West Suffolk NHS Foundation Trust

West Suffolk Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at West Suffolk Hospital

Requires Improvement 

West Suffolk NHS Foundation Trust (WSFT) provides hospital and community healthcare services and is an associate teaching hospital of the University of Cambridge. WSFT was awarded foundation trust status in December 2011.

WSFT serves a predominantly rural geographical area of roughly 600 square miles with a population of around 242,000. The main catchment area for the trust extends to Thetford in the north, Sudbury in the south, Newmarket to the west and Stowmarket to the east. Whilst mainly serving the population of Suffolk, WSFT also provides care for parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

The maternity service at West Suffolk Hospital delivers approximately 2,500 babies per year and offers a choice of three birth settings: birth at home; the co-located low risk midwifery led birthing unit (MLBU); the consultant led labour suite.

The service is provided by a team of consultant obstetricians who provide consultant presence on labour suite, supported by training grade doctors and midwives who work across the inpatient areas. Community maternity services are provided by four teams of midwives, as well as three continuity of carer teams. The maternity service has a number of specialist midwives. A perinatal mental health midwife works in partnership with the perinatal team at the local mental health trust. The service has a midwife who leads on bereavement and offers ongoing support to women and partners who have suffered a pregnancy loss. The service also had two practice development midwifes to assist maternity staff with their mandatory training and competencies and a safeguarding midwife who staff can seek safeguarding advice from.

We last inspected the maternity service between 24 September 2019 and 30 October 2019. The report was published on 30 January 2020. The maternity service was rated requires improvement overall. Safe and effective were rated as requires improvement, caring and responsive were rated good and well led was rated inadequate. Due to the significant concerns within the maternity service we undertook enforcement to enable the improvement of safety within the service. We issued a warning notice under Section 29A of the Health and Social Care Act 2008 on the 14 November 2019 and told the trust it must improve.

We carried out this unannounced focused inspection to follow up on the issues we identified in our 2019 inspection. We have continued to monitor the trust closely and carried out this unannounced inspection to follow up on the actions taken by the trust to address the safety risks to patients. We found that the trust were now compliant with all aspects of the S29A warning notice.

Our rating of services stayed the same. We rated them as requires improvement because:

- The service was frequently short staffed and had to rely on calling in staff from other areas to cover the labour suite and maternity ward. Staff told us that the shortages impacted their welfare and at times they didn't feel listened to.
- The service did not have a tool in place to triage women. Staff told us that they relied on their clinical decision making when triaging women and that this meant decisions could vary from clinician to clinician.

Our findings

- The service had improved their governance arrangements, however we had concerns about continued lack of compliance with the Maternity Incentive Scheme. Arrangements were not in place for oversight of local audits, two audits we saw did not have action plans assigned to them. The service did not always minute meetings or produced minutes that lacked in detail.

How we carried out the inspection

As part of our inspection we visited the following areas within the maternity service: labour suite, midwifery led birthing unit, F11 ward (the combined antenatal and postnatal ward) and the maternity day assessment unit. We spoke with 21 members of staff including medical and midwifery staff, maternity care assistants and service leads. We observed care, handovers/meetings and reviewed 11 sets of maternity records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information about this service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement 

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service didn't always have enough staff to care for patients and keep them safe.
- The service did not meet training compliance targets for medical staff.
- The service did not have a specific baby abduction policy in place at the time of our inspection and hadn't conducted any abduction drills.
- The service did not use a tool to triage women.
- The service was not compliant with swab recording targets.
- Equipment was not always serviced within its due date.
- The service's local audit programme did not have sufficient governance arrangements and oversight The service was not compliant with national safety recommendations.
- The leadership had implemented improvements to address concerns among the consultant body, but these had not yet embedded.
- The service's strategy was in draft.

However:

- Midwives had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well.
- Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients.
- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

Mandatory training

The service provided mandatory training in key skills to all staff and made sure that all midwifery staff completed it. However, mandatory training compliance targets were not met for medical and anaesthetic staff.

Maternity

Nursing and midwifery staff received and kept up-to-date with their mandatory training. The trust set a target of 90% for completion of mandatory training. Compliance for midwifery staff overall was at 95.5% as of March 2021. The service did not meet the training compliance target for fetal monitoring or Growth Assessment Protocol training (GAP). The service achieved 78.1% compliance with fetal monitoring training, however this training had only been introduced three months earlier and compliance was improving with each month. The services GAP training rates had been met throughout the year but fell to 87% in March 2021.

The mandatory training was comprehensive and met the needs of women and staff. The service's mandatory training was split into trust mandatory training and maternity specific mandatory training which included training on screening, smoking cessation, tissue viability, breastfeeding, fetal monitoring and diabetes.

The service used Practical Obstetric Multi-Professional Training (PROMPT) to deliver some of the maternity mandatory training. The topics covered by the PROMPT training included: sepsis, inverted uterus, human factors, sepsis, Modified Early Obstetrics Warning Score, obstetric haemorrhage, shoulder dystocia, breech, eclampsia, twin birth and cord prolapse. The training was delivered by a multidisciplinary team and involved a mixture of skills and live drills sessions and presentations, this was in line with the saving babies lives care bundle.

At the time of our inspection 96% of midwives had completed PROMPT training. This was a significant improvement since our last inspection in September 2019 when only 75% of midwives had completed the PROMPT training.

Medical staff did not always keep up-to-date with their mandatory training. Overall mandatory training rates for medical staff were 84%, this was below the 90% trust target, Obstetric medical staff missed the trusts target for PROMPT (89.7%), Growth Assessment Protocol training (GAP) (80%) and safeguarding children training (85%). Obstetric staff met the training compliance target in fetal monitoring training, achieving 90.9%.

