The Newcastle upon Tyne Hospitals NHS Foundation Trust

Royal Victoria Infirmary

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	**Good** ●
Are services well-led?	**Outstanding** ☆

Our findings

Overall summary of services at Royal Victoria Infirmary

Outstanding ☆ ➔➔

The first 2 pages of this report pertain to the hospital location, from page 3 the report focuses on the maternity service.

We inspected the maternity service at Royal Victoria Infirmary as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice unannounced focused inspection of the maternity service, looking only at the safe and well-led key questions.

The inspection was carried out using pre- and post-inspection data submissions and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records, medicines charts and documentation.

Following the site visit, we conducted interviews with senior leaders and reviewed feedback from women and families about the trust. We ran a poster campaign during our inspection to encourage women and birthing people who had used the service to give us feedback regarding care. We analysed the results to identify themes and trends.

Royal Victoria Infirmary is the main site for maternity services for the trust. It comprises of a delivery suite with maternity theatres, induction of labour beds and an enhanced recovery area. There are post and antenatal wards, a day care assessment area and maternity assessment unit (triage). The service is the regional fetal medicine and maternal medicine centre providing services to women and birthing people from across the North East and North Cumbria region. Ante and postnatal clinics are also provided at this location and there is an alongside midwife led birth unit, Newcastle Birthing Centre.

The local maternity population come from higher levels than deprivation than the national average with 24% in the most deprived decile compared to 14% nationally. Fewer mothers were Asian or Asian British or Black or Black British compared to the national averages.

We last carried out a comprehensive inspection of the maternity and gynaecology service in 2016. The service received an outstanding rating overall. We previously inspected maternity jointly with the gynaecology service, so we cannot compare our new ratings directly with previous ratings.

Our rating of this hospital stayed the same. We rated it as outstanding because our ratings for maternity did not change the ratings for the hospital overall.

How we carried out the inspection

Our findings

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

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated this service as requires improvement because:

- Not all staff had training in key skills.
- The service did not always control infection risk well. Equipment and the premises were not visibly clean in 1 room of the Newcastle Birthing Centre. We found out of date equipment on wards and resuscitation trolleys across the service.
- The service did not have a robust, formal triage process for women and birthing people who attended the maternity assessment unit.
- The service did not always have enough midwifery staff as staffing levels did not always match the planned numbers.
- Staff did not always manage medicines well, we found unsecured and out of date medicines in some areas.
- Some staff did not feel respected, supported, and valued**.** Some staff expressed dissatisfaction that they had not been involved in changes to working practices and the way in which senior leaders had communicated these to them.

However:

- Staff worked well together for the benefit of woman and birthing people, understood how to protect woman and birthing people from abuse, and managed safety well. Staff assessed risks to woman and birthing people, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff mostly felt respected, supported and valued. They were focused on the needs of woman and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with woman and birthing people and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to improving services continually.

Is the service safe?

Requires Improvement

We have not previously rated this service.

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated the safe domain as requires improvement.

Mandatory training

The service provided mandatory training in key skills to staff, however, were unable to provide evidence to show everyone completed some elements of training.

Maternity

The service provided evidence of staff compliance with clinical skills and some role specific training. However, they did not provide evidence to show staff were up-to-date with core mandatory training. Some staff told us they struggled to complete mandatory training due to low staffing levels across the service.

Mandatory training was comprehensive and met the needs of women and birthing people and staff. We reviewed the maternity training needs analysis which detailed all statutory and mandatory training for all staff groups in maternity services. Training included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. In addition to mandatory training staff completed a public health in practice training day annually.

Records showed only 46% of midwives had completed the public health in practice training day, which included antenatal and new born screening, infant feeding, perinatal mental health and safeguarding training. The service told us this training had been suspended for 3 months during the pandemic, but this had now been re-established and they were working towards improving compliance.

However, the service made sure that staff received multi-professional simulated obstetric emergency training. Ninety per cent of midwifery staff and 92% of medical staff had completed clinical skills and drills training. This training included responding to emergency situations such as post-partum haemorrhage and birth pool evacuation.

Managers monitored mandatory training and alerted staff when they needed to update their training. All newly qualified midwives received a period of preceptorship and staff spoke positively about the support they received during this period. All new midwives attended a week long clinical skills 'boot camp' which ensured they had completed all required clinical training when starting work.

Staff allocated to work on labour suite for the first time were given 3 weeks supernumerary period followed by 3 weeks buddying an experienced member of staff.

Safeguarding

Staff understood how to protect women and birthing people 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.

Staff received training specific for their role on how to recognise and report abuse. The service had a target of 95% staff completing level 3 safeguarding adults and safeguarding children training by the end of March 2023. Training records showed that 65% of midwives and 47 % of medical staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. However, the service provided evidence which included staff planned to complete the training which improved compliance to 81%. The safeguarding lead midwife was working to improve staff attendance and access to level 3 training and the service was on target to achieve 95% compliance by the required date.

We looked at the contents of the safeguarding training that staff completed; it covered the expected modules for safeguarding level 3 training in line with the intercollegiate (2019) guidelines.

