



Improvement Action Plan

Healthcare Improvement Scotland: Unannounced Maternity Safe Delivery of Care Inspection

Queen Elizabeth University Hospital, NHS Greater Glasgow & Clyde

27 – 28 January 2026

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: Lesley Thomson

Full Name: Dr Lesley Thomson KC

Date: 7th Oct 2026

NHS board Chief Executive

Signature: Jann Gardner

Full Name: Professor Jann Gardner

Date: 7th Oct 2026

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Ref	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
1.1	Increase staffing in QE triage and implement BSOTS across QE, PRM and RAH services.	02-Mar-26	Director of Midwifery	Midwifery staffing of all triage units and call hub now at appropriate level indicated by BSOTS modelling. Ongoing audit to monitor timely review. Results shared with SCMs for each triage unit and call hub to identify areas of improvement and to celebrate success.	02-Mar-26
1.2	Launch of centralised telephone triage call hub with a dedicated midwifery team and recorded calls.	02-Mar-26	Director of Midwifery	Call hub team fully operational and fully staffed - with 3 midwives on 24/7. Ongoing audit and quality assurance of response times, call times and care pathways. All calls recorded and 20 calls monitored for QA by SCM each month.	02-Mar-26
1.3	Recruited 19 additional full-time midwives	01-Feb-26	Director of Midwifery	All triage units in RAH, PRM and QEUA have appropriate staffing in line with BSOTS modelling - 3 midwives on each shift 24/7 for PRM and QE and 2 midwives 24/7 for RAH.	01-Feb-26
1.4	Strengthen provision of medical staffing for triage building on review already carried out and Implement Medical staffing uplift of 2 middle grade doctors per site to support BSOTS	31-Aug-26	Director of Women & Children	This action is now overdue as funding for recruitment has yet to be identified and implementation will therefore not be completed by 31st August. This has been escalated through governance and the SBAR titled: Improving Medical Staffing to Deliver Safe Maternity Triage Across GGC, has been updated to reflect the current position. This has been submitted for review at CMT 12/10/26 Please note that the use of The Bridges Refugee	Delayed

				Doctors Programme (which enables access to partially funded qualified doctors) was explored as a potential mitigation, however, was not a viable avenue for support in this instance.	
1.5	Continue to improve maternity triage ensuring audit and governance reporting will continue to monitor the timeliness of triage assessment.	Ongoing	Director of Midwifery	Ongoing reporting of triage timeliness and care pathways to maternity governance.	Complete & Ongoing
2.1	Complete review and adaptation of Safe to Start huddles including the addition of discussion regarding medical staffing and attendance by medical colleagues	01-Apr-26	Director of Midwifery	Substantial review and adaptation of the Safe to Start huddle processes and sheets have been undertaken. Medical staffing issues are consistently discussed at cross site huddles. Medical staff are now invited to the cross-site huddles.	01-Apr-26
2.2	Ensure all charge midwives are invited to attend cross site safety huddles to understand decision making and gain experience in initiating appropriate mitigations when activity levels are high.	01-Mar-26	Director of Midwifery	All SCMs and CMs were invited to attend cross site huddles for ongoing learning and development of confidence in decision making processes. This ensures that there are levels of consistency and transparency for all staff about how RAGG rating is applied as well as the mitigations that can be applied.	01-Mar-26
2.3	Invite two external Director of Midwifery colleagues to attend our cross-site huddles and provide feedback on our documentation and processes	01-Apr-26	Director of Midwifery	DoM colleagues attended and provided feedback. Feedback was supportive and complimentary, with suggestion for opening the huddle to the MDT, which was actioned.	01-Apr-26
2.4	Complete adaptations to Safe to Start huddle sheets - which are completed on each shift and in weekly monitoring sheets.	01-Apr-26	Director of Midwifery	Safe to Start huddle sheets have been adapted and are completed each shift. This means they now provide a more comprehensive review of delays; staff breaks and detail in relation to acuity of women and babies in inpatient areas.	01-Apr-26
2.5	Ensure delays in care have been added and are consistently monitored in the weekly Safe to Start	01-May-26	Director of Midwifery	Detailed information about length of delays included in daily Safe to Start huddle reports and also in weekly Safe to Start summary sheets.	01-May-26

	reports, to be shared through Maternity, Women and Children's.			Charts demonstrating the lengths of delays and trends is reported through the weekly Maternity Improvement meetings, Mat, W & C and Acute Clinical Governance meetings. A new 'safe systems of midwifery' PowerPoint has been introduced to the bimonthly Senior Management Group meeting which includes lengths of IOL delays.	
2.6	Ensure acute governance processes are in place, including risk registers.	01-May-26	Director of Midwifery	Delays reported through all governance meetings and in risk register.	01-May-26
2.7	Develop revised and robust processes to ensure that risks around delays in care are consistently escalated through all appropriate processes	01-Jul-26	Director of Midwifery	We have now updated the content of the Clinical governance reports for Mat, W & C and Acute to include Delays in care, number of diverts, number of women moved between units, number of PCBs delayed.	25-Jun-26
2.8	Introduce an on-call model of senior members of the maternity team to support out-of-hours cross-site huddles	01-Jul-26	Director of Midwifery	SOP agreed. Rota now complete and commenced on 01.07.26 10 senior midwives and CSM and GM on call. Two meetings held with all charge and senior charge midwives to discuss the on call. Well received. This has been a four-month pilot. Survey with all staff impacted by the on-call model is currently underway in October 2026 to identify if the model should continue and any improvements required.	01-Jul-26
2.9	NHSGGC will continue the ongoing response to the findings of maternity workload tool runs	01-Oct-26	Director of Midwifery	Agreement to recruit a further 18 WTE NQMs above funded establishment. Offers now made to 62 WTE NQMs - Due to withdrawals and reserve list we expect 55 NQMs on site in October with a second tranche in January 2027. NQMs to start induction programme on 6.10.26 for one week, followed by one week supernumerary practice. Increased staffing to be in place from 20.10.26. Additional interviews of	25-Jun-26