PROMPT training rate compliance was not met for anaesthetic staff with a compliance rate of 73.3%. We asked staff about this on inspection and were told that anaesthetic staff rotated frequently which made it harder for them to complete the training. Staff told us that anaesthetic staff engaged well in the training and that all current anaesthetic staff were booked onto an upcoming session.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training attendance was monitored electronically, and staff received reminders to complete training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the service did not have a baby abduction policy and had not conducted any abduction drills despite this being raised in our previous inspection report in 2019.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. The service was compliant with the safeguarding adult and children training target of 90% for midwifery staff. At the time of our inspection, 98% of midwifery staff had completed safeguarding children training. However, not all medical staff had received training specific for their role on how to recognise and report abuse. The service was not compliant with the safeguarding children training target of 90% for medical staff, 85% of obstetric medical staff had completed safeguarding children training.

The service did not have a baby abduction policy in place and had not undertaken baby abduction drills. The service had a missing persons policy but no specific baby abduction policy. Service leads were aware that they needed a policy and had plans to implement one, we saw evidence of these discussions in the maternity improvement board minutes from April 2021. On our previous inspection we raised concerns that the service had not conducted baby abduction drills. Despite this we found the service had not conducted any baby abduction drills in the intervening 15 months between inspections. We were concerned that in the event of a baby abduction attempt, that staff would not be aware of their roles and escalation procedures.

Actions were undertaken to address our ongoing concerns. Following our inspection, service leads provided us with a draft copy of the new missing persons policy and dynamic risk assessments for a baby abduction. Senior leaders told us after our inspection that a baby abduction drill would take place once the policy had been ratified.

Maternity areas had security measures in place. The labour suite, birthing unit and maternity ward all had locked doors that were accessed using swipe cards by staff and an intercom system for women and their relatives to gain entry and leave the areas.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. At our previous inspection we found that women were not consistently asked if they were at risk of domestic abuse when they were alone. This was not in line with national guidance and the service's policy. We found improvements in this area. We reviewed 11 sets of women's records and saw that women were asked about domestic abuse on multiple occasions, including on their own, for 10 out of the 11 records. The trust had conducted monthly audits on compliance with domestic violence questions and between January and March 2021 had achieved an average compliance rate of 99% in the antenatal period and 95% in the postnatal period. We saw that compliance with the audits was discussed at the monthly maternity quality safety meetings.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of different types of abuse and referrals they had made previously.

Cleanliness, Infection Control and Hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service performed well for cleanliness. At booking all women are screened for Asymptomatic Bacteraemia (ASB) and are screened for MRSA for elective sections (pre-surgery) and emergency sections (immediately pre surgery). Where inpatient women had a known or suspected infection, they were cared for in single side rooms. The service completed monthly audits for MRSA and Clostridium Difficile (C. diff) for F11 ward. The ward had no instances of MRSA or C. diff infections between November 2020 and March 2021.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service completed monthly Infection Prevention and Control (IPC) inspections and performed well. Ward F11 scored 93.5% in the IPC inspection for April 2021, Labour suite scored 93.1% and the midwifery led birthing unit scored 95%.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff using PPE which was readily available, such as disposable gloves and aprons. We observed that all staff were bare below the elbow and performed hand washing before and after episodes of direct care. Hand sanitising units and handwashing facilities were available throughout the unit and handwashing prompts were visible for staff, women and the public. All staff observed were following national guidance in respect of PPE for patient contact. Staff wore surgical masks and visors if they had contact with women and babies. We saw that staff adhered to social distancing guidelines where possible.

Staff adherence with the PPE policy was monitored as part of the services monthly IPC audit. We saw that for April 2021 the service scored 100%.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last clean and ready for use. There was a system in use throughout the service to identify clean equipment by using 'I am clean stickers'.

We were concerned that the use of the water pool in labour and birth guideline did not provide specific instructions for cleaning the waterbirth baths as there was no indication of appropriate amounts of cleaning products to use. We were concerned that without clear instructions that staff were not all following the same process to ensure the bath was appropriately cleaned. We fed this back to the service leads on our inspection. Following our inspection, action was taken and an updated guideline (version 10 amended 4 May 2021) produced to provide specific cleaning instructions.

Environment and Equipment

The design and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, the maintenance of equipment was not always timely.

The service had enough suitable equipment to help them to safely care for women and babies. However, maintenance of this equipment was not always timely. We reviewed five pieces of equipment including bladder scanners, SPO monitors and Cardiotocography machines (CTG) on F11 ward. We saw that four out of the five pieces of equipment had missed their service due date. Three of the pieces of equipment had missed their servicing date by a month or two, however one CTG's due date was May 2019. We spoke with the ward manager who was aware of the concern and had contacted the servicing team and had received a new date to service the equipment.

The design of the environment followed national guidance and the service had suitable facilities to meet the needs of women's families. The service had easy access to an operating theatre located at the end of the labour suite and access to a second operating theatre in the event of an emergency. The neonatal unit was close by if a baby's condition deteriorated and they required an urgent transfer.

The service had suitable facilities to meet the needs of women. The service's labour suite had eight ensuite birthing rooms and the midwifery led birthing unit had a further four ensuite birthing rooms. There was a separate bereavement suite located on the labour suite with an ensuite and small living area for women's families. One of the labour suite rooms had high dependency equipment and one room was used for women recovering from caesarean sections.

The labour suite had been designed to enable women's privacy. Each room had a light up sign above the door stating do not enter when the room was in use to ensure that the privacy and dignity of women was maintained.

Staff carried out daily safety checks of specialist equipment. We saw that between January to April 2021 emergency trolley checks had been completed on all but one day of F11 ward and all but two days on the labour suite. This had improved since our previous inspection.