Maternity

Staff could give examples of how to protect woman and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about female genital mutilation (FGM), and this was a mandatory field in the electronic records system. Where, FGM was identified staff completed a risk assessment and the woman was referred to a specialist consultant led clinic as well as referrals made in line with legislation. Where other safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding lead midwife who staff could turn to when they had concerns. They took a proactive approach to contacting the unit daily to ensure they were aware of all current and new safeguarding concerns.

Staff could access safeguarding supervision from an appropriately trained safeguarding supervisor.

Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and security measures in place. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Though staff used equipment to protect woman and birthing people, themselves, and others from infection they did not consistently use other control measures in all areas. Equipment and the premises were not visibly clean in one room of the Newcastle Birthing Centre.

Maternity service areas were mainly clean and had suitable furnishings which were clean and well-maintained. We saw domestic staff cleaning wards throughout our inspection. However, we found an unclean environment in one room of the Newcastle Birthing Centre with soiled linen and dirty baby scales. Staff took immediate action to ensure the room was cleaned.

Staff completed cleaning checklists and matrons undertook monthly clinical assurance audits to identify any issues.

The service generally performed well for cleanliness. The service told us cleanliness audits were conducted by the trust hotel services teams and these gave each area a star rating and compliance percentage. On ward 32, the postnatal ward, the compliance was 100%. Managers told us If any areas of concern were identified immediate action would be taken, for example following an audit on the postnatal ward in November 2022 a deep clean took place.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Observational audits of use of personal protective equipment between October and December 2022 showed 100% compliance in all areas, except delivery suite which was 97%.

Maternity

During our inspection, we saw staff washed hands before and after providing care and followed 'bare below' elbows guidance. Data showed hand hygiene audits were completed every month in all maternity areas. The audits showed that postnatal and antenatal wards had 100% compliance with hand hygiene in the months October to December 2022. However, compliance on the Newcastle Birthing Centre had declined from 100% in October 2022 to 85% in December 2022. Though compliance on the delivery suite had improved from 65% in October 2022 to 85% in December 2022 this was still below the trust target.

Following our inspection, the service provided information to show twice weekly flushing of water outlets had taken place in all areas. This is important as flushing water outlets helps to control legionella.

Staff cleaned equipment after contact with women and birthing people and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises kept people safe. Staff mainly managed clinical waste well. However, we found out of date equipment and overdue equipment maintenance across the unit, as well as gaps in check of specialist equipment.

Women and birthing people could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. However, during our inspection we saw that although ward areas were secure, women, birthing people and visitors could leave the delivery suite and postnatal ward with a baby without challenge. We raised this with managers who took immediate action to ensure all people exiting the wards were accompanied by a member of staff.

The corridor on ward 33, postnatal ward, was cluttered with equipment that may have impeded evacuation in case of a fire. We raised this with the service who provided assurance appropriate fire risk assessments and drills had been carried out and took action to improve storage so equipment would not be placed on the corridor. The service was also training additional staff to act as fire wardens.

The estate and facilities did not always support staff to easily maintain women's and birthing people's dignity. For example, though midwives delivered personalised and sensitive bereavement support the layout and décor of rooms used by women and birthing people following a bereavement did not support a therapeutic approach to grieving families. Staff recognised this and had plans to refurbish the rooms. Staff told us they felt the lack of ensuite rooms in the delivery suite made it difficult for them to maintain privacy and dignity for women and birthing people.

Leaders told us the challenges of the estate and facility were on the service risk register and there had been significant investment made to improve the estate. The service had purpose-built antenatal and transitional care wards. The transitional care ward was due to open shortly after our inspection. The service had expanded the maternity assessment unit and day care facilities.

The service had enough suitable equipment to help them to safely care for woman and birthing people and babies. However, not all equipment was regularly serviced nor in date. For example, on Newcastle Birthing Centre 50% of the breast pumps used by mothers were overdue their service and we found 13 boxes of sterile gloves which were beyond the use by date.

Maternity

Following our inspection, the service told us the estates department carried out preventative maintenance in line with relevant guidance. They provided information that showed maintenance compliance was 84% in January 2023.

Though staff carried out daily safety checks of specialist equipment, we found out of date items on such equipment across the service. For example, on Newcastle Birthing Centre we found a suction catheter on a wall mounted resuscitaire which had expired in March 2020 and an ambu bag on a resuscitation trolley which had also expired in 2020. On ward 32, the oxygen stored on resuscitation trolley was due to be serviced in July 2022 and a single use syringe had expired in December 2022.

Records showed gaps in the daily checks of resuscitation equipment. There were gaps in checks on wards 32 and 33, the antenatal ward and on Newcastle Birthing Centre. One trolley on the delivery suite had not been checked for 22 days in December 2022 to the date of our inspection.

The service had suitable facilities to meet the needs of woman and birthing people's families. The birth partners of woman and birthing people were supported to attend the birth and provide support.

The service had completed self-harm and ligature risk assessments in all areas. Anti-ligature pull cords were installed in bathrooms.

