led by NHS Greater Glasgow and Clyde's inequalities team, with improvement work including ensuring all new policies and developments are seen through an equalities lens. A focus on ensuring a more diverse midwifery workforce, with an increase in the numbers of global majority midwives and support workers in the service to increase engagement with the diverse communities within NHS Greater Glasgow and Clyde has also been an area of improvement. The innovative teamwork was recognised and shortlisted for a Royal College of Nursing inequalities national award in 2025.

The use of formal interpreter services within maternity care is essential to enable informed consent and ensure patient safety. NHS Greater Glasgow and Clyde maternity services has the highest proportion of pregnant women from ethnic minorities in Scotland (30%). During our inspection many staff raised current challenges within the service regarding obtaining an interpreter, either face to face or through telephone interpreter services. Staff told us this had resulted in them resorting to informal platforms or family members to support communication with women particularly in the labour ward setting and out of hours. We raised this with senior managers who described improving interpreting services as a key priority area since 2023 with long term, widespread, multi-agency work in place. This included work in response to the publication of the AMMA Birth Outcomes & Experiences Report published in 2024 where concerns around process for interpreter provision was also highlighted. Further information can be found here. Senior managers also explained that staff should report any concerns with interpretation services through a patient incident report. However, for the six months prior to inspection, only one incident report was submitted in relation to interpretation issues despite several staff members raising it as a concern during inspection, including an instance of this happening during our onsite visit. Within evidence we were provided with numerical data on interpreter use within maternity services at Queen Elizabeth University Hospital. This showed that in 2025, there was 3,002 requests for a face to face interpreter of which 80.6% were successful. Meaning in 2025, approximately 600 women who requested or required a face to face interpreter, did not receive this. There were 8,715 requests for telephone interpreter with a higher success rate of 98.6%. We were also given information on a plan to pilot an additional four devices within Queen Elizabeth University Hospital maternity services to assist with interpretation services by senior managers.

Within evidence we observed recurring themes identified within adverse events reviews highlighting the need to improve interpretation services within the maternity unit. This was also highlighted within the minutes of the maternity clinical safety meetings between September and November 2025. The multidisciplinary team identified recurring areas for improvement relating to interpretation services. Failure to comply with the interpreter policy can compromise patient safety, consent and could impact on adverse outcomes. For example, women requiring unscheduled care which may be time sensitive, being impacted

by availability of interpreter services. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 1	
1	NHS Greater Glasgow and Clyde utilise an evaluated system within maternity triage and has implemented a dedicated 'red phone' system.
2	NHS Greater Glasgow and Clyde have a Black, Asian and Minority Ethnic (BAME) maternity group.

Requirements

Domain 1	
1	NHS Greater Glasgow and Clyde must ensure timely review for women presenting to maternity assessment to support the safe delivery of care.
2	NHS Greater Glasgow and Clyde must ensure effective governance and oversight to inform improvement and mitigate risk when delays to care occur.
3	NHS Greater Glasgow and Clyde must ensure all women who require interpreter services have access to approved interpretation services.
4	NHS Greater Glasgow and Clyde must ensure that patients are provided with the right care, in the right place, at the right time by the right professional team. This includes but is not limited to: (i) Scheduled care within maternity assessment unit (ii) Non-obstetric unscheduled presentation and admissions (iii) Appropriate level of clinician review.
5	NHS Greater Glasgow and Clyde must ensure effective oversight to ensure essential patient equipment is available and ready for use. This includes, but is not limited to: (i) Fetal monitoring equipment (ii) Obstetric emergency equipment including medication.
6	NHS Greater Glasgow and Clyde must ensure effective senior management oversight and support, to ensure the fundamentals of care are provided and reduce the risks for women, their babies and staff at times of extreme pressure within maternity services, including but not limited to: (i) Preserving dignity (ii) Providing adequate analgesia (iii) Ensuring appropriate level of care provision for clinical situation for women and babies including monitoring.
7	NHS Greater Glasgow and Clyde must ensure systems and processes are in place to monitor and support a consistent approach to the provision of transitional care within the postnatal wards.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

In most areas inspected staff described positive working relations between midwifery, obstetric, anaesthetic and the health care support team within individual wards. However, staff described a lack of civility between different teams within the service due to the consistent pressure for transfers of patients at times of high acuity. Staff also described a disconnect with senior managers in relation to the reality of pressures facing the service. Staff described barriers to submitting incident reports and a lack of assurance that when incident reports are submitted, they are sufficiently reviewed.

Senior managers provided information on the NHS Greater Glasgow and Clyde Maternity and Neonatal Strategy, 2024-29. This sets out the strategic intent, current services and aims and vision of the service. Senior managers explained this strategy was co-produced through a series of meetings with staff, women and third sector organisations.

Psychological safety, organisational culture and incivility have been highlighted as a key factor impacting the safe delivery of care within maternity services and have been evidenced through recent national reports into reviews of maternity care including Kirkup (2015) and Ockenden (2022). Psychological safety is the ability of all staff groups to feel free to speak up, ask questions, report errors, raise concerns and ask for feedback without fear of the consequences and being judged.

During our onsite inspection senior managers took the opportunity to provide a presentation to the inspection team on ongoing improvement work relating to leadership and culture. This included the launch of a behaviour charter as a commitment to creating a safe and positive place to work and provide high-quality care. Senior managers told us the development of the charter undertook a consultative and co-productive approach explaining staff were engaged in this process, through teams' meetings, in person sessions and with an online survey to agree the behaviours. The charter promoted more positive behaviours such as listening, continued learning and displays of kindness, and encouraging staff to address poor behaviours such as racism, belittling and unprofessional behaviours. Monthly leadership walk rounds have also been established encompassing the five maternity units to ensure visible leadership and improved communication between clinical staff and senior leaders. Within evidence, we were provided with staff newsletters titled "maternity matters" which aims to inform staff of celebrations, staff success as well as key learning within the service. We also observed staff wellbeing boards. However, several staff we spoke with voiced concerns about a disconnect with senior managers in relation to the reality of pressures facing the service, describing a lack of senior manager visibility. Staff explained they would not be able to identify or recognise maternity services managers above the level of site lead midwife. Some staff were tearful during discussions with inspectors. Whilst staff acknowledged senior leaders had many responsibilities, they described feeling overwhelmed and frustrated with aspects of the service. During day two of the inspection, there was increased visibility of senior managers within the service. Staff

described this as frustrating, as they felt this was in response to the inspection as they had not received this level of senior managers input before, despite the consistent periods of high acuity and pressure within the service.