				reserve list of NQMs being undertaken for further January intake to ensure all additional funded roles filled.	
3.1	Continue focussed work progressing Interpreter framework and Anti racist action planning, including benchmarking against other boards through MDT inequalities group	Ongoing	Director of Midwifery	NHS GGC involvement complete in new national UK RCM anti racist training. To be rolled out later in 2026. NMC anti racism principles shared on Maternity hub with all staff in September 2026. Maternity inequalities MDT group continues to meet and feed into the Board wide anti racism work, with a range of ongoing actions. This currently includes work with the British Islamic Medical Association (BIMA) to develop staff guidance and a patient information leaflet on fasting during pregnancy, to be launched at Ramadan 2027.	Complete & Ongoing
3.2	Continue to ensure revised guidance that affirms the need to book interpreters in a timely manner for all scheduled appointments and to highlight the need to seek in person and telephone interpreters for unscheduled care is embedded and utilised. This includes guidance that family members should not be used as interpreters.	Ongoing	Director of Midwifery	Our audit has highlighted a very high level of success in booking telephone interpreters when required – at over 96%, whilst in-person interpreters have been available at the time of need in 80% of cases. Where an in-person interpreter is not available, the team progress to book a telephone interpreter. Maternity services in NHSGGC are the second highest user of interpreting services in NHSGGC.	Complete & Ongoing
3.3	Ensure ongoing in-person and online training alongside marketing materials are available to all maternity staff	Ongoing	Director of Midwifery	Two audits of interpreting service provision in maternity services were completed in 2023 and 2024, which demonstrated an improvement in the quantity and quality of interpreting provision between the two audits. New guidance shared with all staff in October 2025, identifying that family members should not be used. Tuesday Topics and in person interpreter training sessions have been held with maternity staff. Marketing materials, including desk toppers and posters are	Complete & Ongoing

				in all clinical areas with guidance about how to book interpreters. Further staff survey on interpreting service provision undertaken in July 2026, highlighting some ongoing issues with quality and access, but indicating high levels of awareness about how to book interpreters. These findings will be actioned through a new MDT SLWG.	
3.4	Introduce new options for interpreting in antenatal classes	01-Jan-26	Director of Midwifery	Women who require an interpreter to attend antenatal classes can be referred by their midwife via a Badgernet referral. All women should be offered antenatal classes as part of their antenatal care. Women are given the option of attending the group classes with an interpreter or having a one-to-one session. Uptake of classes requiring interpreter support has been relatively low, with a high DNA rate despite the classes/one to one sessions and interpreter arrangements being made directly with the women.	01-Jan-26
3.5	Ensure continuous improvement of access to a full range of interpreting and translation services for maternity services	Ongoing	Director of Midwifery	Interpreting improvement group being established to address quality and access issues identified in staff survey. QI project on introduction of continuity of interpreter. Current commissioning process underway in relation to interpreter provider, to be finalised by April 2027. Video interpreting pilot underway, proving successful in initial stages.	Complete & Ongoing
3.6	Seek staff feedback regarding the quality and quantity of the interpreting service provision whilst ensuring ongoing auditing to monitor success rates of interpreter requests.	Ongoing	Director of Midwifery	Survey completed in July 2026, with over 200 responses. Results shared with leadership team. Working group being established to address issues relating to quality and access.	Complete & Ongoing

3.7	Seek feedback through regular meetings with third sector organisations, including Amma Birth companions, on our interpreting and translation services to ensure continuous improvement.	Ongoing	Director of Midwifery	Regular meetings continue to ensure continuous improvement.	Complete & Ongoing
3.8	Commence a pilot in QE of video interpreting provision as a second line option when in person interpreters are not readily available.	01-Jun-26	Director of Midwifery	Video interpreting pilot underway with positive feedback from maternity staff users so far.	01-Jun-26
3.9	Continue to translate all key maternity patient information leaflets into our top ten community languages.	Ongoing	Director of Midwifery	Many of the key patient information leaflets have been translated into our top ten community languages, alongside this, the online single point of access booking system for maternity care is available in translated form in the top ten community languages. These are available to women through their Badgernet app and can also be provided in printed form.	Complete & Ongoing
4.1	(i) To support scheduled care within maternity assessment unit, the BSOTS triage algorithms provide clear guidance for directing women with non-obstetric, medical conditions or trauma into acute and ED services, rather than bringing to maternity services.	02-Mar-26	Director of Women & Children	BSOTs model established across RAH, PRM and QEUH.	02-Mar-26
4.2	(ii) To support non-obstetric unscheduled presentation and admissions, a new revised guideline on sudden onset chest pain and or shortness of breath in pregnancy has been agreed and is subject to final ratification	01-Jun-26	Director of Women & Children	Guideline finalised and uploaded to Right Decisions Platform.	01-Jun-26
4.3	(iii) To support an appropriate level of clinician review, a well-established model with consultant obstetricians on calls out of hours is in place. (When a consultant lives out with the immediate geographical catchment of the hospital, they will stay within the hospital)	Ongoing	Director of Women & Children	Survey underway October 2026 with SCMs and CMs to identify any concerns with consultant labour ward attendance out of hours.	Complete & Ongoing

4.4	(i) This forms part of the completed and ongoing maternity triage improvement work. Audits of the time taken to assessment in our triage units will continue. Monitoring of waiting times in the triage units will also continue and will be reported to Maternity Governance and Assurance groups. Formal reporting process to commence from June	Ongoing	Director of Women & Children	As above, ongoing detailed audit, improvement cycle and governance reporting. Triage project midwife has now finished secondment. Responsibility for ongoing audit sitting with SCMs for each triage unit. Teams channel set up to share audit results.	Complete & Ongoing
4.5	(ii) Establish a SLWG with Acute and ED colleagues to develop a range of agreed pathways for women presenting with non-obstetric presentations, in addition to the recently completed development of guidance on care of women with sudden onset chest pain or shortness of breath.	01-Jul-26	Director of Women & Children	Ongoing work through SLWG group for maternity and all EDs to ensure smooth care pathways, proactive communication and exploration of potential for more MDT joint training.	01-Jul-26
4.6	(ii) Output of SLWG to be shared	01-Oct-26	Director of Women & Children	Meetings of the SLWG have taken place with more scheduled. The output of this is that the Lead for ED has taken the guidance and tailored it for PRM - agreed next steps are for this to be replicated in the other sites. This work will be completed by the end of the year ensuring consistent guidance in place and tailored to each site.	30-Sep-26
4.7	(iii) Continue to monitor out-of-hours consultant presence in the labour suites and encourage staff to submit a DATIX if there is any concern or delay in relation to requested consultant attendance.	Ongoing	Director of Women & Children	No Datix reports of any concerns about consultant presence on labour ward. Included in survey with SCMs and CMs about out of hours presence and support.	Complete & Ongoing
5.1	Implement a plan to inform frontline staff of the appropriate processes to escalate equipment needs and ensure replacement, repair and increase in provision of all equipment including fetal monitoring equipment.	01-Feb-26	Director of Midwifery	New Teams channel and guidance for all SCMs to ensure clarity about expectations of their role, ensure availability of all appropriate checklists and reporting mechanisms now in place for all sites.	01-Feb-26