Staff mainly disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. However, some sharps bins did not have a visible date of first use recorded. Staff separated clinical waste and used the correct bins. They stored waste in bins in locked rooms while waiting for removal.

The service had robust systems for pain relieving gas scavenging in the delivery suite and Newcastle Birthing Centre. This is where excess gas is collected and removed to prevent it from being ventilated back into the room. There were clinical destruction units on the Newcastle Birthing Centre and 1, plus 4 mobile units on the delivery suite. This improved environmental sustainability in line with reducing greenhouse gas goals of COP26. It also protected staff as it reduced their exposure to nitrous oxide.

Assessing and responding to patient 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 and birthing people at risk of deterioration

Staff used a nationally recognised tool to identify woman and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman. We reviewed 11 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff, where appropriate. Staff completed a snapshot audit of 20 records in December 2022 to check they were fully completed and escalated appropriately. This showed good completion of the MEOWS chart although there was poor compliance with completing the urinary output and midwifery concerns boxes. The service planned to share results and lessons learnt with staff and to re-audit the completion of MEOWS following the implementation of the new electronic patient record system.

Staff completed risk assessments for each woman on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a standardised risk assessment tool for maternity triage. Midwives answered the telephone line and followed a 6 point triage process.

However, managers recognised improvement work was needed to formalise the triage and escalation processes within the maternity assessment unit. They had an improvement plan which included implementation of a new triage process in line with national good practice and had plans to recruit midwives in line with this. Following our inspection, the service told us the trust board had approved implementation of an evidence-based, standardised risk assessment tool for maternity triage.

Leaders did not monitor waiting times to make sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. This was because service did not audit waiting times for triage, though these were recorded on the triage assessment form. As part of ongoing improvement work the service had set a target of all women to be triaged within 5 minutes of arrival. However, the service was not able to provide evidence of current triage waiting times.

Staff knew about and dealt with any specific risk issues. We saw risk assessments were completed and updated at every contact in the patient records we reviewed.

The service ran specialist antenatal clinics for women and birthing people who may be at higher risk during their pregnancy. For example, there were specialist clinics for women and birthing people with diabetes or a high BMI or having a vaginal birth following a caesarean section.

Women who requested 'care out with a guideline' had a maternity partnership plan completed after discussion with a professional midwifery advocate (PMA) and an obstetrician. The service had 11 PMA's who supported women and birthing people to make an informed choice when they chose to birth outside guidance.

Staff used the fresh eyes approach to safely and effectively carry out fetal monitoring. Cardiotocography (CTG) is used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a "fresh eyes" or buddy approach for regular review of CTGs during labour. The last audit of interpretation of CTG was completed on October 2020 following which new CTG guidelines were introduced. We looked at the fresh eyes audit for April 2022 and this showed 89% compliance with hourly 'fresh eyes', this was an improvement from 68% compliance in November 2021. The service told us it had plans to re-audit CTG classification in February 2023.

Venous thromboembolism (VTE) assessments were completed in all patient records we reviewed. VTE is a condition where a blood clot forms in a vein.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. The service employed a lead midwife for perinatal mental health.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. Patient records we reviewed showed staff had completed appropriate mental health assessments for women and birthing people.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The patient care record was paper based and used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Maternity

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Interruptions were minimised and it was attended by all relevant staff. The handover shared information using a format which described the situation, background, assessment, recommendation for each patient, though this was not formally recorded.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Managers ensured sufficient midwives with qualification in newborn and infant physical examination (NIPE) were available each shift and moved staff to meet the needs on postnatal wards.

The service provided transitional care for babies who required additional care. One postnatal ward was ringfenced for women and babies who required additional care and could flex the number of beds for babies needing transitional care. At the time of our inspection, 8 babies were in transitional care cots. The midwifery coordinator attended the neonatal handover and ward round and transitional care babies were looked after by midwives and neonatal nurses.

The service was the regional maternal medicine centre for the North East and North Cumbria in partnership and led the maternal medicine network in partnership with 9 maternity units across 7 other NHS organisations. Maternal medicine centres provide pre-pregnancy, ante and postnatal care to women and birthing people with significant medical conditions. The centre was led by a multidisciplinary team (MDT) comprising a maternal medicine consultant, obstetric physician and consultant midwife who was also the consultant midwife for the wider maternal medicine network. The MDT provided clinical leadership for the maternal medicine centre and maternal medicine network. The centre offered women joint clinics with obstetricians and specialist physicians to ensure their needs were met.

The maternal medicine centre facilitated positive multidisciplinary work across the whole network. They were able to hold timely multidisciplinary case conferences for critically ill women that involved all relevant partners including transport services. When such women were transported to the unit they were accompanied by a neonatal and intensive care practitioner. The service reported the multidisciplinary case conference approach ensured women were not transferred unnecessarily and appropriate follow up case conferences were held. The service had monitored transfer times and the average time from referral of a woman to the maternal medicine centre to arrival at the unit was 2 hours 29 minutes.

The service had a robust escalation process to address operational pressures should they arise to minimise patient risk within the unit as well as across the region. The service had developed a policy for the escalation of clinical concerns where there was disagreement between health professionals on a woman or birthing person's care. Following our inspection, the service told us this policy had been ratified and was in use.