Staff described positive working relations between midwifery, obstetric, anaesthetic and the health care support team within individual wards. However, they described a lack of civility between teams in different clinical areas due to the consistent pressure for transfers of patients at times of high capacity and staff movement to support the safe delivery of care whilst working under pressure. Staff in some areas described a reluctance to answer the ward phone due to experiences of incivility between different clinical areas. We saw examples of rudeness and unprofessional behaviours evident between the multidisciplinary teams within correspondence reviewed.

The NHS iMatter survey is a staff experience tool which is completed annually to enable individual teams and health boards to understand and improve staff experience. As such, it can provide clarity on where to focus efforts for team improvement, which in turn can lead to better care, better health and better value. The iMatter questionnaire gives staff the opportunity to feed back on their experience within their team and at an organisational level. Once team results are published, teams are invited to collectively share responsibility for developing an action plan within an 8-week period and to review actions and progress made throughout the year. As an integral part of the iMatter process, teams come together to review the results and share thoughts and ideas to develop and implement action plans. NHS Greater Glasgow and Clyde had an average response rate of 57% in 2025, with an employee engagement index score of 76 which is consistent with the national average. Further information can be found here. Within evidence, we reviewed the latest iMatter reports for maternity wards inspected. The response rate was significantly lower than the board's average ranging from 22-28%. This lower level of engagement limits the interpretation of results. However, whilst staff reported high level scores of clarity about their duties and responsibilities, consistently lower scores were for leadership visibility, involvement in decision making and feeling supported at work. The employee engagement index score was also lower than the average for NHS Greater Glasgow and Clyde, ranging between 48-69. These results are consistent with staff feedback during the onsite inspection particularly in relation to the emerging disconnect between clinical staff and senior management. Whilst we acknowledge a change in culture will take significant time before a true improvement is felt by staff, continued engagement of staff, visibility and commitment of senior leaders is essential to support meaningful improvement. A requirement has been given to support improvement in this area.

Student midwives who were on placement described an excellent environment for learning with supportive practice assessors and supervisors. Newly qualified midwives described a supportive team within the wards and a positive induction experience when starting employment within Queen Elizabeth University Hospital and this was found to be comprehensive within evidence. They report being supported well by the clinical skills midwives, a role that was established to support newly qualified midwives during shifts in

clinical areas. However, newly qualified midwives described regular occasions during staff shortages or high acuity that they did not feel their limited clinical experience was taken into account by clinical leaders. For example, at times they were the only registered member of staff within a clinical area. Within incident forms there was a number submitted with reference to unsafe staffing due to skill mix and references to shifts impacting on junior midwife wellbeing during staff shortages. This will be discussed further in domain 4.3.

Birth language refers to the communication used between healthcare professionals and women to describe their pregnancy and birth journey. Birth language can significantly impact on birth trauma experienced by women with negative language such as those implying failure, impacting and increasing feelings of distress and trauma. During our inspection we observed the use of positive birth language within maternity services has been fully integrated. The Re:Birth project was released in 2022 by the Royal College of Midwives (RCM) to support both maternity professionals and women utilising maternity services to develop a shared respectful language for pregnancy, labour and birth. The aim of the project was to find a language around labour and birth which "could be shared and understood both by those delivering maternity care and those receiving it". As part of our inspection, we observed the use of Re:Birth guidance to support the multidisciplinary teams description of birth outcomes and birth choices throughout the service.

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 Greater Glasgow and Clyde plan to introduce a programme of trauma informed education sessions scheduled for staff to commence later in 2026. However, at the time of this inspection, NHS Greater Glasgow and Clyde were 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.

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. More information on the adverse event framework can be found here.

The national perinatal mortality review tool is a national tool designed to standardise review and learning following the death of a baby. NHS Greater Glasgow and Clyde utilise the tool for review of all stillbirths and neonatal deaths. In the 2024 Perinatal Surveillance Report, published in March 2025, 40% of stillbirths and 64% of neonatal deaths were reported by the service within the recommended seven working days.

NHS Greater Glasgow and Clyde engage families in the significant adverse events and perinatal mortality review process via the bereavement lead midwife or risk lead midwife. However, in evidence we observed there are often delays in reviews when adverse events

occurred. This delay can impact significantly on the mental health and grieving journey of the family involved and delays systematic learning and improvement within the service. Senior managers acknowledged the current delays with significant adverse event reviews and described immediate actions, including a rapid review of any significant adverse events which ensures any immediate patient safety concerns are identified and mitigations can be put in place. A requirement has been given to support improvement in this area.

The adverse events framework guidance highlights significant adverse events should be commissioned within 10 working days of the incident. For the six months prior to inspection, six significant adverse events reviews were commissioned within maternity services, with dates from incidents occurring to commissioning of the adverse events review ranging between 7-120 days. Within evidence we have observed recurring improvement actions identified following significant adverse events reviews. This may suggest a lack of sustained improvement and learning within the service. Examples of these already discussed within this report include improving access to interpretation services, highlighting when obstetric consultant presence within the service should be considered and utilising the correct assessment tool for pregnant women within the emergency department.

Ockenden 2022 states incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner. It recommends that change in practice arising from an incident investigation must be seen within six months after the incident occurred. Delays to completing serious adverse event reviews and implementing learning from these into clinical practice impacts the safe delivery of care for women, babies and families. In evidence provided from completed adverse events reviews there were 34 outstanding actions which vary in delay of implementation between six months and two years overdue. A requirement has been given to support improvement in this area.

Staff provided mixed feedback regarding the submission of incident forms. Whilst all staff had knowledge of the system and process, they described barriers to submitting incident forms. These included reporting limited feedback following incidents, the process being time consuming at the end of a shift with no breaks, lack of engagement from senior managers when submitting concerns and receiving feedback that they were submitting too many incident reports. Staff reported being asked for personal statements following adverse events and the high levels of anxiety this caused due to the lack of support whilst writing these and limited feedback once the statement had been submitted. Evidence provided included reference to hot and cold debrief amongst the clinical team following an adverse event and the use of "hot topics" newsletters to raise learning points and support staff.

We requested details of any trigger list used within the service to support staff in the reporting of patient safety incidents. A trigger list aims to encourage and support staff to submit an incident form following an adverse event. This ensures immediate patient safety concerns are identified and review of the incident is undertaken to support systems

learning. As part of evidence, we observed several trigger lists were in place within the service. These provided differing descriptions of incidents that should be reported by staff. Also, the categories within the electronic incident reporting system did not align to the trigger lists available, resulting in many patient incident reports being submitted by staff under the category “other.” We discussed this with senior managers who explained this had been identified as a barrier to interpreting and understanding themes within incidents and discussed planned work to reconfigure the system.