Staff disposed of clinical waste safely. Clinical waste was placed in appropriate bags and removed from locked dirty utility room by hospital porters.

Assessing and Responding to Risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. However, at the time of our inspection the service did not use a tool to triage women and the service were not compliant with swab recording targets.

Staff completed risk assessments for each woman on admission / arrival to either the maternity day assessment unit (MDAU) or labour suite triage, however they didn't use a recognised tool to triage women. This meant midwives were reliant on their individual clinical judgement rather than a assessment system to triage women according to priority. Two staff members we spoke with felt this was unsafe.

We raised our concerns with the service's leaders who informed us that they had plans to introduce a triage tool with a red-amber-green rating system. Following our inspection, the service implemented the new tool in May 2021, we saw that information about the tool had been placed in the service's daily briefing. Whilst improvements had been made since our inspection the new system would take time to embed.

The service was not compliant with swab counting targets. Swabs used for vaginal birth and perineal suturing were counted for completeness and to prevent a retained swab which posed risk of infection. The service monitored swab count compliance during birth and suturing as part of their quality dashboard. We saw that the service routinely did not meet the target of 100% compliance and between December 2020 to March 2021 scored between 66% and 95%. Audit results improved month on month in 2021 but remained below the trust's target. We saw that the poor compliance was escalated in the maternity quality safety meeting and actions included sending out a reminder in the daily briefing and safety huddle.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. This was an improvement on our previous inspection where we found that staff were not consistently taking all observations required and scoring correctly on the Modified Early Obstetric Warning Score (MEOWS) charts. We told the trust to make significant improvements in identifying deteriorating women and newborn babies in our section 29A notice in 2019. We reviewed eleven sets of women's records and saw that observations were consistently taken and scored in 10 out of 11 records. The service audited compliance with MEOWS documentation monthly, we saw that between August 2020 and March 2021 compliance was consistently 99% and above.

The service had introduced MEOWS charts in MDAU and during triage which was an improvement since our previous inspection.

Staff used a nationally recognised tool to identify newborn babies at risk of deterioration. This was an improvement on our previous inspection, when the service had not utilised a nationally recognised tool to assess newborn babies at risk

of deterioration. We told the trust to make improvements in this area in our section 29A notice in 2019. In six out of the six records we reviewed, we saw that staff had completed the Newborn Early Warning Trigger and Track (NEWTT) chart. The service audited compliance with NEWTT documentation monthly, we saw that between August 2020 and March 2021 compliance was consistently 97.5% and above.

Staff completed risk assessments for each woman at their initial booking visit and throughout their pregnancy. This included a history of previous pregnancies, family history, social, medical and mental health assessments. Staff knew about and dealt with certain specific risk issues, for example, assessments of venous thromboembolism (VTE) were completed in line with the service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein.

In the section 29A notice we issued to the trust in 2019, we identified that the trust were not monitoring women for their carbon monoxide levels during pregnancy in line with the trust's policy. The trust had increased their oversight of this monitoring but nationally carbon monoxide level monitoring was paused during the Covid-19 pandemic due to the risk of airborne particles being produced. At the time of our inspection the service were not monitoring carbon monoxide levels in order to follow national guidance issued in the pandemic. The service had however, implemented a new audit to monitor compliance with smoking status recordings at booking and at 36 weeks. From August 2020 and March 2021, the service had a compliance rate of 99.7% for recording smoking status at booking. However, recording compliance at 36 weeks was lower at 70% from August 2020 to March 2021. Compliance had improved in the later months with an average of 85% from January to March 2021. In the 11 women's records we reviewed we saw that smoking was routinely monitored at booking and 36 weeks. This was an improvement since our previous inspection. We saw that compliance with smoking status was discussed in the service's monthly maternity quality safety meeting and that compliance at 36 weeks was identified as an area for improvement.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. Staff within the service could refer to the local mental health trust's peri-natal mental health team if they were concerned about a woman's mental health. If staff were unsure of what input may be required, they could refer the woman to the service's peri-natal mental health midwife who ran weekly peri-natal mental health clinics. Out of hours staff would refer women to the local crisis team.

Staff shared key information to keep women safe when handing over their care to others. Women's discharge summaries were emailed to their GP to ensure that key information was shared.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed the medical and midwifery handovers, the handovers were multidisciplinary, well-structured and well attended.

Whilst the service had continued to perform skills and drill sessions throughout the pandemic, staff had not practiced removing a woman from the water bath in an emergency. We fed back our concerns to the service leads on our inspection. Following our inspection service leads provided us with evidence that a live evacuation drill had occurred on Thursday 29 April 2021. Service leads told us that repeat drills were planned throughout the year.

In June 2020 the Chief Midwifery Officer wrote to all trust's outlining four actions required to provide perinatal support for Black, Asian and minority ethnic (BAME) women during the COVID-19 pandemic. The trust had responded to all four actions. Actions included producing videos with the service's maternity voices partnership advising BAME women on the increased risks during the pandemic and encouraging them to take a vitamin D supplement. These videos were shared on the service's social media pages and website. The service had advised their clinicians of the increased risks to BAME women and staff asked women about their ethnicity when they called the maternity helpline. The service ensured there was a lower threshold for inviting BAME women to come in for an assessment given their increased risk. We saw that the

service collected data on women's ethnicity and had used this to write to all BAME women in July and December 2020 highlighting their increased risk during the pandemic and advising women on good health and risk reduction during pregnancy. The trust ensured relevant data was recorded in relation to the ethnicity of every woman, as well as other risk factors, such as living in a deprived area (postcode), comorbidities, BMI and aged 35 years or over, to identify those most at risk of poor outcomes.