Midwifery Staffing

The service did not always have enough midwifery staff as staffing levels did not always match the planned numbers. However, managers regularly reviewed and adjusted staffing levels and skill mix.

Staffing levels did not always match the planned numbers. During our inspection we observed a meeting to discuss staffing for the next 24 hours. We saw staffing did not match planned numbers in some areas such as maternity assessment unit and 1 of the postnatal wards.

The service monitored staffing levels regularly using a recognised framework to ensure staffing levels were adjusted to meet the needs of women, birthing people and babies.

Maternity

The service reported staffing challenges had led to the closure of the Newcastle Birthing Centre on some occasions in order to maintain safe staffing levels on the delivery suite. Some staff told us low numbers of staff made them feel unsafe and some told us they were discouraged from incident reporting staffing concerns and shortages.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between December 2021 and July 2022, the service reported 79 red flag events, of these 86% related to a delay between admissions for induction of labour and beginning the process. Between May and October 2022, the service reported to the trust board there were 8 occasions when midwives were unable to provide one to one support to women and birthing people in established labour. They reported 2 occasions where the labour ward coordinator was not supernumerary, this was escalated to managers and staff redeployed.

Managers accurately calculated and reviewed the number and grade of midwives, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in October 2022. This review recommended 254 whole-time equivalent (WTE) midwives Band 5 to 8 compared to the funded staffing of 250.2 WTE. However, the trust had approved a permanent over recruitment of 20 WTE midwives compared to the review figures to allow for increased levels of turnover and sickness. The service had recruited midwives due to start between November 2022 and January 2023 and this increased the number of WTE midwives to 3 WTE above the review recommendations. The trust had also supported the recruitment of international midwives.

Managers adjusted staffing levels daily according to the needs of woman and birthing people using a nationally recognised acuity tool. During the staffing huddles attended by matrons and managers from all areas we saw managers made plans to request bank staff, move staff from other wards and review the situation regularly. We saw decisions regarding staff moves took into account the needs and acuity of women, birthing people and babies in each area. The staffing huddle took place daily and managers met more frequently throughout the day if issues were identified.

There was a supernumerary shift co-ordinator on duty on each shift during the day who had oversight of the staffing, acuity, and capacity. Out of hours this was done by the labour ward coordinator. Twice weekly senior managers attended the staffing huddle to ensure they had oversight of staffing for the week.

The service had low vacancy rates; at the end of October 2022 this was 2%.

The sickness absence rate had increased in 2022 with total sickness absence in November 2022 at 8%. Managers told us they were mitigating low staffing levels due to sickness absence by over-recruiting by 20 midwives against the acuity tool staffing recommendation.

The service had increasing turnover rates. In October 2022, the 12-month rolling turnover rate for midwifery staff was 12.4%. However, though higher than previous years, this was in the lowest 25% nationally for turnover and equated to 33.07 whole time equivalent staff.

The service recognised the challenges of recruitment and retention and had accessed NHS England funding for maternity providers to employ a lead midwife for pastoral support, recruitment and retention. They led work to ensure that the newly appointed midwives retained interest in working at the service through planned regular engagement

events and promoting positive working relationships prior to starting work. They also worked with staff to understand why staff may leave and promote well-being to reduce sickness absence and turnover. The service was also working to develop the non-registered workforce and optimise skill mix and had introduced a training programme to up-skill maternity support workers.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. They offered staff incentive payments and overtime to ensure they could secure bank staff when needed. The induction policy outlined the induction and mandatory training requirements for bank and agency staff.

Managers did not always appraise staff's work performance nor hold supervision meetings with them to provide support and development. Not all staff had received an appraisal in the last 12 months. However, managers made sure staff were competent for their roles.

Managers did not always support all staff to develop through yearly, constructive appraisals of their work. The overall appraisal rate across the service was 57.7%. Leaders told us they had an improvement plan to increase appraisal rates. Appraisal rates were discussed weekly at the directorate management team meeting, attended by managers and leaders from across the service.

Staff were supported by a practice development team comprising a practice development lead and 4 practice support midwives. Practice support midwives supported midwives to complete training and carried out competency checks. Practice support midwives worked with doctors to hold impromptu skills and drills sessions with staff.

Managers made sure staff received any specialist training for their role. For example, the consultant midwife for maternal medicine had developed a research proposal to inform development of the maternal medicine service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service met nationally recommended levels of obstetric consultant presence on the delivery suite. They had processes to ensure consultants were present at any difficult births and guidelines which outlined the specific situations when consultant presence was required.

However, leaders acknowledged further expansion of the consultant and medical workforce was needed to ensure dedicated cover to the maternity assessment unit, to build resilience in consultant rotas and expand capacity for teaching and education of junior doctors. The service had held strategic away days with medical staff and the midwifery leadership team that included putting together a case for increasing medical staffing.

The service had a medical workforce strategy which detailed the strategic and operational planning of the service, including the roles and responsibilities of the consultant. This strategy was presented to trust board level safety champions meeting and regularly updated in line with national guidance.

The service had low vacancy rates for medical staff. There was 1 vacancy for a consultant at the time of our inspection. The service had recruited to this role, and they were expected to start work in April 2023.

The service did not use bank staff and locum cover was always provided by the medical staff.. The service had not used any independent medical locum agencies.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends. They had had a consultant anaesthetist on call after 8pm at night.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors told us they received good supervision and teaching and felt well supported. Seventy six per cent of medical staff had received an annual appraisal.

Records

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

Womrn and birthing people's notes were comprehensive and all staff could access them easily. The service was implementing a new electronic patient record system at the time of our inspection. This meant they were using a combination of paper and electronic records until the new system was fully established. We reviewed 11 paper records and found records were clear and complete. However, though paper records were signed by staff and included the date and time, the staff name was not legible nor their role recorded.

Managers audited the standard of record completion at each midwives annual appraisal. We asked the service to provide audits of patient records and they sent an audit completed in 2021. This audit showed poor levels of documentation in key areas such as if a postnatal consultant review was required or documentation of oral intake on fluid balance charts. There was no recent audit to evidence improvement, however, we did not find these issues in records we reviewed.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, they did not always store medicines safely.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

Staff completed medicines records accurately and kept them up-to-date. Medicines records were clear and up-to-date. The service used an electronic prescribing system. Midwives could access the full list of patient group directions (PGDs) and midwives exemptions, so they were clear about administering within their remit.

Maternity

The service could not provide compliance rates for staff completion of e-record medicines training but told us all new staff completed this when starting work in the service. Medicines management competency checks were completed as part of the preceptorship programme and some staff had completed training in specific PGDs and intravenous drug administration. However, the service did not currently monitor compliance rates for this training.

Staff did not store nor manage all medicines and prescribing documents safely. On the maternity assessment unit the door to the clinic room (where medicines were stored) was unlocked and no key could be found. The cupboard containing intravenous fluids was unlocked. We told managers about this and they took immediate action to ensure the clinic room was locked and medicines stored securely.

In the antenatal clinic area the clinic room for medicines storage was unlocked and the medicines fridge which contained flu and covid vaccinations was also unlocked. The medicines cupboard and fridge were unlocked on the delivery suite, however the room was secure but could be accessed by staff who could not prescribe or administer medicines. This meant there was a risk unauthorised people or visitors could access medicines.

We found out of date medicines including 3 boxes of expired medicines in the medicine's storage room in the antenatal clinic area. On ward 33, we found 10 boxes of out of date medicines. This meant there was a risk that women and birthing people could be given medicines that were ineffective or unsafe.

Pharmacy team support to the service was limited due to absence within the pharmacy team. The lead pharmacist covered the women's and children's directorate and provided a lot of support to the neonatal unit. This meant that pharmacy staff were not always able to provide a medicine top up service to the ward and ward staff were responsible for ensuring medicines stock control.

We highlighted our concerns regarding medicines storage to managers who took immediate action to remove out of date medicines and ensure secure storage. Following our inspection, the service told us they had implemented a new process to monitor and dispose of out of date medicines with the pharmacy department. There was now a process for ward managers to ensure medicines were stored securely. and managers had a process to ensure medicines were stored securely.

However, on the antenatal ward the service had installed an electronic medicine storage and dispensing system. This ensured all medicines were stored securely and helped to staff to access the correct medicines for the electronic prescription through an automated system which only released the medicines on the prescription from the secure locker.

Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted or they moved between services. Medicines recorded on both paper and digital systems for the 10 sets of records we looked at were fully completed, accurate and up-to-date.

Incidents

Maternity

The service managed safety incidents well. 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 women and birthing people honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 623 incidents reported between May and November 2022 and found them to be reported correctly.

The service had no 'never' events on any wards.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers, medical staff and risk and governance midwives met 4 times a week to review incidents and prioritise any rapid reviews which needed completion. Outcomes from rapid reviews were shared with staff at daily handovers.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. We saw the importance of listening to parents' concerns following an incident highlighted in the risk newsletter sent to staff and the parent's perspective on the incident shared with staff.

Managers shared learning with their staff about never events that happened elsewhere. The service had a risk and governance midwifery team who were responsible for sharing learning from incidents with staff. They produced a regular newsletter 'Risky Business' which shared learning from incidents, cases reported to Healthcare Safety Investigation Branch (HSIB), audit outcomes and women's and birthing people's perspective on incidents with staff.

Staff reported serious incidents clearly and in line with trust policy. The service had a team of 4 risk and governance midwives who supported staff to report incidents and reviewed incidents daily.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to the care of women and birthing people. For example, following a serious incident a feedback and review session was organised for staff chaired by a member of staff external to the service. Staff responded positively to this way of giving post incident feedback and the service planned to have an independent chair for any future reviews.

There was evidence that changes had been made following feedback. Staff explained and gave examples of changes made to CTG guidelines following feedback from an HSIB investigation.

Managers debriefed and supported staff after any serious incident. Professional midwife advocates provided restorative supervision to staff following serious incidents.