Obstetric anal sphincter injury can significantly impact a woman’s physical and emotional wellbeing and can lead to long term complications such as faecal incontinence, pain and psychological distress. Within evidence provided, we observed the rising incidence of obstetric anal sphincter injury despite lower vaginal birth rate within the service being discussed in Greater Glasgow and Clyde governance meetings. However, we were provided with evidence of discussions by the multidisciplinary team considering removing this from the incident reporting system to reduce staff burden of reporting. The removal of obstetric anal sphincter injury from the incident reporting system may impact on oversight which could impact on patient safety and improvement actions, to reduce the risk of perineal tears. We discussed this with senior managers who advised they are currently reviewing the process for capturing obstetric anal sphincter injury within the service.

Incident reports submitted by staff were included in evidence provided to us. When reviewing these incident reports we observed concerning use of language to describe the conditions in which staff were working. Staff at times described their working conditions as “unsafe” or “dangerous.” Other descriptions used in reference to staffing and acuity within the service described potential acceptance within the service of suboptimal working conditions such as “shift reflective of many shifts within the unit” and “senior managers aware.” In relation to the impact of suboptimal care on women staff suggested that “outcomes, including mode of birth, could have been different if appropriate care had been provided without delay”. We observed the use of stock responses used during review and closing of incidents, including “Datix closed as per Greater Glasgow and Clyde management“. This included incidents which appeared to be closed prior to the outcome and impact on women and their babies being fully known. Examples of this included incident reports which described delays to care of women being closed prior to the birth where the delay had potential to impact the wellbeing of the baby or maternal condition post-birth. Premature review of incidents could impact on the quality of investigation and prevent the full extent of any harm being known. Inspectors also found occasions where serious adverse event reviews had not been commissioned in response to incidents reported, including following maternal admission for intensive care. We raised concerns at several points through the inspection with senior managers and as part of our letter of serious concern and level one escalation. In response, senior managers propose several actions to address the concerns raised, including a clinical governance review within maternity services to be undertaken by NHS Greater Glasgow and Clyde clinical governance support unit.

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. As part of evidence, we observed incidents which should trigger duty of candour being delayed due to the review process. We raised this in our letter to NHS Greater Glasgow and Clyde as a serious concern. Whilst NHS Greater Glasgow and Clyde responded acknowledging the inspection highlighted omission in triggering duty of candour, they described confidence in their alignment with Scottish Government Guidance.

This inspection has highlighted gaps in incident reporting with staff describing barriers to submitting incident reports and a lack of assurance that when incident reports are submitted, they are sufficiently reviewed. These issues may have an impact on learning from adverse events within the system, reducing opportunities to improve safety. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 2	
3	Student midwives described a friendly and supportive learning environment.
4	We observed the use of positive birth language within the service.

Recommendations

Domain 2	
1	NHS Greater Glasgow and Clyde should consider improving trauma informed training for all staff.

Requirements

Domain 2	
8	NHS Greater Glasgow and Clyde must ensure the continued development of a culture which promotes and supports staff psychological safety.
9	NHS Greater Glasgow and Clyde must ensure effective governance and oversight of adverse events to support and improve the quality and safety of care, including, but not limited to: (i) Reliable and timely reporting of all adverse events (ii) Compliance with the Healthcare Improvement Scotland national adverse events framework (iii) Compliance with statutory duty of candour (iv) Actions from adverse events reviews are implemented timely into practice and monitored to ensure improvement is embedded.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

During our inspection, we identified concerns relating to medicines management, compliance with national infection prevention and control guidance and routine assurance processes within maternity services.

Quality improvement initiatives can improve safety, effectiveness and experience of care. The Scottish Patient Safety Programme is a national quality improvement programme which aims to improve the safety and reliability of care and reduce harm. 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. Effective use of MEWS facilitates early intervention to improve patient outcomes. The most recent quarterly progress report submitted to The Scottish Patient Safety Programme by NHS Greater Glasgow and Clyde referenced actively engaging in ongoing work in all 10 areas for quality improvement including major obstetric haemorrhage and MEWS compliance. However, maternity services within Queen Elizabeth University Hospital do not currently submit MEWS data as part of their engagement with the national improvement programme. We requested evidence of MEWS audits carried out within the service. We were provided monthly data for a five month period between September 2024–January 2025, which demonstrated a percentage compliance with MEWS ranging between 17-35% and included antenatal and postnatal care areas. However, it was not clear what, if any, improvement actions were taken in response to these low compliance rates. Following our onsite inspection, a further audit of 20 MEWS charts from the postnatal ward was undertaken in January 2026 and demonstrated a compliance rate of 100%. Continuous data collection, analysis and audit supports service oversight, to direct quality improvement and improve patient safety. The lack of continuous oversight of MEWS data limits assurance of recognising the deteriorating patient and prevents improvement work being undertaken where necessary. A requirement has been given to support improvement in this area.

Major obstetric haemorrhage is a critical condition defined as significant blood loss in the antenatal, intrapartum and postnatal period exceeding 1.5 litres. We observed NHS Greater Glasgow and Clyde request a patient incident report be submitted for all women who experience major obstetric haemorrhage of 1.5 litres and above. However, the use of multiple trigger lists within the service has resulted in contradictions of when staff should submit forms. An example of this is wording being changed to percentage volume of blood loss rather than specified amount between lists. Inconsistent guidance regarding what constitutes an incident of harm or near miss limits could be a barrier to reporting and impact the submission of patient incidents by staff and prevent learning.

The MBRRACE 2025 report Saving Lives, Improving Mothers' Care details the leading cause of maternal deaths between 2021-2023 remains as thrombosis and thromboembolism. The report highlights a need for continuous evidence-based risk assessment throughout

pregnancy and following birth. From evidence we observed the service provides staff guidance in line with national recommendations and these recommendations are embedded within the electronic patient record platform to further support staff. We were provided with evidence of quality improvement work which included compliance audits of the venous thromboembolism risk assessments carried out in NHS Greater Glasgow and Clyde between September 2024–March 2025. The audit demonstrated a rise from 23% to 53% compliance with required risk assessments. However, we were not provided with any further evidence of continued oversight of this compliance despite the audit demonstrating 47% of women did not receive appropriate assessment. A requirement has been given to support improvement in this area.

NHS Greater Glasgow and Clyde introduced a maternity dashboard in January 2025 with the aim to provide overview of service activity and provide assurance for quality indicators. In discussion with senior managers and review of evidence we can see there are plans to expand and promote awareness of the dashboard amongst staff. However, at the time of our inspection it was unclear how the dashboard that auto-populates from the electronic records is utilised within the service to monitor and inform improvement to support early intervention and review potential early signals in the data. A requirement has been given to support improvement in this area.