Midwifery and nurse staffing

The service didn't always have enough maternity staff to keep women safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and mitigations were in place to reduce the risks of staffing shortages. Managers gave bank staff a full induction.

The service didn't always have enough nursing and midwifery staff to keep women and babies safe however, managers accurately calculated and reviewed the number and grade of midwives, nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service used a nationally recognised acuity tool to decide the level of staffing needed by women when in labour and giving birth and on the antenatal / postnatal ward. This was an improvement since the previous inspection. However, from January to April 2021 the trusts acuity data showed that the service's staffing levels only met acuity 62.7% of the time. We asked the services senior leadership team how they were assured that staffing levels were safe when staffing routinely did not meet acuity levels. Leaders explained the services escalation process which was detailed in the escalation policy. The policy details the minimum number of midwives needed on the ward areas and that escalation should go through the services supernumerary bleep holder who will redeploy midwives not engaged in clinical duties to ensure cover.

Service leads sent us evidence to show that in the event that acuity was not met by staffing needs that appropriate escalation processes had occurred, and that staff were redeployed to supplement staffing levels. In the event that the service could not redeploy enough staff to ensure safe staffing levels, service leads would close the unit in line with the escalation policy. We saw that from April 2020 to March 2021 the unit had closed twice.

The number of midwives and healthcare assistants did not always match the planned numbers. From January to March 2021, 16% of midwifery shifts did not match planned numbers and 27% of maternity care assistant shifts did not match planned numbers. Senior leaders told us that additional staffing was sought if the acuity levels were not met and if they were below template, but acuity was low then they would not seek additional staff. For example, on the day of our inspection, F11 ward was short by one member of midwifery staff, a replacement was not sought as there was a low number of women staying on the ward and managers felt these could be safely managed by the two registered midwives on shift.

The service had implemented a continuity of carer model. The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period (NHS England 2017). Statistically, women who receive midwifery-led continuity of carer have better outcomes than those who do not. The service had implemented three continuity of carer teams, trust leaders spoke positively of this achievement. However, midwives we spoke with had found the transition to the new model difficult and felt it had potentially led midwives to leave the service due to changes in ways of working.

Staff raised concerns with us about the skill mix of midwives when they were called in to cover areas. Staff told us that occasionally newly qualified midwives were covering the services maternity day assessment unit when senior midwives were on breaks or sick.

Maternity

Staff raised concerns about staffing levels on the service's maternity day assessment unit (MDAU). The service's template staffing for the area was one midwife and one maternity care assistant Monday to Friday and one midwife at the weekends. Staff told us they often felt overworked when staffing the MDAU and they were so busy they did not have time to report incidents when they happened. Senior leaders had plans in place to increase senior midwifery support with the MDAU but this had not been communicated to staff and was in the early stages of planning.

The *National Institute for Health and Care Excellence* (NICE) Clinical Guideline 190 (1-1 care in labour) dictates that in order to keep women safe during established labour, one to one care should be provided. The service collected data on this to ensure they were compliant. From April 2020 to February 2021, the service was compliant with one to one care 99.7% of the time.

We raised concerns on our previous inspection that the services labour suite coordinator was not a supernumerary role in line with national recommendations. The service had made improvements since the previous inspection, the role was now supernumerary, and the service monitored the supernumerary status of the coordinator as part of the quality dashboard. We saw that from July 2020 to March 2021 the coordinator was supernumerary, on average, 85% of the time. Whilst this was an improvement from our previous inspection, the service still had to improve further in order to ensure the role was continuously supernumerary. We saw that this had been discussed in the monthly maternity quality safety meeting. The service anticipated increased compliance when two additional senior midwives took up their posts in April 2021.

Service leaders told us that midwifery staffing had been particularly difficult during the pandemic due to staff shielding and increased sickness caused by the virus.

To help address the staffing shortages there had been a rolling recruitment drive. We saw that staffing concerns were escalated and discussed at the service's monthly maternity quality safety meeting. The service sent us evidence to show nine midwives were due to start in April and May 2021 to ease staffing pressures.

The service had a vacancy rate of 9.3% and a turnover rate of 9.2%.

The service had high rates of bank midwives. From January to March 2021, 21% of planned shifts were filled with bank midwives. Managers requested staff familiar with the service. Staff we spoke with said they used regular bank midwives who were familiar with the service. Managers made sure all bank had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications and skills and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe. The service had sufficient consultants to cover presence on the delivery suite in line with national guidance 'Labour Ward Solutions (Good Practice No. 10) 2010'. The service had a weekly average of 117 onsite consultant hours from January to April 2021.

The service always had a consultant on call during evenings and weekends. Monday to Friday, consultants were rostered from 8am to 7pm and from 7pm to 8am the next day on call, off site. At weekends the consultants were rostered for five

hours each day and to provide offsite on call cover for the remaining hours. Monday to Friday 8am to 5pm there were two junior doctors (FY2, ST1 & ST2 level) covering the on-call for Obstetrics and Gynaecology respectively, between 5pm and 9pm this was covered by one doctor. Medical and midwifery staff we spoke with were satisfied with the levels of medical staffing at the service.

An anaesthetist was available 24 hours a day, seven days a week for the labour ward to administer an epidural or spinal anaesthesia.

The service did not have any vacancies for medical staff.

The service had recently assigned job roles to consultants. We were concerned however that no consultant had been appointed to lead on triage and maternity day assessment unit (MDAU). Following our inspection, the service confirmed that the labour suite lead would take responsibility for triage and that a consultant had been assigned as MDAU lead.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive and all staff could access them easily. The service had transitioned to an electronic women's records system three weeks prior to our inspection. Staff told us they had received good support with the transition, including double medical cover for two weeks while they adapted to the new system.