Maternity

Is the service well-led?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated the well-led domain as good.

We have not previously rated this service. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles. However, executive leaders were not always visible and approachable in the service, though they understood and managed the priorities and issues the service faced.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

The service was led by a directorate manager, associate director of midwifery, clinical director and head of obstetrics. The triumvirate were supported through clear professional arrangements and the current team were stable, having been in post since January 2020.

The leadership team met regularly with each other and with local leaders and managers to share information on performance and priorities. They attended senior midwifery meetings twice a week to ensure they had an overview of staffing challenges.

Local leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers and ward managers. The service had no gaps in local leadership at head of department or matron level.

The executive team carried out walk rounds in the service. However, some staff told us though local leaders were visible and approachable, the senior leadership team were not always visible in the service. Some staff commented they did not feel listened to by senior leaders and the executive team. The senior leadership team were aware of the issues raised by staff and that some staff felt there was a disconnection between senior leadership and staff on the wards. Leaders had carried out an extensive consultation process with staff between February and April 2022. They planned to address the issues through further engagement and the development of the strategy for the service.

The service was supported by maternity safety champions and non-executive directors. They demonstrated an understanding of the key issues facing the service and ensured the views of maternity services were represented at the board. The trust safety champions met bi-monthly to share safety intelligence from floor to board. The board level safety champions conducted ‘walkabouts’ with a staff member every month to give staff the opportunity to raise concerns relating to safety issues.

They supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. For example, the service had a competency, education and career development programme for maternity support workers which aligned to national qualifications and apprenticeships. The service supported leaders to access both in-house and external leadership training and there was an enhanced induction for new managers.

Vision and Strategy

The service had a vision for what it wanted to achieve, underpinned by objectives and service specific strategies. The service was developing an updated strategy and 5-year plan at the time of our inspection.

The service had a vision for what it wanted to achieve and had identified key strategic objectives aligned to the trust objectives. Leaders had reviewed progress towards these objectives. The service worked towards short-, medium- and long-term objectives identified in the strategy developed in 2018. The overarching strategic objectives were underpinned by strategies for specific services such as maternal medicine and workforce and digital strategies.

Leaders told us work to renew the five-year plan and develop the strategy aligned with the improvement plan for the service had started January 2023.

Leaders had planned engagement with staff and women and birthing people to re-new the strategy in January 2023. A leadership development day was also planned to start this work. The service aimed to have the first draft completed by May 2023.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and made progress against these. They planned to revise the vision and strategy to include these recommendations and align with the maternity improvement plan. Leaders were clear the strategy under development would align with national standards and best practice such as Saving Babies Lives.

Culture

Staff were focused on the needs of women and birthing people receiving care. The service provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. However not, all staff felt respected, supported, and valued.

Not all staff felt respected, supported, and valued**.** Some staff expressed dissatisfaction that they had not been involved in changes to working practices and senior leaders had not communicated these effectively to them. However, other staff told us they felt local leadership valued their work and they felt able to speak to them about difficult issues and when things went wrong. Some staff told us they felt proud to work in the service.

Senior leaders demonstrated awareness of the impact of recent changes on staff morale and introduced a ‘What Matters to You’ programme and had recruited a recruitment and retention midwife to try and bridge the gap between staff on the wards and senior leadership. Leaders had acted on the results of the 2021 NHS staff survey. They held ‘trolley dashes’, short sessions in the unit to give staff the opportunity to discuss results. They held a series of workshops with band 7 midwives and planned to continue these. We saw the action plan following staff survey results addressed the feedback from the staff survey.

Maternity

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed patient care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Staff reported positive working relationships across all roles and grade within the multidisciplinary team and we saw positive relationships across multidisciplinary teams during our inspection.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They had worked with the local maternity voices partnership to ensure women from all backgrounds were not digitally excluded as the trust moved to an electronic pregnancy notes system and were carrying on with paper notes with women from some specific communities.

The service promoted equality and diversity in daily work. All policies and guidance had an equality and diversity statement. Staff with specialist interests in working with vulnerable women and asylum seekers were supported to complete a master's degree. The service aimed to ensure the skills developed would be shared through education and research and would enhance care to women from these groups.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Midwives told us the culture had changed recently and they now felt there was a 'no blame' culture where they could raise concerns without fear of blame. Staff facilitated 'birth reflections' sessions for women, birthing people and families, where they could talk through their experience of giving birth at Newcastle and discuss any concerns.

Women and birthing people, relatives, and carers knew how to complain or raise concerns. Women and birthing people we spoke to, gave examples of how the service had tried to address their concerns informally, where appropriate, and knew how to contact the patient advice and liaison service. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. Leaders collated information and action points from complaints alongside serious incident and mortality reviews to ensure actions which may be considered 'low level' were not missed and themes identified.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint. The service provided information that showed there were 7 open complaints between September and November 2022. Two complaints that were not upheld were closed. The most common theme from complaints was the attitude of midwives and this had been fed back to staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Maternity

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had expanded the governance team, which was led by the associate director of midwifery and the lead midwife for quality and clinical effectiveness.

The service had a strong governance assurance framework that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics and reported this monthly to the trust through the integrated board report. The service had updated the governance framework and processes to ensure they could report on key performance and safety standards such as the perinatal mortality review tool and maternity incentive scheme (CNST).

The service reported performance to the trust board and local maternity system (LMS) through the intrapartum dashboard, integrated trust board report, CNST board report, staffing report and LMS oversight report. The board maternity safety champions, executive chief nurse and medical director received reports on maternal, neonatal and perinatal mortality including stillbirths at the maternity safety champions meeting. The board received perinatal mortality review tool (PMRT) reports bi-monthly.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The governance framework outlined the process for shared learning events following any incidents that involved the whole multidisciplinary team. This ensured staff understood their role within the wider team and took responsibility for their actions and well as that any learning was identified and shared.

All documents related to governance including meetings and reports were stored on a shared computer drive which staff could access.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. The service had processes to ensure the service met key safety standards such as Saving Babies Lives Care Bundle v2. New policies and guidelines were developed by the relevant clinical group and then reviewed and ratified by the obstetric governance group to ensure they met all relevant national guidelines. Each policy had a review date which was monitored through the obstetric governance group.

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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. Outcomes for woman and birthing people were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes. We reviewed the National Maternity and Perinatal Audit 2022 and saw the service had a lower than expected percentage of small for gestational age babies born after 40 weeks and reported similar outcomes to the national average for vaginal births after caesarean section and 3rd and 4th degree tears. The report identified areas for improvement with clear action plans and timelines.

However, the service was an alert level outlier in the National Neonatal Audit Programme (NNAP) audit published in November 2022 using 2021 data, for mothers who deliver babies between 24 and 34 weeks gestation being given any dose of antenatal steroids. The service provided information to show the findings were as a result of inaccurate data submission to the audit. They had a plan in place to improve data completeness for the 2022 submission.

Maternity

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. We reviewed the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK **(**MBRRACE) reports related to maternal mortality and stillbirth outcomes and saw action plans to address any areas of concern and plans to re-audit to check improvement had been sustained.

The service had a clear audit timetable which set out local and national audits to be completed with timescales and staff assigned. Managers carried out weekly local audits and matrons completed a monthly clinical assurance tool audit. Other audits such as infection prevention and control were completed by staff designated as 'harm free care links'. The results of these local audits were reviewed by matrons and department managers and action plans developed to address any areas of concern.

Managers shared and made sure staff understood information from the audits. Managers presented the outcomes related to national audits such as MBRRACE to the clinical audit and guidelines group monthly and they were also discussed at the monthly maternity safety champions meetings to ensure results were cascaded to staff. There was a robust system for perinatal mortality reviews, which included oversight and involvement of clinicians from other units.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service had 4 risks on the risk register, all had controls in place to mitigate the impact of the risk and had been reviewed regularly and action plans updated. Managers and leaders met quarterly to review the risk register and incident reporting system to ensure all relevant risks were identified and actions monitored.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Information boards throughout the service informed staff how to raise concerns and issues. They displayed information on how to contact maternity safety champions and maternity safety champions held bi-monthly feedback sessions to give staff the opportunity to raise any concerns.

The service conducted a full impact assessment before suspending continuity of carer. This took into account the views of staff and evaluated the impact on other areas of the service and patient safety.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it. The service had an intrapartum dashboard which covered key metrics and performance data on a month by month basis, which was accessible to senior managers. Key performance indicators were displayed for review and some such as post-partum haemorrhage and 3rd or 4th degree tears were red or green rated to show performance agents targets at a glance.

The service also had a quarterly dashboard with core indicators that showed their performance within the region. This meant managers could internally benchmark and compare performance against others.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The dashboard summary included clear infographics which showed staff key performance data such as number of inductions of labour, breast feeding initiation rates and still births. The infographic included a threshold for some clinical indicators so staff could see at a glance if the service was performing above or below this.

The service had a digital lead midwife who staff could access for support with information systems. They had worked collaboratively with the local maternity voices partnership to communicate the move to electronic pregnancy notes to women and birthing people within the community through focus groups and question and answer sessions.

The information systems were integrated and secure. Work was in progress to ensure relevant performance information was integrated into the trust's new electronic reporting hub and ensure patient-level data was included in this reporting. The service was introducing an electronic patient record system at the time of our inspection. We saw the implementation of this was handled well, with staff given sufficient training and time to adjust to the new system to ensure all relevant patient information was captured. The service had floor walkers, easily identified by colourful t-shirts, 24 hour a day to support staff with the new systems.

Data or notifications were consistently submitted to external organisations as required. The service ensured all relevant incidents were reported to the Health Safety Investigation Branch (HSIB).

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local Maternity Voices Partnership (MVP) in decisions about patient care. The chair of the MVP was part of the obstetric governance group and met regularly with managers in the service. They had a dedicated link midwife who they could raise any concerns with directly.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. The service had adapted a space on the postnatal ward as a prayer room and displayed posters in different languages promoting this.