Evidence-based clinical guidelines are used to assist clinicians in decision making regarding treatment and care in specific circumstances. They are a resource within clinical practice to improve communication between patients and health professionals and help patients make informed decisions. NHS Greater Glasgow and Clyde have undertaken recent work to improve the process of oversight of clinical guidelines. They had identified that over a third of clinical guidelines within maternity services were overdue for review. Within submitted evidence we observed the percentage of expired guidelines within maternity had been reduced from 33% in August 2025 to 23%, in January 2026. However, 36 guidelines are due for review with the longest waiting five years since the anticipated review date. One of the overdue guidelines “antenatal fetal monitoring for inpatients” was due a review and potential update from 2024.

Within review of adverse events, incorrect classification of antenatal cardiotocography (CTG) was highlighted as a recurring theme and did not align with either NHS Greater Glasgow and Clyde guidance or available national best practice guidance. For example, during antenatal review of cardiotocography recordings, incorrect classification such as “suspicious” rather than normal or abnormal was being applied. This may impact on recognition and appropriate escalation of concerns, potentially delaying essential intervention. However, despite multiple actions from adverse events highlighting this guideline requires to be updated, it does not appear to have been prioritised within the guidelines group. Ensuring clinical guidelines are consistent with evidenced based practice requires oversight and a system of review to ensure they remain relevant. Whilst we acknowledge the ongoing improvement work, a requirement has been given to support ongoing improvement in this area.

Accurate documentation and record keeping is an essential part of midwifery practice and maternity care. Senior managers told us NHS Greater Glasgow and Clyde developed a Maternity Combined Care Assurance Tool in 2024 and this had been shared with other NHS boards. We observed documentation audits undertaken as part of the Maternity Combined Care Assurance Tool in November 2025. The audit required five sets of case notes to be reviewed, however, we observed only three sets of notes were reviewed. There appeared to be gaps in the audit; for example, it did not appear to assess data completeness for triage attendance as detailed earlier in the report. The compliance for individual components ranged from 50-100%. However, there did not appear to be actions identified to support areas for improvement. A requirement has been given to support improvement in this area.

During our inspection we observed the majority of women had call bells and were familiarised with the ward environment on arrival and all patients spoken to reported they felt confident they could ask for assistance if required. However, within the maternity assessment unit, nurse call systems were observed to be secured in position on the wall and not allowing for easy access for women. A requirement has been given to support improvement in this area.

Hand hygiene is an important part of standard infection control precautions to minimise the risk of infection. Other standard infection control precautions include patient placement, the use of personal protective equipment (such as gloves and aprons), management of the care environment, safe management of blood and fluid spillages, linen and waste management and prevention and exposure management (such as sharps injuries).

Hand hygiene involves '5 moments' when hand hygiene should be performed. These are prior to touching a patient, prior to performing a procedure, after a procedure or body fluid exposure risk, after touching a patient or after touching a patient's surroundings. During inspection we observed that there were occasions where staff missed opportunities to carry out hand hygiene including before and after contact with patients. A requirement has been given to support improvement in this area.

The National Infection Prevention and Control manual states: Clinical wash hand basins should only be used for the purpose of performing hand hygiene. Clinical wash hand basins should not be used for disposal of any foodstuffs, drinks, bodily fluids, clinical or medicinal waste, medical or patient care equipment in clinical wash hand basins, patient sinks, showers or baths.

We observed breastfeeding equipment being cleaned in a sink assigned to handwashing. Staff we spoke with explained this was common practice in all areas. We raised this as a concern with senior managers. During our return visit we observed this practice had changed and breastfeeding equipment was being cleaned in individual basins with potable water.

In one area, due to a broken waste disposal unit, we observed staff disposing of urine into a sink. We raised this concern with senior managers and on the second day of our inspection information had been circulated to staff on the correct use of hand hygiene basins and the waste disposal equipment had been repaired.

We observed poor compliance with sharps management in all areas, such as sharps containers not having temporary closures in place and incorrect labelling of sharps boxes. The use of the temporary closure prevents needles or other sharp objects protruding from the boxes or falling out of the container if it is dropped. A requirement has been given to support improvement in this area.

NHS Scotland dress code for clinical area recommends appropriate steps must be taken to adhere to good practice and to minimise the risks of infections and cross-contamination for patients and the public. Inspectors observed noncompliance with uniform policy, including multiple staff wearing false nails, hair observed below collar of uniform, staff wearing long sleeves and jewellery whilst providing clinical care. A requirement has been given to support improvement in this area.

We observed instances of poor compliance with the safe management of linen including segregation of clean and used linen and staff using personal protective equipment incorrectly when handling clean and used linen. A requirement has been given to support improvement in this area .

Transmission based precautions are additional infection control precautions that should be used by staff when caring for a patient with a known or suspected infection. We observed several areas where these precautions were in use. Clear signage was in place and staff were observed correctly using personal protective equipment in these areas. However, in one ward area, we observed that signage on patients rooms, used to inform staff and visitors of transmission based precautions, also included the type of infection. This does not promote patient privacy and is not in line with guidance in the National Infection Prevention and Control manual which states that signage should be used to communicate isolation requirements. The process for decontamination of rooms following discharge was unclear amongst staff we spoke with, which we raised as a concern to senior managers and a new system was in place during our return visit. A requirement has been given to support improvement in this area.

We observed within inpatient wards, several beds spaces did not comply with national guidance. We raised this with senior managers who told us an audit would be carried out of how often these beds are used and complete an action plan detailing mitigations to reduce risk when in use. A requirement has been given to support improvement in this area.

Care equipment can be easily contaminated and a source of transferring infection if equipment has not been effectively cleaned. We observed patient care equipment such as blood pressure monitors were dusty and sharps disposal bins were contaminated with blood. We observed storage issues within clinical areas resulted in equipment being stored in bathrooms and corridors within wards.

Effective management and maintenance of the healthcare environment is essential to support the safe delivery of care. We observed several areas for improvement relating to the healthcare built environment. These included issues with showers throughout inpatient wards which appeared to have mould within trays, multiple patient room windows were known to be leaking and causing condensation and water to gather on windowsills which appeared to have mould around the frames. A leaking toilet was also observed which had a towel placed under the pipework to collect water. These concerns were raised as serious concerns with senior managers during our initial onsite inspection.

Staff we spoke with highlighted delays to repairs being carried out within the wards when reported, including repairing broken equipment around a bedspace, causing the bed space to be unusable for months. We requested evidence of outstanding facilities management tasks for all areas inspected. This highlighted a wait for repairs of up to 10 months for reported issues and contained limited narrative around actions taken for progress. During our return visit, outstanding repairs had been carried out, including fire doors, ceiling tiles and the leaking toilet. A requirement has been given to support continued improvement in this area.