When women transferred to a new team, there were no delays in staff accessing their records. All admissions had an electronic discharge letter sent to their GP. The service's doctors prepared discharge letters if women went home with medication postnatally.

Records were stored securely. Records were stored electronically and accessed using individual log ins. Previous paper records were stored securely in a locked room and sent to the site team for archiving.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. On our previous inspection in 2019 we found that staff did not consistently record women's weights when prescribing medicines. Since September 2020 the service had implemented an audit looking at compliance with recording weight and allergies on prescription charts. We saw that performance had improved over time. In September 2020 the service scored 7% on the audit, this improved to 76% in February 2021 and 100% in March 2021. We reviewed 11 women's prescription charts and saw that weights and allergies were recorded on all 11.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Controlled medicines were stored in a double locked cabinet in line with The Misuse of Drugs (Safe Custody) Regulations (1973). We viewed the controlled drugs register on ward F11 and the labour suite and saw that entries were correct, dated and signed.

On our previous inspection in 2019 we identified that the service did not record the ambient air temperature of their medicine rooms. Medicines often have storage instructions that include not exceeding certain temperatures, therefore

the service would not be able to determine if the medicines were still safe to use. We found improvements on this inspection; we checked the medicine rooms on labour suite and F11 ward and found that daily checks had been completed. The service audited compliance with checking ambient room temperatures as part of their maternity quality dashboard. We saw that between December 2020 and January 2021 compliance ranged from 96-100%.

Incidents

We were not assured that immediate actions were taken and recommendations followed in the event of a serious incident. However, staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

We were not assured that immediate actions were taken and recommendations followed in the event of a serious incident. The service had recently had an increase in serious incidents involving stillbirth between December 2020 and February 2021. We reviewed four 72 hour reports for the recent incidents but did not have access to the full investigations as these had been referred to an external investigator in line with policy. We saw in one 72 hour report that no immediate actions were identified despite listed recommendations. In another two 72 hour reports we saw that actions were identified but dates to complete the actions were not assigned.

Staff knew what incidents to report and how to report them. The service encouraged staff to raise incidents and would send reminders out using the services daily take five briefings if incident numbers fell below expected reporting levels. The services clinical risk manager performed daily walk rounds on labour suite asking staff if any incidents had occurred and reminding them to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy. However, one member of staff told us that due to staffing pressures they found they did not always have time to report incidents.

The service had no never events on any wards.

Managers shared learning with their staff about incidents that happened elsewhere. The service compared incidents with neighbouring trusts in the service's monthly maternity quality safety meeting.

Staff received feedback from investigation of incidents. Staff told us that managers were supportive when they had been involved in incidents and they received feedback in one to one sessions. Wider feedback was shared in the services risk and governance newsletter, "Risky business". For example, learning points from an amber incident included double checking all transfusion samples and ensuring that Anti D appointments were booked on the electronic system rather than verbally confirming with women.

Staff reported serious incidents clearly and in line with trust policy. From April 2020 to April 2021 the service had reported six serious incidents. The service had referred them to the appropriate investigatory body. Staff were encouraged and supported to engage with incident investigations. Managers debriefed and supported staff after any serious incident. Staff could give examples of debriefs that had occurred after incidents including baby resuscitation and cooling. Staff told us that during the pandemic the briefings have been held using videoconferencing technology which has increased attendance.

Maternity

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Staff told us that they were aware of the duty of candour and could explain the trust's processes.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at the services monthly risk and governance meetings. These were attended by the service's risk midwives, risk and governance failsafe officer, quality assurance midwife obstetric lead for governance and the obstetric lead for labour suite. Themes from incidents were identified and discussed in the maternity quality safety meeting.

Is the service effective?

Inspected but not rated

Evidence based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983. However, the service did not always have action plans in place for local audits and was not compliant with national incentive scheme safety actions.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. This was an improvement since our previous inspection in 2019 when we found the service had 23 out of date guidelines. The service had recently assigned a consultant obstetric lead for guidelines to ensure they were regularly reviewed and up to date with national guidelines. At the time of our inspection there were two guidelines out of date which were going through the review process.

We saw that updates to national guidance and compliance were discussed at the services monthly risk and governance meetings as well as the maternity quality safety meetings,

The service ensured it provided care in line with national guidance by monitoring women's outcomes and quality of care using a maternity dashboard. The dashboard was Red-Amber-Green (RAG) rated with targets set for smoking, intrapartum transfers of care, mode of delivery and neonatal morbidity and mortality. The dashboard was reviewed in detail at the service's monthly maternity quality safety meeting. We saw that service leads discussed and escalated any red metrics. For example, the high rate of caesarean sections for February 2021 (29.5%) was assigned to be presented at the clinical governance steering group.

The service identified where they weren't meeting national guidance and put plans in place to mitigate and reach compliance. For example, the service wasn't compliant with Saving Babies Lives, version 2 which is a care bundle for reducing perinatal mortality. The service was not compliant on using intrauterine doppler measurements, they mitigated the risk by performing additional scans whilst a consultant trained the services sonographers to perform intrauterine doppler measurements. The service had plans for the sonographers to use intrauterine doppler measurements by the end of April 2021.

There was a clinical audit programme in place. The service had consultant leads assigned to national audit programmes and reports including Saving lives-improving mothers care 2020 and Perinatal Confidential Enquiry- Stillbirths and

neonatal deaths in twin pregnancies. However, the service did not have an extensive local audit programme in place and did not always have action plans for recommendations. We reviewed local clinical audits and saw that an audit had been completed by a senior midwife looking at missed cases of fetal growth restriction and an audit completed by medical staff looking at mechanical induction of labour. We saw that both audits had recommendations from their findings but neither had action plans with named individuals responsible for implementing the recommendations. This meant we could not be assured that recommendations and learning from audits were being fully implemented.