5.2	Complete audit all CTG (fetal monitoring equipment)	01-Feb-26	Director of Midwifery	As above, guidance for ongoing monitoring of fetal monitoring equipment in place. As part of Listen to Baby project to support improved intermittent auscultation, review of availability of IA equipment completed. Orders for appropriate equipment including pinards and duotones then submitted as required.	01-Feb-26
5.3	Implement new rigorous daily checklists in all areas including checking of all emergency equipment and medication has been implemented. To be monitored weekly by the ward senior charge midwives and the unit lead midwife and then overseen by the Associate chief midwife on a monthly basis.	01-Apr-26	Director of Midwifery	Well embedded as business as usual in all wards in all units. This process is assured and verified through the weekly ward level support visits. Reported weekly to maternity improvement group and nurse director.	01-Apr-26
5.4	Procure new emergency trollies across maternity areas. Final numbers and allocation will be confirmed once product selection has been agreed with the Resuscitation Team.	01-Sep-26	Director of Midwifery	New standardised adult resus trollies in place in all units.	12-Aug-26
5.5	Ensure all emergency trollies are appropriately stocked and maintained in line with current recommendations	01-Feb-26	Director of Midwifery	Daily checks well established as business as usual, take place immediately after handover each day.	01-Feb-26
5.6	Ensure currently approved checklists in use	01-Feb-26	Director of Midwifery	As above, this is verified in the weekly support visits and through the SCM teams channel.	01-Feb-26
5.7	Introduce tamper-evident tagging systems in Labour Ward and Ward 47. To be checked and replaced weekly (every Monday) unless opened.	01-Feb-26	Director of Midwifery	Tagging systems in place on new resus trollies.	01-Feb-26
5.8	Continue to carry out daily emergency trolley checks and provide weekly assurance that checks are completed and documented in all other clinical areas	Ongoing	Director of Midwifery	As above, well established as business as usual.	Complete & Ongoing

5.9	Explore the benefits of developing a new digital approach to the maintenance and checking of all emergency trollies	01-Oct-26	Director of Midwifery	New emergency trollies with consistent specifications have recently been installed at the QE, PRM and RAH and signed off by resus team. They do not have digital capability. The benefits of changing these trollies have been explored and it may be a possibility for the future when trollies need renewed. The resus Team are currently scoping a quote for the digital checking system. Clear process in place to check the trollies along with access to the same equipment in each unit.	25-Sep-26
5.10	Ensure the revised and updated processes for monitoring, ordering and checking of fetal monitoring and obstetric emergency equipment are continuously monitored and revised as required.	Ongoing	Director of Midwifery	As above, new guidance and Teams channel for all SCMs and CMs and LMs.	Complete & Ongoing
6.1	Ensure Diamorphine/Morphine is available for use in both the Maternity Assessment Unit and the antenatal ward, in line with local guidelines and clinical assessment.	Ongoing	Director of Midwifery	Diamorphine/Morphine is available for use in both the Maternity Assessment Unit and the antenatal ward, in line with local guidelines and clinical assessment.	Complete & Ongoing
6.2	Ensure Mobile Entonox is only used within the antenatal ward for short duration procedures, such as examinations or other brief interventions and not for prolonged periods	Ongoing	Director of Midwifery	Use of Mobile Entonox is not prolonged and only used within the antenatal ward for short duration procedures	Complete & Ongoing
6.3	When one to one care cannot be accessed in labour ward, women will continue to receive appropriate monitoring of their own and their baby's wellbeing. This includes continuous electronic fetal monitoring where this is indicated and the full range of maternal observations.	01-Apr-26	Director of Midwifery	In circumstances where one-to-one care cannot be provided, women will continue to receive safe and appropriate monitoring of their own wellbeing and that of their baby. This includes continuous electronic fetal monitoring when required, together with the full range of maternal observations. This is set out in a Standard operating procedure.	01-Apr-26

6.4	Increase the funded midwifery establishment by more than 35 whole time equivalents	01-Apr-26	Director of Midwifery	Step wise increase in midwifery staffing has continued - by January 2027 there will be 55 WTE midwives above funded establishment, compared to October 2025. This is the equivalent to 10 additional midwives on each shift across GGC. This represents a 10%+ increase in overall staffing.	01-Apr-26
6.5	Embed formal postnatal ward rounds with an obstetrician, accompanied by a midwife, in each postnatal ward	01-May-26	Director of Midwifery	Postnatal ward rounds embedded with consideration of potential improvements to this will be part of the postnatal inpatient improvement group commencing October 2026.	01-May-26
6.6	Implement a guideline for women experiencing delays to care which will include standardised monitoring protocol for women not receiving 1:1 care in labour, supported by a structured risk assessment and escalation process, clear documentation standards within the clinical record, and real-time senior midwifery oversight at shift level.	01-May-26	Director of Midwifery	New guideline developed and due for ratification at guidelines group October 2026, will then be uploaded to Right Decisions Platform and highlighted to all staff through Maternity Matters newsletter and cascaded through team meetings.	01-May-26
6.7	Ensure compliance is monitored through regular audit of cases where 1:1 care is not achieved; each case should be individually datixed with findings reported through local governance structures and the Maternity Assurance Group	01-May-26	Director of Midwifery	Regular audit processes are in place to monitor compliance in cases where one-to-one care is not achieved. Each occurrence is individually recorded, with findings reported through established governance processes.	01-May-26
6.8	A further workload tool to be run in June 2026	30-Jun-26	Director of Midwifery	Workload tool ran from 1st - 14th June 2026. Data processing and triangulation continues. This was the first SLT for Maternity utilising the SafeCare platform, recently released by HIS. In assessing the data as per the common staffing method and our senior team has encountered some issues with the calculation formula, and the results are in query with the local N&W Health & Care Staffing Team and HPS in HIS. Moving this action	25-Jun-26

				forward has a dependency on receiving support and resolution.	
6.9	Implement planned further recruitment above funded establishment continue the stepwise increase in response to the workload tool findings.	01-Jun-26	Director of Midwifery	Recruitment for NQMs successful. 62 WTE job offers out for NQMs. 55 WTE commenced in post October 2026. Ongoing recruitment of reserve list NQMs for start dates in January 2027 underway.	01-Jun-26
6.10	Staff will be reminded to submit DATIX reports for delays in admission to labour suite; these will be reviewed, acted on and escalated as required.	01-Jun-26	Director of Midwifery	Communication issued to all CMs and SCM in April to reinforce requirement to submit Datix reports for delays. The induction delays are automatically monitored daily. The Flow coordinators oversee this and ensure the details are captured on the audit schedule. Associate Chief Midwife reviews the delays for the previous week and produce a report.	01-Jun-26
6.11	Delays in care will be reported through monthly clinical governance and the maternity risk register.	01-Jun-26	Director of Midwifery	All governance and Acute Management group reports now include updates on monthly delay figures, number of diverts and number of PCB delays and women moved between units.	01-Jun-26
7.1	Ensure additional support for babies on the postnatal ward is provided through an 'in reach' approach by the neonatal team.	Ongoing	Director of Midwifery	In -Reach approach by neonatal team well established	Complete & Ongoing
7.2	Ensure there is readily available transitional care criteria included in the daily Safe to Start huddle sheets.	Ongoing	Director of Midwifery	Transitional Care criteria are included in the Safe to Start huddle sheets	Complete & Ongoing
7.3	Ensure the evidence-based guidance/the provision of transitional care within postnatal wards that was updated in Nov 25 continues to be shared with the maternity and neonatal team.	Ongoing	Director of Midwifery	Guidance shared and re-shared with all appropriate staff groups	Complete & Ongoing
7.4	Re-share the above guidance with all staff to ensure continued awareness.	01-Mar-26	Director of Midwifery	Guidance shared and re-shared will all appropriate staff groups	01-Mar-26