We spoke with staff regarding water flushing regimes within maternity services. Water flushing regimes support the prevention of the build-up of bacteria within the water system. However, staff were unclear of the process and who was responsible for water flushing across all areas, including little used outlets. Senior managers provided evidence that water flushing had been carried out, however this information was inconsistent with onsite observations, where water flushing checklists within several areas inspected had significant gaps. A site wide water flushing assurance audit was carried out within NHS Greater Glasgow and Clyde during January 2026. An improvement action from this audit includes the development of a water safety education module to improve staff awareness. A requirement has been given to support improvement in this area.

During our onsite inspection, we identified a number of concerns relating to medicines management which have wider implications for medicines governance and routine assurance processes. These included out-of-date medicines on emergency trolleys and within ward stock, posing a direct risk to the timely and safe management of obstetric emergencies. Inappropriate storage of medical gases, including cylinders in cupboards and bathrooms, is contrary to required safety standards and presenting environmental and operational risks. We observed practice not consistently aligned with established local policies for safe storage, handling and monitoring of medicines, indicating procedural non-compliance. These gaps in accountability and routine assurance mechanisms with insufficient oversight of medicines safety and unclear ownership of day-to-day governance processes are not in line with the Royal Pharmaceutical Society Professional guidance on the safe and secure handling of medicines or the Nursing and Midwifery Council code of professional standards. Given the central role of medicines management in safe maternity care, these findings reinforce broader concerns regarding governance, leadership and

consistency of safety processes across the service. A requirement has been given to support improvement in this area.

Inspectors observed that in most areas chlorine-based cleaning products were not stored securely, resulting in a risk that it may be accessed by women, children and members of the public. This is not in line with The COSHH Regulations 2002 which stipulate that these products must be kept in a secure area such as a locked cupboard. A requirement has been given to support improvement in this area.

Within incident reports provided there was a reported incident of pigeons nesting in a plant room near the maternity assessment unit within the six months prior to inspection. Due to the previous concerns from pigeon droppings within the Queen Elizabeth University Hospital we completed a walk round of the area with estates during our revisit but we did not observe any evidence of pigeons within the plant rooms. The reported incident was identified through compliance with assurance processes and NHS Greater Glasgow and Clyde provided substantive assurance for their process of oversight in this area including records of compliance with monthly walk rounds and escalation guidance.

As highlighted earlier in this domain the safe storage of medical gases was not being adhered to which included a lack of signage to reflect the storage within the ward. We also observed further lack of compliance with fire safety such as a lack of fire door signage which we raised at the time of the inspection with the senior charge midwife for the area. Other issues raised included broken fire doors in multiple areas, fire doors being wedged open, missing fire exit signage, use of oil heaters in clinical areas without risk assessment and missing ceiling tiles. We highlighted this in our feedback to senior managers, requesting immediate action. Managers responded quickly with the appropriate actions. Following this, NHS Greater Glasgow and Clyde provided further evidence on request that included the latest fire risk assessment for the unit. Evidence of staff fire safety mandatory training was also provided which demonstrated low staff compliance for the mandatory TURAS fire safety module, with a range of compliance of between 45.5-69.2% among obstetric staff tiers and an average of 70% of midwifery inpatient staff having completed the module. We raised this with senior managers who acknowledged this and planned to prioritise staff fire safety training. A requirement has been given to support improvement in this area.

Requirements

Domain 4.1	
10	NHS Greater Glasgow and Clyde must ensure governance and oversight of unit data and ensure a robust documentation audit to support learning and improvement, including, but not limited to: (i) Venous thromboembolism risk assessment (ii) Maternity early warning score (MEWS) chart (iii) Postpartum haemorrhage (iv) Obstetric anal sphincter injury (v) Data completeness (vi) Cardiotocography interpretation.
11	NHS Greater Glasgow and Clyde must continue to ensure clinical guidelines are up to date and reviewed within agreed timescales.
12	NHS Greater Glasgow and Clyde must ensure the healthcare built environment is effectively maintained to allow decontamination and ensure potential risks to patients and staff safety are effectively identified and mitigated.
13	NHS Greater Glasgow and Clyde must ensure that all women have access to a call bell.
14	NHS Greater Glasgow and Clyde must ensure compliance with national guidance. This includes but is not limited to: (i) Hand hygiene (ii) Linen management (iii) Sharps management (iv) Uniform policy (v) Transmission based precautions (vi) Correct bed spacing (vii) Environmental and equipment cleanliness.
15	NHS Greater Glasgow and Clyde must ensure infrequently used water outlets are flushed in line with current national guidance and support staff in understanding the process of assurance regarding water flushing.
16	NHS Greater Glasgow and Clyde must ensure the safe and secure use of medicines at all times, including the governance and oversight of compliance with safe storage and administration of medicines..
17	NHS Greater Glasgow and Clyde must ensure all hazardous cleaning products are securely stored and labelled appropriately, as per manufacturers' guidelines.
18	NHS Greater Glasgow and Clyde must ensure fire risk assessments are up to date and fire actions and improvements identified within fire safety risk assessments are addressed. This includes, but is not limited to: (i) Staff training compliance (ii) Safe storage of medical gases and appropriate signage.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Staff described midwifery skill mix impacting on the ability to provide safe maternity care and maintain patient safety. Many staff told inspectors they were unable to take their break due to work pressures and acuity and this appeared to become an accepted practice.

NHS Greater Glasgow and Clyde maternity services use a bespoke staffing system which monitors real-time staffing levels in relation to patient care needs. This uses a traffic light system red, amber, grey and green (RAGG), with red areas having the highest shortfall of staff available to meet women's needs. Senior managers informed us this enables informed decision making when deploying staff to help mitigate risk. The RAGG system helps to take account of acuity of the women and babies versus available staffing numbers, allowing for professional judgement to be made on required staffing. However there is potential overlap within the categories which may lead to ambiguity when determining the safe to start position. For example, the amber category should be applied when unable to transfer women from the antenatal ward to labour ward for care. The red status should be applied when unable to provide safe levels of care. Both could be interpreted as the same situation.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that NHS boards have a duty to apply the Common Staffing Method (CSM), which includes a staffing level tool run and requires this to be applied rigorously and consistently. The application of the CSM and staffing level tools supports NHS boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care. As part of evidence, we observed staffing level tool runs had been undertaken in August 2025 for all areas inspected, with the associated CSM reports containing broad references to concerns identified during our inspection and service delivery challenges. These included regular use of contingency beds, delays to transfer for intrapartum care and lack of consideration for transitional care complexities within the wards funded establishment. All areas inspected used the professional judgement field to recommend a significant increase in staffing as defined by the tool as greater than a 5% uplift but there was no narrative around next steps or plans for improvement within the tool.

Senior managers provided an update on staffing levels, describing in 2022 it was recognised that there had been no review of the midwifery funded establishment since 2014. In response to this, since 2022, 55 new midwifery posts were created. This focused recruitment has led to an overall increase in the number of midwives employed in NHS Greater Glasgow and Clyde including maternity services within Queen Elizabeth University Hospital where the number of midwives has increased from 125.8 whole time equivalent in 2019 to 129.03 whole time equivalent in 2025.

During discussions senior charge midwives were able to discuss the workforce tool and professional judgement tool and being involved in submitting data to this. However, they

did describe that they would not receive any feedback from this and did not know why this was taking place. They described frustration that when tools were used to help understand staffing and they identified staffing short falls, no action was taken. Some staff described they felt it was normal practice that staff were operating at maximum capacity with no breaks, with no time for learning and a lack of support from senior managers. Some staff also expressed concerns that in instances where adverse events happened, they felt the response from senior managers was punitive rather than supportive.

We were able to observe safety huddles aimed at assessing the services safe to start position. The 08:15 huddle was for Queen Elizabeth University Hospital to assess their unit risk and safe to start position. On day two of the inspection the assessment was an amber position due to capacity and acuity within the service. A 09:15 huddle is facilitated to gain oversight of all of NHS Greater Glasgow and Clyde maternity services and to see if pressures can be resolved over the three sites. The huddle was inclusive of the community setting and allowed for discussion regarding incident reports which had been submitted in the last 24 hours.

Staff described disconnect with senior managers in relation to responding to mitigations when escalation of staffing and patient safety concerns occurred. Some senior charge midwives we spoke with described a perceived pressure to make RAGG ratings green and feeling their professional judgement was challenged and undermined. They described changes being made to their professional judgement decisions for their clinical area by senior managers at the 09:15 safety huddle. For example, they described regular downgrading from amber to grey/green with no discussion or feedback as to why the change had been made leaving the senior charge midwife not agreeing with the change or reduction in risk status as it did not reflect the current risk within the department.

We reviewed the RAGG summary for the three months prior to our inspection and observed there were inconsistencies found with the application of the RAGG status. Inspectors identified days including out of hours where the shift narrative described a unit over capacity and unable to facilitate one-to-one midwifery care. However, the RAGG rating was scored lower than the description of the situation would suggest. We raised this with NHS Greater Glasgow and Clyde as a serious concern. In response, NHS Greater Glasgow and Clyde have provided an update that the associate chief midwife will now attend unit huddles to ensure consistency in terms of decision making and RAGG rating. Senior charge midwives and charge midwives will also be encouraged to attend the cross-site huddle as often as possible. The application of RAGG status should be consistently representative of unit activity.

Neither of the safety huddles we attended reviewed obstetric or anaesthetic staffing. Medical staff we spoke with raised concern over a lack of process when medical staff sickness occurs particularly at short notice. They described the use of a messaging app and a perceived expectation that staffing gaps would be filled through goodwill which several obstetricians described feeling obliged to do despite perhaps being clinical for the last six days. We raised this with NHS Greater Glasgow and Clyde as a serious concern. In response

NHS Greater Glasgow and Clyde provided improvement actions including details of circulation of absence reporting guidance for medical staff responsibilities in this area. They also reported changes to the cross-site huddle following inspection feedback to include obstetric staff attendance to enable multidisciplinary involvement in determining the safe to start position. A requirement has been given to support ongoing improvement in this area.

We requested to observe the wider hospital acute site huddles to gain understanding on wider hospital situational awareness and how this may impact or support maternity services. However, this request was not accommodated and we were informed that the maternity acuity is fed into the higher-level huddle and not part of the acute safe to start discussions. As discussed earlier within this report, maternity services regularly care for women with complex and joint care needs requiring other specialised input such as cardiology. This approach may limit senior managers within the wider hospital oversight of potential risks within maternity services. A requirement has been given to support improvement in this area.

Appropriate midwifery skill mix is the combination of skills and experience required to meet the acuity and dependency needs of patients. Skill mix was raised as a concern by all staff members, particularly the addition of band 5 midwives to the maternity assessment unit. The team welcomed colleagues who were new to the profession however due to the acuity, capacity and complexity of the triage workload this gave limited time to support and nurture colleagues. Newly qualified midwives described a supportive clinical skills network with midwives identified for this purpose. However, they also recognised it was difficult for other members of the senior staffing to continue to provide this support due to the complexity and volume of patients. Whilst communication appeared to be respectful and kind, staff did discuss feeling vulnerable during periods of increased activity due to shortfalls in staffing and all staff being stretched across the service. This was also observed within evidence, with 15 incident reports submitted that discussed skill mix as a staffing concern during the six months prior to inspection. However, these concerns did not appear to be captured or reflected in the safe to start position for corresponding shifts. A requirement has been given to support improvement in this area.

Staff we spoke with described the process of diverting women to other maternity units as very stressful and, at times, a challenging process, particularly when this occurs in the out of hours period due to lack of senior professional support. Staff described an escalation pathway and risk assessment to support safe transfer of women at times of high acuity, capacity and reduced staffing. Whilst the guidance includes escalation to the senior manager on call, staff described feeling that there was limited support available when they do escalate through this route.

It is the role of the unit coordinator, including during out of hours periods to manage and coordinate the safe transfer of women. This includes cross-site collaboration with the other two obstetric led maternity units within NHS Greater Glasgow and Clyde and, at times, other health boards across the country in an aim to support patient safety. Within the

evidence reviewed, periods of increased clinical acuity were described in shift narratives during out of hours periods, however no corresponding escalation or resolution was recorded within the information provided. It was unclear how episodes of unmitigated risk out of hours were recorded to support adequate oversight of risk and inform potential improvement to support the safe delivery of care. There was also no information available relating to delays to the induction of labour process, occurring over the weekend for the three months prior to inspection despite this having established oversight during weekdays within the safety huddles.

The National Workforce Strategy for Health and Social Care in Scotland outlines a plan to develop a robust system of workforce support, nurturing leadership to prepare staff to take on senior leadership roles including a focus on succession planning. More information can be found here. Senior charge midwives explained their experience being promoted into senior roles, however with limited training or succession planning to support them in this transition.

Staff appraisals are essential to assessing and supporting staff performance, resulting in a positive work culture. In evidence received we observed completed appraisals for midwifery staffing had a compliance rate of 63%. However, obstetric compliance rate with appraisals was not provided in evidence.

The Health and Care (Staffing) (Scotland) Act 2019 states that health boards have a duty to ensure safe, high-quality, person-centred service provisions through having the right staffing in place. A requirement has been given to support improvement in this area.

Each senior charge midwife is responsible for a midwifery team. This includes quality and performance management, HR requirements, ensuring training is up to date and wellbeing support for their team. Time to lead is a legislative requirement under the Health Care Staffing (Scotland) Act (2019). This is to enable clinical leaders to provide and oversee the delivery of safe, high-quality and person-centred healthcare. In discussion with clinical leaders, we were told that time to lead was regularly impacted on due to clinical capacity. We raised this with senior managers requesting evidence of oversight of allocated time to lead and when this is compromised. However, we received limited assurance of protected time to lead and evidence of increased unit capacity and acuity regularly requiring the senior charge midwife to be clinical. Interruptions to time to lead significantly impacts on the capacity to complete their leadership and management responsibilities. A requirement has been given to support improvement in this area.

Oversight of capacity and acuity is essential to inform safe staffing levels and support the safe delivery of care. The three inpatient wards have 57 funded beds, which can be increased to 72 beds with use of contingency beds at times of increased capacity. Senior managers provided narrative regarding bed occupancy which demonstrated a potential occupancy rate of 86%, with peaks above 90%. However, as the wards funded establishments is reflective of the original 57 inpatient beds, the inpatient wards are regularly between 7% and 13% over capacity and funded establishment. Senior managers

informed us of plans to conduct a three-month audit into the use of contingency beds within maternity. A requirement has been given to support ongoing improvement in this area.

Staff described on almost every shift they were unable to take breaks, with no improvement plans in place to address the issues. Staff described being encouraged by senior managers to escalate concerns however they described a lack of improvement when escalating issues, such as lack of breaks, left them feeling there was not much point in raising this. We raised this with senior managers who were unable to provide oversight of the facilitation of staff breaks within the service but have since raised an action to monitor when staff breaks cannot be taken. We were informed of a recent ward initiative introduced by a senior charge midwife to monitor when staff had not had their break. However, staff explained it was not possible to claim time back due to ongoing pressures although they could get paid. Staff reported being frustrated by the lack of options to take their time back as they felt this would help their wellbeing. Compliance with working time regulations in relation to rest on shift is essential to staff wellbeing and a legislative requirement under the Health Care Staffing (Scotland) Act (2019). A requirement has been given to support improvement in this area.

Through evidence we observed 30% of sickness absence within maternity services was attributed to psychological reasons. In discussion with senior managers, we were advised of the use of wellbeing boards within clinical areas that displayed information highlighting local trained peer supporters and an option for staff to contact the NHS Greater Glasgow and Clyde central hub, which facilitates timely connection to peer support. NHS Education for Scotland (NES) 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's development and professional growth by offering dedicated time, feedback and guidance in a psychologically safe space to critically reflect practice. The aim is to enable and empower staff to provide high-quality, safe, person-centred care. Senior managers advised us of significant challenges in delivering formal clinical supervision across NHS Greater Glasgow and Clyde and were unable to provide compliance rates for midwifery staff. Medical staff described medical peer support which can result in signposting onto specialised care as required. However, during inspection staff were unaware of any initiatives to support their wellbeing and unable to describe how they would access wellbeing support. Following review of evidence and discussion with senior managers, we are not assured the NHS Greater Glasgow and Clyde staff health and wellbeing measures in place are sufficient to support individual staff and ensure that their concerns are able to be raised, responded to and appropriately addressed. A requirement has been given to support improvement in this area.

In 2018 the Scottish Government published the core mandatory training requirements for midwives and obstetricians. This required each NHS board to establish training around fetal (unborn baby) heart monitoring, obstetric emergencies and neonatal resuscitation. Wider

national reports on the provision of safe maternity care over the last decade such as, each baby counts (RCOG 2019) and Kirkup (2015) have highlighted the essential safety feature of teams working and training together to improve outcomes for families. During inspection, staff spoke of barriers to completing training, such as not being released from clinical work and the expectation that it will be completed in their own time for additional pay.

Evidence provided on compliance with mandatory training programmes demonstrated midwifery compliance between 39-53% across areas inspected and 37% of obstetric staff had completed online cardiotocography training, however no record of participation with face to face training was available for the current obstetric workforce. Obstetric trainees we spoke with explained difficulties in accessing training and education available due to system pressures. This was raised with senior managers who were unaware of any barriers and reported a positive Deanery report following extensive work from being under special measures historically for this. However we reviewed the latest available Deanery report, which identified concerns regarding accessing training and education for medical staff with Queen Elizabeth University Hospital, scoring low in this area. A requirement has been given to support improvement in this area.

The Best Start (2017) recommends the newborn and infant physical examination (NIPE), a screening programme designed to identify congenital abnormalities undertaken within 72 hours of birth can, in most cases, be performed by appropriately trained midwifery staff. During our onsite inspection patient flow was affected both days with over 13 outstanding examinations. The examination was facilitated in a separate room by medical staff therefore it was not always possible for a parent to be present within this room as it did not accommodate a bed for post-operative women. This impacts on the parents' oversight of the examination and opportunity to ask questions. As part of evidence, we observed only 1% of midwives across areas inspected have maintained competency in this area of practice. We raised this with senior managers who described a renewed focus to increase the number of midwives who are accredited and increase the number of midwife-led newborn and infant physical examinations. Recruitment to increase postnatal ward staffing by 2.5 whole time equivalent midwives was approved in December 2025 to enable the establishment of a weekday office hours midwife-led newborn and infant physical examination clinic within the ward. Senior managers anticipate this new approach will support flow, reduce workload of neonatologists and give greater opportunities for midwives to develop and maintain competence and support student midwives in developing competence. A recommendation has been given to support improvement in this area.

Recommendations

Domain 4.3	
2	NHS Greater Glasgow and Clyde should continue to take steps to enable midwifery staff to undertake examination of the newborn as per Best Start recommendation number 23.

Requirements

Domain 4.3	
19	NHS Greater Glasgow and Clyde must ensure that there are clear, consistent systems and processes in place to support management of any potential identified staffing risks within maternity services. This includes accurate recording of any clinical risk, escalation, mitigation/inability to mitigate, communication of outcomes with all relevant clinical teams and any disagreements with decisions made.
20	NHS Greater Glasgow and Clyde 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. Assessments should consider skill mix of available staff, dependency and complexity of patients to support staff to confidently apply and record professional judgement in relation to required staffing when declaring "safe to start."
21	NHS Greater Glasow and Clyde must ensure oversight of potential risks within maternity services are consistently captured and discussed where appropriate within the wider hospital safety huddle.
22	NHS Greater Glasgow and Clyde must ensure a supportive and inclusive working environment for staff which supports staff to raise concerns, with systems and processes in place to ensure that these concerns are responded to and appropriately addressed.
23	NHS Greater Glasgow and Clyde must ensure that there are systems and processes in place to safeguard all clinical leaders within maternity services being able to access appropriate protected leadership time in order to fulfil their leadership and management responsibilities such as oversight of quality of care and provision of support for staff. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls and/or increased service demand.
24	NHS Greater Glasgow and Clyde must have robust systems and processes in place to ensure that all staff are appropriately trained to carry out their role. This includes protected learning time and monitoring of training completion.
25	NHS Greater Glasgow and Clyde must ensure that maternity and obstetric services are appropriately and effectively staffed in order to reduce delays to care, preserve patient safety and support wellbeing by enabling staff to take statutory rest breaks on shift.