The service had introduced a monitoring and audit programme relating to quality and safety. This was an improvement on our previous inspection in 2019. Quality and safety audits were monitored through the trust's new midwifery service quality dashboard which included but was not limited to: equipment audits, birth ratios, documentation audits, mandatory training and appraisal rates, outstanding incidents and continuity of care outcomes. We saw that the dashboard was presented to the executive board and discussed at the service's monthly risk and governance meeting.

The trust engaged in national programmes to improve delivery of maternity services but did not always implement changes quickly and demonstrate compliance. The trust provided us information in response to the Maternity Incentive Scheme. This was an incentive scheme that outlined ten essential actions designed to improve the delivery of best practice in maternity and neonatal services. The service was working towards compliance and were monitoring this closely. However, at the time of our inspection the service had rated themselves amber for six out of the ten areas. We saw that compliance was discussed across different governance meetings including the maternity quality safety meeting and the risk and governance meeting. When we asked staff about this, they told us they were progressing well and were in the process of collating evidence for all areas and anticipated full compliance by their submission in May 2021.

In 2020 the service had written to NHS resolution to inform them that following a review, the trust had downgraded their Maternity Incentive Scheme assessment from compliant to non-compliant. This meant the trust hadn't been compliant with the safety actions for two years. We were concerned that at the time of our inspection the service still weren't compliant with the safety actions and the pace of implementation of actions was slow.

The trust had created an action plan in response the recommendations from the Ockenden report and were working towards compliance. This independent report outlined seven immediate and essential actions based on emerging findings and recommendations. The service had eight actions associated with the report. Four actions were completed or were rated green, the other four were rated amber with further actions detailed for compliance.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, not all staff were up to date with their annual appraisal.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. However, staff told us they had concerns about the skill mix within the workforce as there was a large number of newly qualified midwives.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, not all staff were up to date with their annual appraisal. The services target for appraisal rates was 90%, we saw that in March 2021 appraisal rates for community midwives were within target at 98%, however hospital midwives and support staff did not meet the target with 80% and 81% respectively. Service leaders told us it had been more difficult to arrange appraisals during the COVID-19 pandemic with staff shielding and having to ask more staff to work clinically to meet acuity levels.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Compliance with medical staff appraisals was 94% in April 2021.

Managers supported midwifery staff to develop through regular, constructive clinical supervision of their work. This was an improvement on our previous inspection in 2019 when we found the trust had not put in place any process to replace the supervisor of midwives' role. The service had implemented professional midwifery advocates (PMA) since our previous inspection. PMA's were available Monday to Friday and wore a t-shirt to identify themselves to staff when they were active in their PMA role.

The clinical educators supported the learning and development needs of staff. The service had two practice development midwives (PDM). The PDM's role included organising mandatory training, inductions for new staff and junior midwives preceptorship training. A preceptorship is a period to guide and support all newly qualified practitioners to make the transition from student to develop their practice further.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meetings were held by videoconferencing technology to enable more staff to attend and to adhere to social distancing.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The PDM's helped decide the content of the services multidisciplinary training and used incidents within the service to determine areas of focus. The service had implemented a new specialist fetal monitoring midwife role to assist with cardiotocography training and support for staff. Since the introduction of the training in January 2021, the service had a compliance rate of 89% for midwives.

Managers made sure staff received any specialist training for their role. The service operated emergency drill sessions to ensure staff had practiced emergency scenarios. Emergency drills had included shoulder dystocia, neonatal resus, theatre simulation and postpartum haemorrhage. This was in line with the saving babies lives care bundle.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary handover meetings to discuss patients and improve their care. These were attended by all members of the multidisciplinary team including anaesthetists. The handover was well structure using situation, background, assessment, recommendation (SBAR). SBAR is a tool used to facilitate prompt and appropriate communication between wards/services.

Staff worked across health care disciplines and with other agencies when required to care for patients. Multidisciplinary teams worked together in the antenatal clinic to provide holistic care for women. For example, in the diabetes clinic women could receive a joint consultation with the consultant endocrinologist, diabetes nurse, consultant obstetrician and midwife with a specialist interest in diabetes.

Maternity

The service's transitional care bay was an area where neonatal nurses, midwives, neonatologists and obstetricians worked together to care for women and their babies.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. The service had a specialist midwife in post to support women at risk of or suffering with mental health conditions. Staff sought advice from the specialist midwife who provided support to women themselves or referred women to the local mental health trust's peri-natal mental health team. Support provided by the peri-natal mental health midwife included a weekly clinic to assess women's peri-natal mental health needs, advanced care planning and referrals to mental health services.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement because:

Leadership

There had been significant change within the maternity service leadership team which had provided stability to the triumvirate.

Maternity services were within the women's and children's division in the trust's structure. There was a head of midwifery (HOM), clinical director (CD) and associate director of operations (ADO). Since our last inspection in September 2019, this was a new maternity senior leadership team. The head of midwifery has been in post since December 2019. The ADO has been in the role for just over six months. The clinical director has been in the role since February 2021.

This meant there now was a clearly defined management and leadership structure in place. We observed and were told by senior staff of joint working between leaders both within the department, the rest of the trust and with external agencies and bodies to maximise care provision for women and babies.

The head of midwifery was supported in her role by two dedicated midwifery matrons and a team of senior midwives.

The trust's medical director was the executive lead and there was a non-executive director with responsibility for the maternity service. This meant there was a high profile for the maternity service at board level. This was an improvement from the last inspection in 2019.