7.5	Continue monitoring the suitability of the babies cared for in the postnatal wards to ensure that all babies receive the appropriate level of care.	Ongoing	Director of Midwifery	The suitability of babies cared for in the postnatal wards, is and will continue to be closely monitored	Complete & Ongoing
7.6	Continued focus and further development of postnatal ward staffing to enable increased transitional care on the postnatal ward	31-Dec-26	Director of Midwifery	Postnatal inpatient improvement group to focus on range of measures to test to improve postnatal care. Ongoing consideration of postnatal ward staffing. Uplift in postnatal ward staffing in PRM and QE agreed to support midwife led NIPE clinic model.	On schedule
8.1	Introduce a positive workplace culture group and a co-produced Behaviour's Charter	Ongoing	Director of Midwifery	Group and behaviour charter in place. OD lead to facilitate sessions on refresh of behaviours charter.	Complete & Ongoing
8.2	Carry out a five-week culture survey from April 2026 and analyse the responses to further develop our NHSGGC culture programme.	01-Apr-26	Director of Midwifery	Culture Survey carried out and results shared.	01-Apr-26
8.3	Complete analysis of the maternity, neonatal and gynaecology culture survey	01-Jul-26	Director of Midwifery	Full analysis completed and shared to teams and through governance. Actions resulting from the survey include increased peer support training; additional maternity adverse event training; refresh of midwifery supervision provision; appointment of two new clinical safety midwives and a practice development midwife and the implementation of ongoing culture groups supported by the Organisational development team.	25-Jun-26
8.4	Continue to encourage MDT staff to become trained peer supporters.	Ongoing	Director of Midwifery	Advanced peer supporter training for 12 members of MDT running in October 2026. This will lead to a new SharePoint site to ensure all staff aware of availability of peer support network.	Complete & Ongoing
8.5	Implement an Organisational Development action plan, with a particular focus on QEUH, including	01-Jul-26	Director of Midwifery	Plan developed by OD and implementation work commenced with overall completion expected by March 27. Consultant Midwife is leading on this.	26-Jun-26

	Civility Saves Lives sessions and targeted team support.			Targeted OD team support for triage teams planned for October 2026. CSL planned for later in 2026.	
8.6	Carry out advanced peer supporter training	01-Oct-26	Director of Midwifery	Training for 12 advanced peer supporters commissioned to be run in Autumn 2026. Applicants sought and offers made to successful candidates, with good mix of MDT	12-Aug-26
8.7	Invite the NMC and GMC to support further teamwork and culture sessions.	01-Oct-26	Director of Midwifery	NMC invited. Dates in December agreed for three in person workshops in RAH, PRM and QEUH.	12-Aug-26
8.8	Commission training for 60 senior and frontline staff on incident investigation, family communication and psychological safety.	01-Sep-26	Director of Midwifery	Programme commissioned and will run in November 2026	01-Aug-26
9.1	Increase the maternity clinical safety team by one full-time role and explore further expansion of the team	01-Mar-26	Director of Midwifery	Clinical safety team has been reinforced with the recruitment of 2 additional clinical safety midwives and increased medical staff time in QEUH through allocated job planning for clinical safety.	01-Mar-26
9.2	Ensure the SAER Recommendations Implementation Group (an MDT monthly group) established in 2024 continues to monitor the timely implementation of actions from significant adverse event reviews.	Ongoing	Director of Midwifery	Improved compliance with completion as per data.	Complete & Ongoing
9.3	Introduce the M&M module and the incident module within Datix to Maternity.	01-Apr-26	Director of Midwifery	Clinical safety team have completed,	01-Apr-26
9.4	Implement stronger processes for local safety meetings, including wider access to action notes and minutes as well as recording of attendance to support greater oversight.	01-Apr-26	Director of Midwifery	Increased medical staff time in QEUH allocated in job planning for clinical safety. Commitment for one meeting each week in QEUH. These meetings are minuted, with agenda and clear actions.	01-Apr-26
9.5	Establish local Datix RIGs and will monitor this for each site.	01-Apr-26	Director of Midwifery	This has been established and monitoring continues.	01-Apr-26

9.6	Approve and implement a GGC wide revised Policy and Procedure for Managing Adverse Events (including Maternity services)	01-Jan-26	Director of Midwifery	Revised policy in place.	01-Jan-26
9.7	Develop and implement a revised SOP to ensure senior oversight of all incidents reported and that reviews initiated are appropriate and timely	01-Jun-26	Director of Midwifery	Clear governance processes reinforced. Improved communication channel approach for clinical safety team to ensure team leader has oversight of progress on all clinical risk and adverse events. Weekly AEOG MDT well established for ongoing oversight of all cases.	01-Jun-26
9.8	Complete a review of factors that inhibit compliance with the Healthcare Improvement Scotland national adverse events framework in terms of timescales for commissioning and completing reviews will be completed. This will include consideration of the need for further expansion of clinical risk midwifery and medical staffing capacity.	01-Oct-26	Director of Midwifery	Complete - the clinical effectiveness unit have undertaken and completed their internal review - meetings completed and evidence submitted. 2 additional clinical safety midwives will be in post in Oct and increase in obs time allocated to clinical risk at the QE - new consultant undertaking clinical safety meetings.	25-Sep-26
9.9	Develop and implement a single Women's Health Quality and Safety SharePoint to support the senior oversight of incident review.	01-Jul-26	Director of Midwifery	SharePoint established	23-Jun-26
9.10	All members of the clinical safety team will evidence completion of DoC modules on LearnPro/Turas.	01-Jul-26	Director of Midwifery	Module completed by all of clinical safety midwifery team	26-Jun-26
9.11	Complete a thematic analysis of recommendations and report to Maternity Clinical Governance at its bi-monthly meetings.	01-Jul-26	Director of Midwifery	Thematic analysis developed and to be shared with Mat Gov in regular reporting.	01-Jul-26
10.1	Implement a plan to capture data in relation to obstetric anal sphincter injury through our Badgernet records and report through national reports including NMPA.	Complete & Ongoing	Director of Midwifery	Work has been undertaken to ensure these data are captured and monitored through appropriate channels.	Complete & Ongoing

10.2	Continue to ensure regular audits in all areas using the maternity specific care assurance tool that was developed and implemented in 2024 (includes documentation audit).	Complete & Ongoing	Director of Midwifery	Currently paused for GGC wide review and revision of CCATT and MCCATT tools. This is currently replaced by the weekly support visits. To be relaunched early 2027.	Complete & Ongoing
10.3	Ensure an ongoing Quality Improvement approach for VTE continues to demonstrate improvements. Including an additional user guide and local guidance, narrated presentations as well as other support mechanisms being implemented.	Complete & Ongoing	Director of Midwifery	QI approach continues. A range of work focussing on VTE and PPH is underway.	Complete & Ongoing
10.4	Undertake regular documentation audits by MCCAT peer and external reviewers, and ward managers. The MCCAT will continue to be reviewed to ensure it supports assurance of all key aspects of quality of care.	Complete & Ongoing	Director of Midwifery	The MCCATT is being revised in line with GGC wide improvement work. Where any trends of concern are identified, deep dives have been instigated. Weekly support visits/ward level assurance visits are in place.	Complete & Ongoing
10.5	Ensure continuation of existing data collection including consideration to identifying any further required staff resource to ensure robust and reliable data collection.	Complete & Ongoing	Director of Midwifery	We continue to ensure data is collected in a robust and reliable way.	Complete & Ongoing
10.6	Support the implementation of the National MEWS, including a robust audit of documentation, compliance and escalation.	25-Sep-26	Director of Midwifery	This has been completed and rolled out including education for staff.	25-Sep-26
10.7	Implement further communication channel and approaches to ensure the data collected is visible, shared in a meaningful way with the MDT and discussed routinely at governance forums to support learning and improvement.	30-Sep-26	Director of Midwifery	Maternity Hub and dashboard in place, presentation will be shared with the frontline team.	30-Sep-26
11.1	We have introduced a range of new approaches to ensure a reduction in the number of breached guidelines. We will ensure a continued reduction in the number of breached guidelines during 2026. Our aim is to reach a position where all	31-Dec-26	Director of Midwifery	Good progress is being made through focussed work on reducing the number of breached guidelines, with all breached guidelines assigned to a lead reviewer.	

	guidelines are reviewed and updated in a timely manner.				
11.2	A Consultant obstetrician and Consultant Midwife to be allocated as co-chairs of the Guidelines group	18-May-26	Director of Midwifery	A Consultant obstetrician and Consultant Midwife have been allocated as co-chairs of the Guidelines group.	18-May-26
12.1	Establish weekly meetings with facilities and estates colleagues to meet with the general management and midwifery team to address identified issues.	01-Apr-26	Director of Midwifery	Weekly meetings established.	01-Apr-26
12.2	Establish monthly MDT walkabouts including Estates and Facilities colleagues of the unit,	01-May-26	Director of Midwifery	Monthly MDT walkabouts in place with the support of Estates and Facilities colleagues.	01-May-26
12.3	Ward managers to receive a reminder of their key role in reporting and following up the need for repairs to the environment and their central role in providing a clean and safe environment and escalating any concerns to their unit lead to address if required.	01-Apr-26	Director of Midwifery	Completed and ongoing. New Teams channel with detailed and robust one stop shop guide for all SCMs to be clear about their roles in this area, identifying the daily, weekly and monthly tasks.	01-Apr-26
12.4	Ensure a renewed focus on the importance of effective maintenance for the QEUH maternity unit	Ongoing	Director of Midwifery	Clear focus remains on maintenance of QEUH maternity unit and of course all maternity sites. This is supported by the weekly meetings, monthly walkabouts and clear communication.	Complete & Ongoing
13.1	All staff have been reminded to ensure that call bells are always put within reach of a woman who is confined to a bed.	20-May-26	Director of Midwifery	We have ensured staff are aware to make all call bells accessible for women.	20-May-26
13.2	A full audit of all call bells has been undertaken (There are currently no known issues with call bell availability or functionality across QE Maternity services	01-Apr-26	Director of Midwifery	The full audit of call bells was undertaken and no issues re availability or functionality were found. The maintenance of the call bell system is monitored and discussed regularly with estates and facilities colleagues	01-Apr-26

14.1	Implement revised checklists for completion daily, weekly and monthly. <i>(The responsibility for the maintenance of these standards sits with every individual employed by NHSGGC in the maternity unit and is clearly set out in a range of policies and their job descriptions)</i>	01-Feb-26	Director of Midwifery	Revised checklist in place in all units.	01-Feb-26
14.2	Remind each shift lead and ward manager about their key role in implementing and overseeing the implementation of these key areas of care and provided with supportive documentation to complete.	01-Apr-26	Director of Midwifery	As above, range of new documentation and new channel for reporting up to LM. Workshops x 3 for all SCMs provided by DoM and ACM emphasising this area of responsibility.	01-Apr-26
14.3	Ensure each ward area continues to complete a handover checklist to be used at the beginning of each shift. This will be overseen on a weekly basis by the unit lead, and then, monthly, by the Associate chief midwife.	Ongoing	Director of Midwifery	This continues to be in place ward areas complete a handover checklist at the start of each shift. This is be overseen on a weekly basis by the unit lead, and then, monthly, by the Associate chief midwife.	Complete & Ongoing
14.4	Implement a new monthly walkabout, with a detailed checklist, to enable the Associate chief midwife to observe and feedback all these areas of environmental and infection prevention and control to the lead midwife for the unit has been implemented.	01-Apr-26	Director of Midwifery	Monthly walkabout now well established.	01-Apr-26
14.5	Ensure increased presence in maternity areas from Infection prevention and control colleagues as well as domestic facilities colleagues.	01-Apr-26	Director of Midwifery	There is increased presence in maternity areas from IPC and domestic facilities colleagues.	01-Apr-26
14.6	Introduce a new weekly Maternity improvement meeting, chaired by the Director for Women and Children's.	01-May-26	Director of Midwifery	Meeting ongoing and well attended, chaired by Director of W & C or DoM; notes and actions recorded.	01-May-26
14.7	Complete work currently being undertaken with wider NHSGGC teams to identify effective approaches to ensure compliance with uniform	31-Jul-26	Director of Midwifery	In conjunction with Partnership colleagues, new guidance for all staff re uniform policy and dress code shared during September 2026. A core brief	17-Jul-26

	policy; this will lead to a change to the approach to address non-compliance by staff.			reminder for staff was published in July 2026. Video by DoM in September 2026, shared with all staff. New posters on uniform to be shared in all areas. Await finalisation of slightly revised uniform policy in October 2026 which will ensure consistency for all staff.	
14.8	Ensure a more robust approach to ensuring regular risk assessment and mitigations are in place to address reduced bed spacing, particularly during busy periods, has been implemented.	Ongoing	Director of Midwifery	Robust approach to address reduced bed spacing, particularly during busy periods, has been implemented and continues.	Complete & Ongoing
14.9	Introduce and recruit to a new housekeeper role in the labour suite to support midwifery teams with these particular areas of the environment, particularly storage, line management and equipment cleanliness.	01-Jul-26	Director of Midwifery	Housekeepers now recruited for both QEUH and PRM. Started July 2026.	25-Jun-26
15.1	Introduce a formal process whereby each SCM undertakes a weekly audit of compliance within their clinical area. SCMs provide weekly assurance to the Lead Midwife confirming that flushing has been completed in line with current guidance.	01-Feb-26	Director of Midwifery	A formal weekly assurance process confirming flushing has been completed in line with guidance was introduced February 2026.	01-Feb-26
16.1	Implement monthly Medicines Administration and Observation of Practice (MAOP) audits.	01-Apr-26	Director of Midwifery	Monthly Medicines Administration and Observation of Practice (MAOP) audits in place and monitored.	01-Apr-26
16.2	Introduce standardised audit schedules and templates. SCMs will report audit findings to the Lead Midwife/DoM through a designated centralised location.	01-Apr-26	Director of Midwifery	To provide oversight and transparency, standardised audit templates and schedules are in place with audit findings reported to Lead Midwife/DoM	01-Apr-26

16.3	Utilising audit findings, develop action plans and identify risks/capacity issues which will be escalated through Maternity Governance routes.	01-Apr-26	Director of Midwifery	Action plans now developed from audit findings.	01-Apr-26
16.4	Appoint a Risk Midwife to the Women and Children's Safer Use of Medicines Committee.	01-Mar-26	Director of Midwifery	Risk Midwife appointed to the Women and Children's Safer Use of Medicines Committee.	01-Mar-26
16.5	Responsibility and expectations regarding SSHM and Medicines management assurance has been clearly communicated to all SCMs, outlining MAOP audit requirements and responsibilities.	01-Apr-26	Director of Midwifery	The NHSGGC Safe and Secure handling of Medicine (SSHM) policy outlines definitive responsibility and accountability for medicines safety in all clinical areas and is applicable to ALL staff working within NHS GGC who handle medicines and is clearly communicated	01-Apr-26
16.6	Introduce robust systems to improve compliance with NHS GGC policy on SSHM, with a system for regular monitoring and reporting to provide ongoing assurance.	01-Aug-26	Director of Midwifery	Systems in place to improve compliance with NHS GGC policy on SSHM, including regular monitoring and reporting to provide ongoing assurance.	Complete & Ongoing
16.7	Develop plans to ensure increased compliance within the system and to identify and train medicines safety champion roles in each ward area.	01-Aug-26	Director of Midwifery	Increased assurance of medicines management through weekly support visits in all wards. Increased pharmacy presence in all wards. The majority of wards has a Medicines Safety Champion in place with two wards pending where champions have been nominated.	Complete & Ongoing
16.8	Develop a business case for a pharmacy technical team with the aim of providing collaborative support for midwifery staff for all aspects of the SSHM to tackle the lack of pharmacy presence across maternity services	01-Oct-26	Director of Midwifery	Business case completed and submitted to senior team for consideration	25-Sep-26
17.1	Issue communication to all areas to reinforce the requirement that all hazardous products must be always stored securely in locked units.	01-Feb-26	Director of Midwifery	Communication issued to all areas reinforcing the requirement that all hazardous products must be always stored securely in locked units.	01-Feb-26
17.2	Repair to identified broken lock and order a new cupboard for the labour ward	01-Feb-26	Director of Midwifery	Broken lock repaired and new cupboard installed	01-Feb-26

	(In the interim, all cleaning fluid is being stored safely in a different locked cupboard)				
17.3	Ensure staff are aware of the requirement to label all hazardous cleaning products clearly, including appropriate concentration details, in line with manufacturer guidance.	01-Mar-26	Director of Midwifery	Staff are aware of this requirement which is also reinforced at through ward assurance visits	01-Mar-26
17.4	Raise a request with Estates to procure appropriate lockable storage for Titanchlor once diluted.	01-Jul-26	Director of Midwifery	Lockable storage unit being provided by estates.	01-Jul-26
18.1	Continue to regularly monitor fire safety training compliance with systems in place to ensure staff complete required training and remain up to date	Ongoing	Director of Midwifery	Fire safety training compliance is regularly monitored, with systems in place to ensure staff complete required training and remain up to date.	Complete & Ongoing
18.2	Procure gas cylinder trolleys to ensure cylinders are stored safely and appropriately and remove excess cylinders from ward areas to reduce risk and maintain compliance.	01-Feb-26	Director of Midwifery	Gas cylinder trolleys have been procured and installed and excess cylinders removed.	01-Feb-26
18.3	Order appropriate gas signage and install in the relevant clinical areas as planned.	01-Aug-26	Director of Midwifery	Appropriate signage was ordered and installed.	01-Aug-26
18.4	A member of the maternity team to be invited to join the GGC medical gases committee. To ensure ongoing awareness and focus,	01-May-26	Director of Midwifery	A member of the maternity team has joined the GGC medical gases committee.	01-May-26
19.1	Continue to develop and improve the Safe to Start huddle processes and recording to enable real time monitoring of risks and delays in care will continue to be developed and improved.	Ongoing	Director of Midwifery	Although Safe to Start huddles are well established, we are continually reviewing the processes to implement improvements	Complete & Ongoing
19.2	Encourage and reinforce the submission of Datix by staff where there are significant concerns about staffing. Where staff have not been able to access a rest break and where there have been delays in care, the senior team will continue to review and respond to these concerns promptly,	Ongoing	Director of Midwifery	We continue to promote and reinforce the use of Datix reporting where staff have significant concerns regarding staffing levels, missed rest breaks or delays in care. The senior team promptly reviews and responds to all reported concerns, implements appropriate actions to	Complete & Ongoing

	undertake necessary actions to prevent recurrence and feed back to staff the results of the Datix process.			mitigate the risk of recurrence, and ensures feedback is provided to staff on the outcomes and learning arising from the Datix process.	
19.3	Ensure delays in care are monitored in the weekly Safe to Start reports, to be shared through the Maternity, Women and Children's and Acute governance processes including risk registers.	01-May-26	Director of Midwifery	Delays in care are included and monitored through the safe to start process and shared through appropriate governance and risk channels.	01-May-26
19.4	Ensure the operational senior team are encouraged to escalate any concerns through bimonthly maternity governance reports or by more immediate methods if they are unable to address the concerns raised in the Datix	Ongoing	Director of Midwifery	We continue to ensure the operational senior team escalates unresolved concerns through bi-monthly maternity governance reports or more immediate routes where timely action is required.	Complete & Ongoing
19.5	Share and escalate the findings of the maternity workload tool in line with Safe staffing legislation. This will include a further workload tool run in June 2026	01-Oct-26	Director of Midwifery	Workload tool ran from 1st - 14th June 2026. Data processing and triangulation continues. This was the first SLT for Maternity utilising the SafeCare platform, recently released by HIS. In assessing the data as per the common staffing method and our senior team has encountered some issues with the calculation formula, and the results are in query with the local N&W Health & Care Staffing Team and HPS in HIS. Moving this action forward has a dependency on receiving support and resolution.	At Risk
19.6	Ensure Datix is submitted to record if a woman has had a delay in admission to labour suite. These delays in appropriate care will be included in monthly clinical governance reporting and added to the maternity risk register.	01-Jun-26	Director of Midwifery	Delays in admission to labour suite are recorded on Datix and reported through clinical governance	01-Jun-26
20.1	Ensure charge and senior charge midwives have been provided with training on use and escalation of Safe to Start huddle sheets.	01-Apr-26	Director of Midwifery	Training on the use and escalation of Safe to Start huddle sheets has been rolled out to all senior staff	01-Apr-26

20.2	Develop and add new descriptors to the Safe to Start huddle sheets which indicate more accurately and in line with the new 'Safe start' workload tool descriptors and include further guidance on transitional care, RAGG rating criteria for each ward.	01-Apr-26	Director of Midwifery	Development of the Safe to Start huddle sheets continues including the addition of new descriptors and RAGG	01-Apr-26
21.1	Ensure risks and pressures within maternity services continue to be included in the Acute daily touchpoint, attended by senior executive team by the Director of W & C	Ongoing	Director of W&C	All maternity pressures and risks are communicated at the Acute Daily Touchpoint.	Complete & Ongoing
21.2	Ensure existing mechanisms such as senior walkabouts, Tuesday Topics, SharePoint updates, newsletters and six-weekly meetings with charge midwives continue to be fully utilised to support senior visibility and engagement with all staff	Ongoing	Director of Midwifery	Senior staff continue to utilise all channels of staff engagement to maintain visibility and accessibility for staff	Complete & Ongoing
22.1	Implement improvements to the medical staffing pastoral care provision (single point of consultant contact, consultant attendance at induction meetings to highlight pastoral care, regular formal pastoral care meetings throughout the year).	10-May-26	Director of Midwifery	We have made improvements to the pastoral care provision for staff	10-May-26
22.2	Increase Peer supporter capacity across the MDT.	08-May-26	Director of Midwifery	12 MDT colleagues supported to undertake advanced three-day peer support training in October 2026, to then establish a maternity and gynaecology peer support team and Share point. All staff have been encouraged to undertake the one-day internal GGC peer support training.	08-May-26
22.3	Test additional approaches to improve visibility and communication, including town hall meetings, short films, narrated updates, podcasts and 'You said, we did' posters	01-Jul-26	Director of Midwifery	Engagement with comms colleagues underway with implementation plan taken forward on an ongoing basis from Aug 26. DoM drop-in sessions in each unit commenced October 2026. DoM handover and catch-up sessions at all ward	26-Jun-26

				handovers in all units in September 2026. Short films from DoM for all staff on key topics shared x 2. Wider senior team to share short films to provide key updates.	
22.4	Further develop the safety culture work and education on raising concerns and adverse event review	01-Sep-26	Director of Midwifery	NMC and GMC workshops dates set; Baby lifeline training dates set; new online recording by DoM and OD manager on culture survey results and next steps	01-Aug-26
22.5	Ensure Senior charge midwives and lead midwives provide direct feedback to staff who raise concerns or submit DATIX reports.	01-Sep-26	Director of Midwifery	A process is in place to ensure SCMs and Lead Midwives provide feedback to staff who raise concerns	01-Sep-26
22.6	Implement advanced peer supporter training to strengthen staff support after critical incidents.	01-Sep-26	Director of Midwifery	Candidates chosen for advanced peer supporter training and dates set for training in October	01-Aug-26
23.1	Through continued implementation of the 'Leading the Way' strategy. We are working to ensure clinical leaders have protected leadership time through measures including increasing our overall midwifery staffing levels, responding to the maternity workload tool findings	Ongoing	Director of Midwifery	Ensuring clinical leaders have protected leadership time continues to be a priority. This is supported by the increase in midwifery staffing levels and continued implementation of the 'Leading the Way' strategy	Complete & Ongoing
23.2	Implement a new monitoring approach for lead midwives to ensure that charge and senior charge midwives can report when they are unable to have nonclinical time required for their leadership and management responsibilities. The results will be reported at the monthly lead midwife meetings with the DoM and to the operational meeting, chaired by the General Manager.	01-Jul-26	Director of Midwifery	Reporting mechanism has been agreed and in place	26-Jun-26
23.3	Continue to undertake the maternity workload tool to monitor and address our staffing levels. This will reduce the number of instances where leaders are required to work clinically.	01-Jul-26	Director of Midwifery	Workload tool run for June 2026 completed and results being collated, as noted previously difficulties with the new calculations are being escalated. Midwifery staffing levels have continued to rise during 2026, with significant	26-Jun-26

				NQM intake above previous funded establishment.	
24.1	Continue to utilise the digital dashboard introduced in 2025 to support monitoring of compliance rates with core mandatory training and tracking attendance at educational sessions.	Ongoing	Director of Midwifery	Continue to utilise the digital dashboard introduced in 2025 to support monitoring of compliance rates with core mandatory training and tracking attendance at educational sessions.	Complete & Ongoing
24.2	Continued focused work to encourage and support attendance at core mandatory training sessions and build on improvements already made	Ongoing	Director of Midwifery	Continued focused work to encourage and support attendance at core mandatory training sessions and build on improvements already made	Complete & Ongoing
24.3	Pilot a new approach for the provision of midwifery core mandatory training which is anticipated to make a positive contribution to increasing the ability of staff to attend all core mandatory training.	30-Jun-26	Director of Midwifery	Pilot a new approach for the provision of midwifery core mandatory training which is anticipated to make a positive contribution to increasing the ability of staff to attend all core mandatory training.	26-Jun-26
24.4	The key mitigation to ensure greater training compliance is the work underway and continuing to increase our midwifery staffing levels.	30-Jun-26	Director of Midwifery	The key mitigation to ensure greater training compliance is the work underway and continuing to increase our midwifery staffing levels.	26-Jun-26
25.1	Completion of 3 rounds of active recruitment of midwives over a period of 12 months addressing all vacancies and increasing our overall staffing.	01-Apr-26	Director of Midwifery	Our staffing levels have continued to increase over 2026. 55 additional midwives in post by January 2027.	01-Apr-26
25.2	Ensure staff have received training and guidance to complete the revised maternity Workload Tool Run effectively.	01-May-26	Director of Midwifery	Staff have undertaken training on the completion of the maternity Workload Tool run and continued guidance is in place	01-May-26
25.3	Continue recruitment in response to workload tool findings	Ongoing	Director of Midwifery	We are continuing to incrementally recruit in response to the Workload tool run outputs. Although there has been significant investment in maternity workforce over 2026, some gaps still remain.	Complete & Ongoing

26.1	Continue to consider and regularly share themes from the Patient Engagement care opinion posts and complaints through clinical governance reports	Ongoing	Director of Midwifery	Thematic analysis of complaints and care opinion posts undertaken by PEPI team and to be shared through governance routes in October 2026.	Complete & Ongoing
26.2	Ensure there are robust complaints processes with the majority of complaints responded to within agreed timescales and in-person meetings offered where appropriate	Ongoing	Director of Midwifery	There are robust complaints processes in place, with high rates of responding to complaints within set timescales.	Complete & Ongoing
26.3	Develop an innovative approach to track themes, identify learning and any service change required, and implement these in a timely way. This will be carried out in collaboration with the complaints and public engagement team and governed through our Maternity Assurance Group	01-Jul-26	Director of Midwifery	Engagement with PEPI underway and work commissioned	26-Jun-26
1a.1	Consider and decide whether Trauma Informed Practice Training should be made mandatory in GGC for Maternity staff. (this is not yet mandated by Scottish Government as part of mandatory training for maternity staff)	31-Dec-26	Director of Midwifery	Trauma informed care SLWG being established to commence November 2026, with MDT representation, chaired by MNPI midwife and supported by consultant midwife. The group will develop training plans and explore debriefing approaches.	
1a.2	Design a plan for the nationally available trauma-informed practice modules to be further rolled to all staff groups	31-Dec-26	Director of Midwifery	TURAS modules have been shared with team	30-Sep-26
1a.3	Embed Trauma Informed Approach in all SMMDP programmes, including SCOTTIE, SNRC and REACTS.	Ongoing	Director of Midwifery	Trauma informed approaches are embedded in all Mandatory training sessions including SCOTTIE.	Complete & Ongoing
1a.4	Ensure all core mandatory training for midwives is delivered using trauma informed principles.	Ongoing	Director of Midwifery	Already embedded.	Complete & Ongoing
2a.1	Increase staffing in the postnatal ward to support increased midwife-led NIPE.	01-Apr-26	Director of Midwifery	Staffing has been increased. One midwife to undertake NIPE clinic on postnatal ward from	01-Apr-26

				October, to be joined by two further midwives in November and December.	
2a.2	Re-establish the midwife led NIPE service across postnatal wards	01-Oct-26	Director of Midwifery	Midwife led NIPE will incrementally commence from October - This will be supported by the NQM starting - to release experienced staff - full service likely Nov	
3a.1	Continue to implement a revised visiting approach based on substantial engagement with staff and women.	Ongoing	Director of Midwifery	Survey with women in July 2026 explored views on visiting. This will feed into the MDT postnatal inpatient improvement working group to commence October 2026.	Complete & Ongoing
3a.2	Ensure availability of some side rooms for each ward. (Allocated on an individualised and flexible basis to enable partners to be able to stay overnight.)	Ongoing	Director of Midwifery	We continue to ensure the availability of some side rooms for each ward	Complete & Ongoing
3a.3	Ensure suitable accommodation is provided to families and partners when their babies are unwell on the neonatal unit.	Ongoing	Director of Midwifery	Suitable accommodation is provided to families and partners when their babies are unwell on the neonatal unit.	Complete & Ongoing
3a.4	Ensure continued careful monitoring is undertaken to allow that all families with babies in the neonatal unit are able to stay with them.	01-Oct-26	Director of Midwifery	New approach to embed this in the daily unit huddles and then cross site safety huddle sheets to identify when this has not been possible. Implemented October 2026.	
3a.5	Carefully monitor the feedback we receive from women and families about their experience of visiting +and having their partners with them and repeat the survey with families to gather views on visiting arrangements.	01-Oct-26	Director of Midwifery	Survey has been completed - postnatal inpatient ward improvement group to be established	25-Sep-26
4a.1	Continue to further develop the maternity bereavement services. Building on the appointment of 2 full-time additional bereavement midwives in addition to the previous one.	Ongoing	Director of Midwifery	Further 0.4 bereavement midwife advertised for QEUH to join bereavement team to increase capacity.	Complete & Ongoing

4a.2	Continue to implement the rolling action plan aligned to the senior-led MDT multi-agency bereavement coordinating group for Women and Children's bereavement care improvement	Ongoing	Director of Midwifery	We continue to implementation of the rolling action plan	Complete & Ongoing
4a.3	Continue to encourage all staff to undertake further bereavement training. MDT bereavement training will continue to be offered every six months, with over 200 staff trained.	Ongoing	Director of Midwifery	Over 200 staff already trained	Complete & Ongoing
4a.4	Implementation of the National Bereavement care pathway and the Miscarriage Framework. The service has submitted progress reports to Scottish Government. This progress has received positive feedback from the NBCP national team. ONGOING	01-Apr-26	Director of Midwifery	National Bereavement care pathway and the Miscarriage Framework are implemented and ongoing	01-Apr-26
4a.5	Develop and implement a suite of patient information leaflets relating to a range of pregnancy and infant loss and translated into our key community languages.	01-Apr-26	Director of Midwifery	A suite of patient information leaflets relating to a range of pregnancy and infant loss have been developed and translated into our key community languages.	01-Apr-26
4a.6	Consider and decide whether Bereavement Training should be made mandatory in GGC for Maternity staff. (this is not yet mandated by Scottish Government as part of mandatory training for maternity staff) Six monthly in person and virtual one day MDT bereavement sessions will continue.	31-Dec-26	Director of Midwifery	Additional SANDs workshops offered summer 2026 to increase training offer.	
4a.7	Develop a dedicated space for bereaved families in addition to the counselling rooms and two bereavement rooms in labour suite.	31-Dec-26	Director of Midwifery	Work is ongoing to develop a dedicated space for bereaved families	
4a.8	Utilising a significant donation from the Glasgow Children's Hospital Charity, carry out substantial refurbishment of the two bereavement rooms in	31-Dec-26	Director of Midwifery	Refurbishment is expected to commence December 2026	

	the QE labour suite, that will also have a separate entrance.				
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