Domain 6 – Dignity and respect

Quality 6.2 – Dignity and respect

We observed staff providing positive and kind care to women, babies and their families. However, during our onsite inspection women told us of varied experiences of maternity services within the Queen Elizabeth University Hospital.

Despite high activity and acuity, staff remained positive, respectful and kind to women, babies and their families. However, women told us of varied experiences of maternity services within the Queen Elizabeth University Hospital. In some areas women described their experience as positive, highlighting they were well informed, complementing the informed consent process within the service. In contrast, other women and partners described not feeling informed or knowing what to expect.

Learning from patient feedback is essential to service development and improvement. As part of the inspection, we noted the compliments and complaints NHS Greater Glasgow and Clyde received in feedback from women and families. Whilst there were service users highlighting positive examples of commendable care by staff, there were consistent themes from complaints of incidents including clinical treatment, attitude and behaviour of staff and lack of communication with women as areas for improvement. Patient feedback is monitored through clinical governance meetings and senior managers provided information to staff in the form of a power point presentation to highlight recurring complaint's themes. However, no further evidence was provided demonstrating how feedback from complaints facilitated improvement within the service. A requirement has been given to support improvement in this area.

The national maternity voices partnership supports the co-production of maternity services ensuring the "voices of all women including those from diverse backgrounds" are heard and used to plan, design and improve maternity services. As part of evidence, we were provided an overview of NHS Greater Glasgow and Clyde maternity voice partnership latest meeting which occurred in October 2025. The group has a rolling and evolving membership and members are invited through different avenues such as previous attendees, communities and families with recent experiences of the service. Key discussions from the latest meeting included development and feedback on maternity communication materials, development of the maternity unit virtual tour and perinatal mental health and wellbeing workshop initiatives.

Opportunity for partners to stay overnight within inpatient wards was limited unless patients were in a side room. This was a change implemented following staff and patient feedback that parents staying overnight in bays was impacting on safety, security and the ability to provide safe care. In a survey of 242 staff, 96% reported the previous arrangement resulted in too many visitors and partners staying overnight. A patient survey was also undertaken with around half of respondents highlighting concerns around open visiting. Staff also described frustrations around increased patient flow and demand meaning they

frequently discharge well women home who are newly postnatal however, their babies are, at times, very unwell with no accommodation available onsite to support a prolonged period of stay. This is in contrast with The Best Start plan 2017, that recommends all units should take a flexible approach to the presence of partners, to ensure that families can stay together, with suitable accommodation and facilities being provided. It also recommends that all neonatal facilities should provide emergency overnight accommodation on the unit for parents, with accommodation available nearby for parents of less critically ill babies. A recommendation 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. There are nine standards within the pathway relating to patient focused care, staffing and communication. An NHS board that meets these standards is providing good bereavement care. Through discussion with staff onsite and review of evidence submitted, we acknowledge work in progress by NHS Greater Glasgow and Clyde to meet these standards. These include a system in place to highlight a bereavement has occurred within the electronic patient records and the appointment of a bereavement lead midwife. Memory making equipment, clothing, cuddle cots and memory boxes were available to families to support spending time together following the death of a baby. However, whilst we were made aware of two dedicated rooms for bereavement care in labour ward, there is no dedicated area for other aspects of bereavement care within the unit. This resulted in women and their families being admitted to the antenatal ward or labour ward depending on their clinical picture. Staff expressed concern to inspectors regarding providing care for bereaved women without completing any bereavement training, within a non-dedicated area. Within evidence supplied compliance for bereavement training of the maternity workforce was 28% at the time of inspection. Staff bereavement training and women having access to a room where bereavement care can be provided in a suitable and sensitive environment are recognised standards recommended by the National Bereavement Care Pathway. A recommendation has been given to support in this area.

Areas of good practice

Domain 6	
5	We observed staff providing positive and kind care to women, babies and their families.
6	NHS Greater Glasgow and Clyde have an established maternity voice partnership.

Recommendations

Domain 6	
3	NHS Greater Glasgow and Clyde should consider a flexible approach to the presence of partners, to ensure that families can stay together, with suitable accommodation and facilities being provided when babies are unwell in the neonatal unit.
4	NHS Greater Glasgow and Clyde should consider improving staff bereavement training compliance and providing dedicated space for caring for bereaved families.

Requirements

Domain 6	
26	NHS Greater Glasgow and Clyde must ensure learning and improvement from themes highlighted from patient complaints.

Appendix 1 - List of national guidance

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

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Antenatal care (NICE, August 2021)
- CMO(2018)18 - Core mandatory update training for midwives and obstetricians (Scottish Government, December 2018)
- Delivering Together for a Stronger Nursing & Midwifery Workforce (Scottish Government, March 2025)
- Fire (Scotland) Act 2005 (Fire Scotland Act, Acts of the Scottish Parliament, 2005)
- Food Fluid and Nutritional Care Standards (Healthcare Improvement Scotland, November 2014)
- Generic Medical Records Keeping Standards (Royal College of Physicians, October 2015)
- Guidance — NHS Scotland Staff Governance (NHS Scotland, June 2024)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards (Healthcare Improvement Scotland, 2022)
- Intrapartum care (NICE guideline, September 2023)
- Maternity Triage (RCOG Maternity Triage good practice paper, December 2023)
- MBRRACE-UK (Maternal, Newborn and Infant Clinical Outcome Review Programme, 2025)
- National Infection Prevention and Control Manual (NHS National Services Scotland, June 2023)
- NMC Record keeping: Guidance for nurses and midwives (NMC, August 2012)
- Operating Framework: Healthcare Improvement Scotland and Scottish Government: (Healthcare Improvement Scotland, November 2022)
- Person-centred care - NMC (The Nursing and Midwifery Council, December 2020)
- Prevention and management of pressure ulcers standards (Healthcare Improvement Scotland, October 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)

- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2024)
- Recommendations | Postnatal care | Guidance | NICE (NICE, April 2021)
- Scottish Patient Safety Programme (SPSP) (Healthcare Improvement Scotland)
- The best start: five-year plan for maternity and neonatal care - gov.scot (Scottish Government, January 2017)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)
- The UNCRC Act - UNCRC (Incorporation) (Scotland) Act 2024 (Scottish Government, September 2024)
- The Quality Assurance System (healthcareimprovementscotland.org) (Healthcare Improvement Scotland, September 2022)

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