Maternity service presented directly to the board and this was in line with Spotlight for Maternity 2016. The 'Spotlight on Maternity' March 2016 states 'to ensure that there is a board-level focus on improving safety and outcomes in maternity services, organisations should provide the opportunity for the Medical Director for maternity and the Head of Midwifery to present regularly to the board.' This was an improvement since the last inspection in 2019.

Maternity

The service triumvirate leadership team informally met weekly to discuss performance, operational capacity and any concerns. However, these meetings were not minuted, so we were unable to see evidence of these meetings and any actions from them. In addition, the team had a '3 on 3' monthly meeting with the executive leads for the service. We were told this meeting was a supportive meeting and was not minuted.

The triumvirate were aligned on the challenges to quality and sustainability within the service and had plans in place to address them. This meant that steps had been taken to improve the stability and effectiveness of the leadership of the service. However, at the time of our inspection, the new leadership team was in its infancy with all leaders in post less than 18 months. In the time that the leads had been in post, they had implemented new audit systems and ways of working which were improvements since the previous inspection. However, the new systems and ways of working were in their infancy. The changes needed to be sustained and embedded before the full impact and effectiveness could be assured but early indications were positive.

Service leaders were responsive to concerns we raised during inspection. In the weeks following our inspection service leaders acted promptly on the feedback we had provided. This included conducting a drill for the evacuation of a woman from the bath, updating the waterbirth guideline, the service implemented a triage tool in the midwifery day assessment unit and assigned an obstetric lead for maternity day assessment unit (MDAU) and triage.

Staff told us they received good support from their managers within the service at all levels. Staff were mostly positive when speaking about the senior leaders in the service and told us they were trusted and respected. Two members of staff we spoke with were frustrated with staffing levels within the service and voiced concerns that they didn't feel listened to by senior staff. However, staff consistently told us leaders were visible and frequently attended handovers and huddles. Staff told us the head of midwifery did a walk round of the unit three times daily.

Medical staff we spoke with told us their leads and educational leaders were very supportive, approachable and open to challenge.

Staff spoke positively about the executive team and told us they were visible and approachable. Staff told us that both the chief executive officer (CEO) and executive chief nurse would regularly see them on their walk arounds. More recently, due to the Covid-19 pandemic, the non-executive maternity lead conducted virtual drop-in sessions for the unit where staff had the opportunity to share information and any concerns.

Vision and strategy

The service had a vision for what it wanted to achieve and a draft strategy to turn it into action developed with all relevant stakeholders.

At the time of our inspection the service had a draft five year strategic plan which aligned with the trust's vision and strategy, which was being developed with input from staff and service users. The trust's five year strategy was awaiting final sign off by the board at the time of our inspection.

The maternity service's strategy detailed the service's ambitions for the next five years and was aligned to the NHS Long Term Plan 2019 and key recommendations from investigations into maternal and neonatal adverse outcomes including Ockenden report (2020). However, as the strategy was in draft, we did not see an action plan in place with actions assigned to individual staff members, to achieve the strategy.

Culture

Maternity

The culture had improved within the service, however staffing shortages had impacted morale and staff told us they didn't always feel respected and valued as a result. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

We observed strong multidisciplinary working between midwifery and medical teams and it was clear there were strong working relationships, and respect for team member's skills, from junior staff through to the most senior leaders.

Staff told us this was a good place to work and that the culture of the unit was positive. Staff told us there had been a noticeable improvement since the appointment of the new head of midwifery. However, midwifery staff also told us that staffing shortages affected morale and the pressure of being the only midwife assigned to the midwifery day assessment unit left staff feeling unsupported.

Medical staff told us there had been an improvement in the culture since the appointment of the clinical director for obstetrics and gynaecology. The new director had assigned job plans and lead roles for each consultant, ensuring they were aware of their responsibilities and were engaged with their lead area. Some medical staff told us the culture within the consultant body was hierarchical dependent on length of service, however the new job roles had improved this. However, the changes in the job roles had recently been implemented and needed time to embed to be assured that the improvements would be sustained.

Governance

Governance within the service had improved since our previous inspection. However, we found that there was a lack of oversight with local audit action plans and a slow pace of improvement in relation to compliance with national recommendations.

At the last inspection we had concerns about the governance structure of the service. At this inspection there had been improvements in governance processes of the maternity service. We noted that the service had improved oversight in relation to reviewing guidelines, monitoring use of the Modified Early Obstetric Warning Score (MEOWS) scoring, documentation of carbon monoxide monitoring and the documentation of domestic violence monitoring.

However, the service was slow to implement national recommendations from the Maternity Incentive Scheme and the Ockenden report. The service had six amber actions for the Maternity Incentive Scheme and had been non-compliant for the previous two years. The service was not compliant with the recommendations from the Ockenden report at the time of our inspection but were actively working to achieve compliance. The service had four actions that were rated as amber out of the eight actions they had designated to the report.

The service did not have an extensive local audit programme in place and did not always have action plans for recommendations. We reviewed two local audits and found they had recommendations from their findings but neither had action plans with named individuals responsible for implementing the recommendations. This meant we could not be assured that recommendations and learning from audits was being fully implemented. We were concerned that there did not seem to be oversight of local audits to ensure recommendations were implemented and monitored.

We reviewed various governance meetings and noted they were well attended by senior managers and MDT staff and covered areas such as incidents, staffing, risk register, risk management, complaints, information governance, monthly audit and quality dashboard, investigations, quality performance indicators, complaints, reviewing of guidelines reports, patient experience and medicines.