Leaders understood the needs of the local population. Leaders had engaged with diverse communities in the area for example by meeting with cultural leaders. The service worked closely with doulas from the local Jewish community and they attended MVP meetings. Doulas provide women and birthing people with emotional, informational, and physical support during pregnancy, birth and the immediate postpartum period.

The service provided a social media online midwifery service to women and birthing people using the service called 'Connie E-Midwife'. This was a collaboration with the local MVP and a team of midwives coordinated the social media page and bi-weekly online question and answer sessions and responded to direct messages. The service had evaluated the service and found it had over 3,000 followers and was positively received by women and birthing people. Staff had attended community events with 'Connie E-Midwife' to share information about maternity services.

All women who had been given an anaesthetic or epidural received a text 24 hours following the delivery. This asked for feedback on their current clinical symptoms, but women also shared feedback about the service in the free text box. Feedback from this was used to improve services and shared with the MVP.

The maternal medicine centre had introduced patient reported experience measures (PREMS) for women and birthing people to give feedback on the service. They received a text asking them if they had been involved in decision making, how easy they were able to access the service and if there were any barriers to accessing the service. As the service was new, staff told us they would use this feedback to make improvements.

Women we spoke to during our inspection told us staff gave them informed choice throughout their pregnancy. The 'birth reflections' service was well embedded within the service and gave women, birthing people and families the opportunity to reflect on their care and give feedback. Midwives running the service had received counselling skills training to enable them to support women, birthing people and their families.

Leaders were part of several regional and national projects and workstreams to improve services for women and birthing people. For example, an obstetrician was part of regional project into intrapartum risk assessment and the prevention of hypoxic-ischemic encephalopathy (HIE). Managers were part of a national group to develop the recruitment of international midwives.

The fetal medicine service used telemedicine to facilitate multidisciplinary team discussions across the region. This ensured women referred to the fetal medicine unit who lived far from the hospital had a timely care plan put in place. Some women and birthing people received clinical consultations via telemedicine so they did not have to travel great distances.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service provided examples of using quality improvement methods to develop and improve services. They told us about the regional work on pre-term birth prevention they were involved in, and how this enabled the implementation of specialist pre-term birth clinics and development of an online decision-making tool.

The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. Staff gave examples of quality improvement programmes which had improved services for women and birthing people. For example, the Reducing Blood Loss in Newcastle (ROBIN) programme was a quality improvement initiative with multidisciplinary involvement from obstetricians, midwives and anaesthetists. Through the project the service reduced the rate of post-partum haemorrhage significantly.

Leaders encouraged innovation and participation in research. The service played an active role in the North East and North Cumbria clinical research network. There was a team of research midwives who were leading on 35 studies at the time of our inspection. Staff across the service could give examples of current research projects and the research team supported midwives across the unit to deliver aspects of some research projects. Staff spoke highly of research carried out by the service and were proud that it informed local and national guidance.

Maternity

Outstanding practice

We found the following outstanding practice:

- The delivery suite and Newcastle Birthing Centre had innovative systems for pain relieving gas scavenging. This meant staff were protected from exposure to nitrous oxide, which may be harmful over time, and aligned with national and international priorities on climate change.
- The service provided a maternal medicine centre for the North East and North Cumbria region. This provided a multidisciplinary approach to pre-pregnancy, antenatal and postnatal care across a number of providers and NHS trusts for women and birthing people who had significant medical problems.
- The service provided a social media online midwifery service to women and birthing people using the service called 'Connie E-Midwife' in collaboration with the local MVP. This provided a social media page and bi-weekly online question and answer sessions for women and birthing people.
- Following an anaesthetic all women and birthing people received a text asking them to complete a survey. This provided feedback about symptoms and also their experience and feedback was shared and used to improve services.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Maternity

- The trust must ensure staff complete daily checks of emergency equipment. They must ensure equipment used by staff and women and birthing people is in date, checked regularly and safe for the intended purpose. Regulation 12 (1)(2)(e)
- The trust must ensure all staff receive such appraisal as is necessary to carry out their duties. Regulation 18 (1)(2)(a)
- The trust must ensure the proper and safe management of medicines, ensuring out of date medicines are removed and medicines are stored securely. Regulation 12 (1)(2)(g)

Action the trust SHOULD take to improve:

Maternity services

- The trust should ensure that all staff complete the required mandatory training including the appropriate level of safeguarding adults and children training. (Regulation 12)
- The trust should ensure all areas are clean and staff use control measures to prevent the spread of infection. (Regulation 12)

Maternity

- The trust should ensure sufficient midwifery staff are deployed to keep women, birthing people and babies safe. (Regulation 18)
- The trust should ensure estates and facilities in the delivery suite are suitable to meet the needs of women, birthing people and families and protect their privacy and dignity. (Regulation 15)
- The trust should act to ensure staff fully complete all aspects of modified obstetric early warning scores in order to assess the risks to women and birthing people.
- The trust should continue to monitor the security of the unit continues to be reviewed in line with national guidance.
- The trust should continue work to introduce a robust formal triage and escalation process within the maternity assessment unit.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 3 other CQC inspectors, and 3 specialist advisors including midwives and an obstetrician. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Specialist and Secondary Care.