Maternity

We met with the departments triumvirate who told us they met regularly to discuss development of the maternity service and to review and resolve issues. However, we were told this meeting was not a regular scheduled meeting. Rather, they would meet on an ad hoc basis. Furthermore, they did not have an agenda or take minutes to evidence that they met.

We reviewed minutes of the divisional board meetings that were held monthly and found these to be well attended by representatives of the multidisciplinary team and appropriate discussion were held and actioned such as the risk register, staffing and concerns.

We reviewed the minutes of the maternity quality safety meetings. The purpose of the meeting was to oversee all issues related to clinical governance, quality and safety and approve reports and guidelines prior to submission to divisional board and trust board as required. We saw the meeting was well attended, and actions were assigned to named individuals to progress.

We reviewed guidelines and policies for the department as part of our inspection that were available electronically to all staff to access when they needed. We found they were all within date and referenced national guidance.

We reviewed minutes of the maternity departmental meetings that were held monthly and found these to be well attended by representatives of the multidisciplinary team with appropriate discussion held and actioned such as the risk register, staffing and concerns.

The service held monthly perinatal mortality and morbidity meetings, however the minutes from these sessions were poor and it was not clear what was discussed or whether actions and learning were shared. The service recently had a cluster of serious incidents involving stillbirths. We were concerned that we could not see clear actions and discussions about these cases.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were processes in place to identify risk. Risks were identified and recorded in line with the services maternity risk management policy, version 5 dated January 2019. The maternity service had a risk register and we saw that risks within the service were on the risk register and risks aligned with those identified by service leads. Risks were recorded and managed using the trust's electronic risk reporting system. All risks on the register were allocated to a member of staff responsible for reviewing and monitoring them; they were in date and had been reviewed. Risks included monitoring compliance with saving babies lives care bundle and the Maternity Incentive Scheme.

During our inspection we identified a risk that was not featured on the services risk register. The services triage room had not been operational for an extended period of time due to a faulty call bell. The service was awaiting a service engineer visit to fix the problem. We raised this as a concern with the leadership team. Following inspection, we were informed that the room was in the process of being permanently decommissioned as a clinical room and therefore had not been recorded on the risk register, as it did not present an active risk.

The risk register was discussed at the service's monthly risk and governance meetings and the monthly maternity quality safety meetings as a standing agenda item. The service had introduced risk posters that were displayed on notice boards and highlighted specific risk in areas to encourage staff engagement on risk management.

Maternity

Daily handovers included a briefing of any issues highlighted by managers. We observed this during our inspection and found the briefing included local audit results and safety information on the service's new electronic records system.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. We saw that the services dashboard was reviewed as part of the monthly risk and governance meetings as a standing agenda item and was presented monthly to the trust board by the head of midwifery. We saw that nearly all performance measures had improved in the last 12 months. Improvements shown in checking emergency equipment, mandatory training, supernumerary status of the labour suite coordinator, midwife to birth ratio, compliance with domestic violence questions and completing drug chart information.

There had been an improved commitment to managing risks, issues and performance. Since our inspection in 2019 the service had allocated additional resources into the risk and governance team and had employed three additional midwives into risk, governance and clinical quality roles.

The service had introduced quality improvement (QI) training as part of their mandatory training to ensure all staff engaged and took responsibility for quality improvement.

The midwifery department had a dedicated clinical quality midwife who oversaw quality improvements within the service and were running different quality improvement projects at the time of inspection. Projects included reducing the incidence of post-partum haemorrhage, increasing smoke free pregnancies, mobile epidurals, improving the quality of care during caesarean sections, antenatal colostrum harvesting for high risk neonates and improve the decision to delivery time for births in theatre.

The projects had affected change within the service. For example, the service's increasing smoke free pregnancies project. Actions identified included providing targeted information via email to women and the smoking cessation midwife having telephone contact with all women referred for smoking cessation. The QI project showed sustained improvement over seven months and in February 2021 the service achieved the target for smoking at the time of birth set by NHS England for 2022.

We saw staff were engaged with QI processes and involved with suggesting projects. The service had undertaken a QI project into mobile epidurals at the suggestion of a midwife who had come from another trust where this was implemented. The service were in the process of reviewing guidelines from other trusts to ensure their new mobile service would be in line with others.

The service shared learning from QI projects and encouraged staff to get involved through the "risky business" newsletter. Following the success of the newsletter in the maternity department, the trust had decided to roll out the newsletter across the trust for other speciality areas.

Outstanding practice

We found the following outstanding practice:

- The maternity service had a keen focus on quality improvement (QI) and had multiple projects ongoing with demonstrable service improvements being seen. Staff throughout the service were engaged with QI and contributed to the projects.

Maternity

Areas for improvement

MUSTS

Maternity service

- The trust must ensure that medical and anaesthetic staff meet mandatory training compliance levels. Regulation 12 (1) (2) (c).
- The service must ensure they complete emergency drills in a baby abduction scenario. Regulation 12 (1) (2) (a) (b) (c).
- The service must ensure equipment is serviced within its due date. Regulation 12 (1) (2) (e).
- The service must ensure it implements a tool to safely triage women in the maternity day assessment unit and labour suite triage. Regulation 12 (1) (2) (a) (b).
- The service must ensure its staffing levels meet acuity levels within the service. Regulation 18 (1).
- The service must ensure governance arrangements establish timely compliance with national recommendations and ensure oversight of local audits. Regulation 17 (1) (2) (a) (b) (f).

SHOULDS

Maternity service

- The trust should improve appraisal rates for midwifery staff.
- The trust should consider minuting triumvirate meetings.
- The trust should consider improving the quality of perinatal mortality and morbidity meeting minutes.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector and two specialist advisors, including an obstetrician and a midwife. The inspection team was overseen by Philippa Styles, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance