Great Western Hospitals NHS Foundation Trust

Great Western Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Great Western Hospital

Requires Improvement 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Great Western Hospital.

We inspected the maternity service at Great Western Hospital 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.

Great Western Hospital provides maternity services to the population of Wiltshire and surrounding areas.

Maternity services include a delivery suite with triage, a maternity theatre and a bereavement suite, midwife led birthing centre (White Horse Birth Centre), an antenatal and postnatal ward (Hazel Ward), a day assessment unit and antenatal clinics. Between April 2021 and March 2022, there were 3,740 babies born at Great Western Hospital.

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

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

Our rating of this hospital stayed the same. We rated it as Requires Improvement because:

- Our rating of Requires Improvement for maternity services did not change ratings for the hospital overall. We rated safe Requires Improvement and well-led as Requires improvement.

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited Maternity assessment (Triage), Delivery Suite, the antenatal and postnatal ward (Hazel ward), White Horse Birth centre and the Day assessment centre.

We spoke with 2 matrons, 11 midwives, 4 specialist midwives 1 support worker, 2 student midwives, 2 women and birthing people, 1 birthing partner and or relative and 7 doctors. We received 2 responses to our give feedback on care posters which were in place following the inspection.

We reviewed 6 patient care records, 6 observation and escalation charts and 10 medicines records.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

You can find further information about how we carry out our inspections on our website:

Our findings

: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- Not all staff had sufficient training in order to recognise and understood how to protect women and birthing people from abuse, and manage safety well.
- Leaders did not always act promptly when risks were identified. Risks identified on a risk register were not mitigated in a timely manner.
- Women and birthing people were not always assessed in a timely way and their care was not prioritised according to clinical need when they visited the service with pregnancy related concerns.
- Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service.
- Staff told us the service had issues with sickness. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- Staff could not always find the information they needed or know where to look for information due to the service using several different recording systems.

However:

- The service controlled infection risk well. The environment was well maintained.
- Leaders had recognised improvements needed to be made at the service and had started to make some improvements. For example, when monitoring fetal heart rate during labour and increased compliance with the 'fresh eyes' approach.
- Staff worked well together as a team and said they enjoyed working at the service.

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. Most staff had completed their mandatory training.

Nursing and midwifery staff received and kept up-to-date with their mandatory training. The trust target of 90% compliance was achieved in the majority of training modules. However, for adult life support level 2 staff were 64% compliance and infection prevention and control level 2 was 79% compliant.

Maternity

Midwives and Obstetricians undertook training in fetal surveillance. Improvements had been made to compliance of fetal surveillance training. Midwives were consistently above the trust's target of 90% for compliance and obstetricians met the target in 8 out of the 12 months during the last year. The months in which compliance was lower than target was due to doctor rotations. The trust told us this was mitigated by the trust providing training to new staff when they joined the service.

New starters attended a trust induction followed by local induction to the area of work. Safety related training formed part of the induction and was expected to be completed as part of the probationary period.

Staff told us specific competencies to ensure women and birthing people were kept safe were completed in the first year after joining the service. A preceptor was assigned a mentor who supported the individual with achieving the competencies in addition to the practice development midwife. There were formal opportunities to review progress at 2-monthly intervals, as well as annual appraisal.

A student midwife who spoke with us told us they felt very well supported and were working closely with their mentor to learn about maternity care.

Face-to-face training was booked in advance for the year ahead by the training department and each person was responsible for adding this to the duty roster so they could attend. E-learning was arranged by each staff member and generally done at a time convenient to them, and the trust paid them to complete it. Staff told us they received alerts and reminders about up-coming training or when a subject matter needed to be completed.

The service made sure, and staff told us they received multi-professional simulated obstetric emergency training the compliance rate for in August 2023 for midwives was 89%, 98% for anaesthetists and 82% for obstetricians.

Safeguarding

Staff told us they understood how to protect women and birthing people from abuse. However, training records showed poor compliance with safeguarding training for both children and adults.

Staff we spoke with told us they knew how to protect women and birthing people from abuse and when to make referrals to local authority safeguarding team. However, incidents we reviewed showed there were incidents that were not reported at all, or in a timely way. This included a case of female genital mutilation (FGM) which may have led to missed opportunities to support the family following the birth of their child. During the factual accuracy process, the service said it had investigated individual incidents and provided additional information about the processes in place. The service said documentation demonstrated staff understood their roles and responsibilities with safeguarding issues and followed trust processes. Some safeguarding incidents were recognised by staff on the delivery suite and actioned appropriately, which leaders said demonstrated effective safety-netting procedures. However, opportunities for providing early intervention and support could have been missed in any such case.

Not all staff had received recent training specific for their role on how to recognise and report abuse. Information provided by the trust showed all registered nursing, midwifery, allied health care professionals (AHP), healthcare staff, and specific medical and corporate staff who may take a lead role in adult safeguarding at Band 7 or above within their clinical areas, or in their roles and responsibilities were expected to complete level 3 safeguarding adults training. The National Safeguarding Intercollegiate Guidelines state that all staff risk assessing women and birthing people should

complete training to level 3. Adult safeguarding level 3 compliance ranged from 0% for birth centre and day assessment staff, 12.5% for Hazel Ward and delivery staff and 46% for specialist midwives. This was not in line with national recommendations and was not enough staff to ensure vulnerable women, birthing people and their families were kept safe.

At the time of the inspection, compliance rates for level 3 children's safeguarding were as follows: specialist midwives 100%, day assessment 75%, Hazel ward and delivery suite 47%, Birth centre 40% and medical staff 59%. This was not in line with national recommendations and was not enough staff to ensure vulnerable children were kept safe.

The service had an action tracker in place as high numbers of staff were non-compliant with their adult and children safeguarding training. The action tracker had non-compliance with safeguarding training as a risk and noted that it is an outstanding action from the previous CQC inspection. In May 2023 the tracker stated the service looked at down grading the risk as compliance had increased however, it was decided by leaders that the risk score should remain the same. In the action tracker the service had given themselves a 50% compliance target by 1 October 2023 as well as development of a trajectory for 90% compliance by 1 April 2024. However, this compliance trajectory was not for all staff members as set out in the intercollegiate guidelines and during the factual accuracy process the service did not address why all recommended staff were not included in the training schedule for level 3 safeguarding. During the factual accuracy process the service told us it maintained oversight of safeguarding training and mitigated against poor levels of compliance at level 3 by maintaining compliance at level 1 and 2 and providing additional training webinars. It was not clear that these mitigating actions would be enough to ensure the safety of women, birthing people and babies accessing the service.

Safeguarding training compliance was discussed at Maternity Governance Meetings. However, we could not see from the minutes of these meetings what if any action to be taken due to poor compliance with training.

Staff we spoke with said that they had received safeguarding training and knew how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. However, low compliance with training posed a risk staff would not know how to support vulnerable women, birthing people, babies, and unborn babies.

The service had a small safeguarding team consisting of a safeguarding midwife and a named midwife for safeguarding for maternity and neonatal services. The team offered support to midwives and safeguarding supervision to community midwives. They had a good relationship with the local authorities involved with women and birthing people who may use the service.

The safeguarding midwives attend wards daily to offer support with women and birthing people who may have a safeguarding need.

The safeguarding team offered monthly "Lunch and Learn" sessions providing learning on several different safeguarding subjects including but not inclusive, parental substance misuse, working with vulnerable fathers, and looked-after children's training.

We were told that the safeguarding team had prioritised training and supervision. However, they had found meeting this difficult as there were only 2 staff in safeguarding roles.

Care records detailed where safeguarding concerns had been escalated in line with local procedures. Staff followed safe procedures for children visiting the ward.

The service had access to an independent domestic abuse adviser who was allocated to work with the trust.

Staff followed the baby abduction policy. The last baby abduction drills took place in November 2021. During the inspection a staff member said they were not confident in what to do if there was a baby abduction. Leaders at the trust advised us, following our visit an abduction drill had taken place and that there was now an annual programme in place. Personnel changes within the security team had impacted on the delays in repeating the exercise sooner.

Cleanliness, infection control and hygiene

The service generally controls infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves, and others from infection.

We saw most furnishings were suitable, clean and well-maintained. However, there was sticky residue on some storage items in White Horse Birthing Centre (WHBC) which could not be cleaned off with disinfectant wipes and a patient couch in triage area of the delivery suite which needed replacing. Birthing balls were available on WHBC we found these looked dirty; however, when we checked to see if any dirt could be removed with disinfectant wipes, no dirt came off. The sealant around shower trays needed to be checked on WHBC and Hazel Ward, as some were marked and looked dirty.

Call bells in in shower rooms and toilets were via a red cord, these call bells were not encased in suitable material to minimise the spread of infection and to ease cleaning.

We found privacy curtains were clean and had been marked with the date they were changed.

We saw staff were bare below elbow and did not wear false nails, nail polish or unpermitted jewellery. Staff used aprons and gloves when attending to patient care and had access to hand wash facilities.

Equipment on Hazel Ward was marked with green labels indicated they had been cleaned and were ready for use. No such labelling was seen in the delivery suite or WHBC. A box used for the testing of blood glucose on Hazel Ward was found to be blood spattered on the inner lid, suggesting it had not been noticed and cleaned. Equipment that had been used to take a person's blood in the triage area of the delivery suite had not been properly disposed of. This was brought to the attention of staff.

There were infection control champions working in wards, although the staff we spoke with were not sure who they were. We were told the infection control team came on the ward regularly and fed back their observational audits.

Domestic staff were available on the ward areas, and we saw them undertaking their duties. Safe colour coded cleaning equipment items were used, and waste was handled correctly.

The trust had contracted the cleaning of their wards to a private company, who worked with the trust when auditing cleanliness. These audits were fed back to an infection control committee via a divisional report. Reporting on themes such as hand hygiene compliance, Infection prevention and control training compliance and ordering of equipment such as beds and mattresses.

Environment and equipment

The design, maintenance and use of facilities did not keep people safe. Plans were in place to improve the environment, however, there was no current date for when this work would be started.

Maternity

Leaders at the trust identified there needed to be improvements in ventilation made to the second maternity theatre to ensure it was effective for women, birthing people and staff. This was identified and added to the service risk register in July 2017, and was also identified as a should do action in the 2020 CQC inspection. The inspection report stated, “The trust should install appropriate ventilation and scavenger units as soon as possible for the delivery suite rooms that have nitrous oxide” This was placed on the trust’s corporate risk register in May 2020.

We saw evidence which demonstrated a lack of pace regarding work required to improve ventilation systems in the second theatre in November 2021. However, the work had not been approved or completed by the time of our inspection despite a further review by leaders in September 2022. During the factual accuracy process, the service provided evidence of how this risk was managed and mitigated against whilst awaiting large-scale remodelling of the environment in the second maternity theatre. Emails shared with us by the trust showed the service had not been fully kept informed with the progress of actions that would need to be taken.

The service was using 2 different areas within the department to assess and triage women and birthing people, who presented with pregnancy related concerns. Women who were high risk or thought to be in labour would be seen in assessment rooms on the delivery suite 24 hours, 7 days a week, whereas women with lower risk complications, during the hours of 7.30am and 8.15pm would be assessed in the day assessment unit. Having the women and birthing people being assessed in different areas had led to staff using different assessment tool in each area. The initial assessment room and waiting area on the delivery suite were very small. Although the ward clerk would make clinical staff aware when women and birthing people arrived and were seated in the waiting area, there was no clear line of sight for clinical staff to see women and birthing people while they were waiting. This placed women and birthing people at risk as staff may not identify a deterioration in the waiting person’s condition.

Staff told us that they wanted a separate triage area away from the delivery suite that would be open 24 hours, 7 days a week, but this was difficult due to the available space within the hospital estate.

There was a dedicated bereavement room on the delivery suite. There was no separate access to the room as it was located in the middle of the delivery suite. The room was not sound proofed, however, there were 2 sets of doors separating the bereavement room from the delivery suite. There was a bedroom and separate living area to keep the area as self-contained as possible for women, birthing people and their families. The bereavement room had been able to utilise monies from the charity SANDS to buy equipment to provide a comfortable stay for women, birthing people and their partners.

The delivery suite had 1 birthing pool and all rooms had ensuite facilities.

WHBC had 4 birthing rooms with en-suite shower and toilet facilities. These areas were spacious and dressed in a less clinical way with the furnishings. The décor of the rooms however, remained clinical and as a result the rooms were not particularly inviting. There were birthing pools in 2 of the birthing rooms. The pool was accessible via steps and there was a safety handrail attached to these. Emergency evacuation prompts were available for midwifery staff to follow, there were pool evacuation nets available, and staff had training to use these.

Women could not reach call bells on the WHBC, if they were on the birthing bed, as they were built into the wall and were situated out of reach to the bed. We asked how they would call for help if needed and were told, if the woman or birthing person was alone, the door would be left open. Otherwise, they would have a member of midwifery staff with them. This approach did not take women and birthing people's privacy and dignity into account.

Call bells in shower rooms and toilets were via a red cord. These had not been risked assessed for a ligature risk and as a result, were not encased in suitable material to minimise being used for this purpose. A National Patient Safety Alert was issued around ligature and ligature point risk assessment tools and policies in March 2020. The expectation on the response to this was to ensure risk assessments were undertaken and responded to. The service informed us they adhere to their trust policy and would assess any women and birthing people who were assessed as red on the Mental Health Risk Matrix. However, the Safety alert is around the environment as well as personal risk assessments and therefore people whose mental health needs had not been recognised would remain at risk.

Most electrical equipment items had been safety checked. However, we identify several items including phototherapy lamps on Hazel Ward that were out of date for their checks. We found oxygen cylinders which were out of date on both Hazel Ward, delivery suite and WHBC. All out of date items were removed and given to staff. These issues suggest the safety checks are not as strong and reliable as would be expected.

Some staff reported finding equipment when it was needed could be frustrating. During the factual accuracy process the service said it had procured many new pieces of equipment in 2022, and there was no evidence of lack of equipment in incident reports.

Staff carried out daily safety checks of specialist equipment. However, we checked a range of consumable items and found many were out of date. This included ECG electrodes, face masks, blood culture specimen bottles, and dressings and bungs for intravenous lines. These were removed and given to a staff member for disposal. We were concerned the checking processes for stock control management were not effective or safe. The risk was out-of-date items may have been used for treatment or care.

Staff disposed of clinical waste safely and in accordance with policy. Bins were operated by foot pedal and were marked for domestic or clinical waste. Some bins had rust to the metal bar by the foot pedal, which prevented thorough cleaning.

Assessing and responding to risk

Staff did not always complete risk assessments for each woman and birthing person, when presenting in triage. Standard operating procedures did not always give staff enough information or were not followed by staff. This put women and birthing people at risk of not being assessed effectively or staff not identifying when women and birthing people's conditions deteriorated. Fetal monitoring in labour had improved following quality Improvement work.

The service had a standard operating procedure (SOP) for maternity triage. This SOP was due to be reviewed on 12 August 2023. Staff and evidence such as audits shared with us during the inspection told us that the SOP was not being followed. The SOP stated that women and birthing people who attend for unscheduled visits with urgent pregnancy related concerns would be seen in the maternity triage in Delivery suite. On arrival women and birthing people will be assessed using a maternity triage assessment tool, within 15 minutes of arrival and be allocated a category of clinical urgency.

In practice, women and birthing people did not always know where to go if they had urgent pregnancy related concerns. We spoke with a pregnant woman who said they had googled where to find their nearest pregnancy assessment centre. We saw a sticker on a woman's notes with phone numbers to call. Handwritten on the sticker was 24 hours next to

delivery suite and waters/ labour and 8am to 8pm and movements next to day assessment unit. A staff member told us that women and birthing people should contact the day assessment unit if they had reduced movements and contact delivery suite if their waters had broken or thought they were in labour. We were told that some triage assessments were carried in Day assessment during the daytime. However, this was not in the SOP for triage.

Woman and birthing people who were seen in the Day assessment unit as part of triage were not prioritised or allocated a category of clinical urgency. The assessment paperwork used in Day assessment was different to the assessment paperwork used in triage on the Delivery suite.

At the last CQC inspection in 2020 the service had been advised that they should implement a triage system. Staff and leaders told us the implementation of triage had been paused during the COVID-19 pandemic and had been reintroduced in January 2023.

The first audits of the new triage system were carried out in June 2023 and showed that staff were not compliant with seeing women and birthing people within 15 minutes of arrival or with allocating a category of clinical urgency. Audit information for June 2023 showed 22% of women were seen within 15 minutes of arrival and 40% of women were assigned a triage urgency category. Actions from the audit were to continue to audit, educate staff in the importance of the triage system the service was trying to implement, and plans to reorganise clinical space looking into the possibility of triage moving to day assessment unit. July 2023's audit showed 15% of women were seen within 15 minutes of arrival and 50.5% of women were assigned a triage urgency category. August 2023's audits showed some improvement with 45% of women seen within 15 minutes of arrival and 47.8% of women assigned a triage urgency category. Patient records we reviewed showed poor recording of assigning a triage urgency category and that staff had not always recorded the time a woman or birthing person had arrived.

During the inspection we observed and spoke with staff who informed us that calls for triage were answered by the labour ward receptionist/ patient coordinator, who would then try to find a midwife to take the call. This was not always possible as midwives were often busy, and a midwife was not always assigned specifically to triage. We were told there were occasions where the receptionist/ patient coordinator had taken the woman or birthing person's details for a midwife to call them back or if they had felt they needed to be seen by a midwife told the person to come in to triage to be assessed. This put women, birthing people, and babies at risk of not getting timely advice and assessment.

There was no designated phone line for triage. Women and birthing people would either contact the delivery suite or day assessment unit. Leaders shared with us a business plan for a centralised triage phone line that would be used by all maternity hospitals within the local maternity network.

As triage was part of an ongoing quality improvement programme, the trust was continuing to look at ways they could improve the quality of service received by women and birthing people. Leaders at the service listened to feedback given by the inspection team during the inspection and made changes. The service provided additional assurance following the inspection there will be a designated midwife allocated to triage. This midwife will handle all calls coming into triage. The day assessment unit will continue to see women and birthing people for triage who are classed as lower risk and will use the same triage paperwork as being used in triage on the delivery suite.

Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people this a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them

appropriately. We reviewed 6 MEOWS records and found these were not always completed correctly. Five out of the 6 records we looked at had not been scored. This meant there was a risk that staff would not identify when women and birthing people were at risk of deterioration. Staff completed audits of records to check they were fully completed and escalated appropriately. Audits for January 2023 scored 92%, February 2023 90% and March 2023 93%.

During the CQC inspection in 2020 the service was told they should participate in the wider trust sepsis group to monitor women who should have a sepsis screen when triggering MEOWS, according to trust policy. Leaders acted on this, and an email had been sent to all staff to ensure they were aware and acted appropriately.

Risk assessments included consideration of previous history and possibility of venous thrombosis, risk related to elevated body-mass index (BMI), and existing co-morbidities, such as diabetes and mental health. They also asked questions about vulnerability and safeguarding. Questions related to the identification of depression were asked by midwifery staff too. These are known as the Whooley questions, which come from NICE guidelines for antenatal and postnatal mental health. The questions are a screening tool which is designed to try and identify two symptoms that may be present in depression.

The service had a mental health and substance misuse specialist midwife who was available to support staff as well as access to support from mental health services.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff did not always share key information to keep women and birthing people safe when handing over their care to others. The care records were a mixture on a secure electronic care record system and paper records. The trust had recognised in April 2019 that there was a risk of critical information being missed as staff needed to look in more than one place for the information. During the 2020 CQC inspection the trust was encouraged to work on a system where their maternity records would be more easily accessible to all staff. Leaders told us of plans for a maternity electronic system that would be in place within the next 9 months.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

The service provided transitional care for babies who required additional care.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third party organisations were informed of the discharge.

Midwifery Staffing

The service had made improvements to staffing over the last 6 months with inpatient vacancies now being fully recruited, although vacancies remained in community services. However staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

The service completed a maternity safe staffing workforce review in line with national guidance in May 2022. This report identified a registered midwife gap of 3.33 whole time equivalent (WTE).

Maternity

The service reported a 6-monthly staffing review to the board in April 2023 which showed the service recognised midwifery staffing was challenged nationally with high numbers of vacancies. The Trust's midwifery staffing had improved over the last six months by identifying different staffing models, local and international recruitment, and recruitment of band 5 nurses to work in specific areas within maternity services.

Despite successful recruitment where the service had recruited internationally and utilised nursing staff, staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. On the day of inspection there were 2 midwives short on delivery suite, resulting in the lack of a midwife being allocated to triage. The WHBC was also short of a midwife, although they were able to manage this as only one woman or birthing person was using the service at the time this posed a risk if another woman or birthing person attended in established labour. During the factual accuracy process, the service told us the escalation policy was followed to manage staffing and workload safely. However, despite the escalation policy being followed the service did not allocate a dedicated midwife to triage.

Following the inspection, the Trust assured us they had implemented changes to their triage systems and processes and a nominated midwife is now allocated to triage on the roster in advance.

Leaders monitored sickness levels and levels were low overall. The 6-month average sickness rate between April and September 2023 was 3.66% and this was well below the national average of 4.5%.

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 March 2023 and August 2023 there were 22 red flags reported. During June 2023, 9 of the red flags were due to delays in triage, putting women, birthing people and babies at risk of not being assessed in a timely way.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. However, the maternity red flags reported showed that on 2 occasions in the last 6 months the shift co-ordinator on duty had not been able to remain supernumerary status.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice, and they were expected to work in areas unfamiliar to them.

During the inspection we found that there were no dedicated staff working in triage. The labour ward coordinator who was responsible for having a helicopter view and managing the delivery suite, was also responsible for allocating staff from the delivery suite to work in triage. Not all labour ward coordinators were on board with this staffing model. 3 staff members from the delivery suit told us that there was not always a midwife allocated to triage. This meant that staff were not following the triage standard operating procedure (SOP) designed to keep women, birthing people and babies safe. We were told that not having a dedicated midwife in triage led to delays. Senior managers and leaders did not have oversight or act when staff were not following the SOP.

We were told the various areas of maternity worked closely together and staff moved between areas to cover gaps as needed. There were regular bank staff who had previously worked at the hospital, and agency staff had been used 11 times over the 6 months prior to the inspection.

Maternity

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.

Managers supported staff to develop through yearly, constructive appraisals of their work with 84% of staffing having received an appraisal. A practice development team supported midwives. The team included a practice development midwife, practice educator midwife and a practice educator nurse.

Newly Qualified midwives and student midwives told us they felt supported by the staff team. Newly Qualified midwives were supported by practice development midwives to achieve competencies. They worked supernumerary shifts for 5 weeks alongside another midwife prior to being counted in the staffing numbers.

Medical staffing

The service did not always have 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.

Clinicians told us that there were vacancies for consultants and middle grade doctors. This meant the service did not always have enough medical staff to keep women and birthing people and babies safe. Clinicians reported delays in care due to staff shortages.

We were told the service had tried to separate the rota for obstetrics and gynaecology. However, this was only possible up to the hours of 20.30 as there were not enough staff to cover a full rota, therefore after 20.30 the on-call staff were shared with gynaecology.

The service had a comprehensive induction pack for locum doctors. Junior Doctors told us they felt supported by senior staff and received a good induction when new to the service.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always completed fully, although they were stored securely and were available to all staff providing care.

Women's notes were in different formats, paper and electronic. Some paper items were scanned onto the electronic patient record (EPR) and others were not. When the latter happened, the hospital number was used, rather than the NHS patient number, which meant the viewer had to look in different parts of the EPR to find information.

There was a lack of clarity for staff regarding where some information was stored for example, whether information was on the paper records or the EPR. During a ward round that we observed a junior doctor documented care on the EPR. However, the consultant was only using the paper records.

Maternity

We reviewed 6 records in full, which included the women's paper and electronic details. Secure access was required before any EPR could be viewed. We saw records related to post-delivery suturing were not always completed, so it was not clear what degree the perineal tear was or the location.

Paper records were not always completed as fully as expected, with some parts of the record not having information added to. Triage records often had gaps, which meant that information was not wholly available to staff dealing with second or third in-coming calls via triage. This could lead to potential or actual risk of harm.

Partograms were used to monitor the active phase of the first stage of labour and were used to give an early, easy way of recognising problems. However, we found partograms were not always routinely completed in their entirety.

Records of the cardiotocography (CTG), a technique used to monitor the fetal heartbeat and uterine contractions during pregnancy and labour, were not completed with important information. Out of 10 CTG records, we found none of them had an entry at the start of the recording made by the midwife. It would be expected that the midwife writes the start time, date and that they had heard the fetal heart rate via sonicaid or pinard. National Institute for Health Care Excellence (NICE) guideline [NG229] indicates the separate manual capture of the fetal heart rate must be done initially to avoid confusion with maternal heart rate.

The service used a system to handover care of where they report on the Situation, Background, Assessment and Recommendation (SBAR). The service did not routinely audit if staff were carrying out effective SBAR's. However, a snapshot audit was undertaken in May 2023 following an incident, which showed compliance in 2 of the 20 areas within the audit. Following identification of areas for improvement, an "Improving together" approach was undertaken, looking at root causes for the non-compliance and an engagement session was facilitated. Leaders told us that due to a change in ward manager there had been a delay in repeating the audit. This meant leaders could not be assured staff were compliant with completing SBAR when handing over care of women birthing people and babies.

Consent forms were seen for surgical procedures in relevant records. We noted a consent form for caesarean sections was used for a trial vaginal birth, rather than a form specific to the procedure.

Paper records were stored securely in locked cupboards. Documents needing to be scanned were held for collection on Hazel Ward, until ready for scanning.

Following a CQC inspection in 2020, the service rolled out an electronic patient records system over all appropriate areas of practice in 2020 and 2021 and had procured a newer system to integrate with the wider region to be implemented in 2024. The service had documented the risk of information being held in several different formats and locations to the risk register in 2019, and during the inspection in 2020 we told the service they needed to improve this. During the recent inspection, we found that a full transition to an electronic system had not been completed, which required the continued use of additional paper records. This was a risk as doctors and other staff told us they did not always know where to find the information they needed, and there were inconsistencies. This demonstrated ineffective, incomplete, or slow action to mitigate identified risks.

When reviewing governance documents, it was noted that a number of staff were leaving their computers/laptops unlocked whilst leaving the room/work area. The service had recognised this posed a significant risk to information governance as, with single sign on, it will allow access by anyone to view multiple patient data systems. Communications were made to all staff to ensure they were aware of the risk and acted accordingly.

Maternity

During inspection in 2020 CQC reported concerns around the storage of paper notes on Hazel ward. The service acted on this and purchased new lockable cabinets for paper records.

Medicines

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

Staff received training around medicine management and compliance rates were 85.5%, which was below the trust target. During the factual accuracy process, the service told us that medicines management was included in the service's mandatory training package and that this assisted leaders to be assured that staff were competent in administering medicines.

Medicines were stored safely within locked cupboards, with secure code access to the room. Each area had its own system for storage within the cupboards, with clear labelling to prompt ease of access. Medicines checked by us were in date and in their correct packaging. On Hazel Ward we noted there were significant quantities of some medicines, particularly paracetamol. It was not clear if there had been a review of stock levels.

Medicines to take home were stored and labelled appropriately medicines were dispensed by 2 staff members, documented in the patient record, and a paper form was retained and audited by the pharmacy team.

Controlled medicines, subject to additional safety and control measures were stored and managed safely. Records for the use of these medicines were accurate and up to date. A separate logbook was used for the safe management of medicines brought in by women and birthing people. We checked the logbook against personal medicine stored in the cupboard and found it to be accurate.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines. Pain relief was given to those who needed it and a range of different types of pain management medicines were available, in addition to pain relief gas (Entonox).

There was no evidence to suggest antibiotic prescribing was being carried out over and above recommendations.

Staff completed a medicine record for each woman. Medicine charts were reviewed and found to be mostly completed in full. There were a small number of gaps in the recording of when a medicine was not given and the reason for this.

We saw a list of midwife exemptions was available for staff to reference when medicines were administered.

Incident records reviewed during the inspection showed several medicine errors. Prescribing issues were discussed during a maternity governance meeting in June 2023. These minutes did not state any actions to be taken. During the factual accuracy process the service provided evidence to show documented actions and learning during and since the review process. The service had adopted a new method of learning from patient safety events that supported identification of sustainable and effective actions. However, we would have expected to have seen actions within the minutes of the meeting. This would have identified a person responsible for the actions and an audit trail for completion.

Incidents

Maternity

The service did not managed safety incidents well. Staff did not always recognise and reported incidents and near misses. Incidents were not always correctly categorised. Leading to lack of oversight by senior leaders.

Staff we spoke with said they knew what incidents to report and how to report them. However, not all reportable incidents and near misses were reported in line with trust policy.

Maternity governance meeting minutes in February 2023 stated that staff were under reporting Postpartum Haemorrhage (PPH), these minutes did not show what actions leaders were taking to ensure reporting happened. We would have expected to have seen actions within the minutes of the meeting. This would have identified a person responsible for the actions and an audit trail for completion. However, evidence provided showed a series of quality improvement measures were being undertaken by the service including data reviews, audits and improved documentation aids.

When reviewing incidents reported by staff, we found incidents were harm-rated inappropriately according to national guidelines (NHS England National Reporting and Learning System, 2019), with incidents often harm-rated at a lower grade than appropriate. Obstetric anal sphincter injuries (OASI), also known as 3rd and 4th degree perineal tears, were routinely downgraded from moderate harm rating, which is appropriate, to no or low harm. We reviewed 32, 3rd and 4th degree tears 1 was rated as moderate harm whilst 31 were rated as low/no harm. A similar pattern was seen with cases of obstetric haemorrhage.

During the factual accuracy process, the service told us all incidents (including those rated low and no harm) were reported in line with the local Patient Safety Incident Review Framework (PSIRF), where opportunities for learning were identified and shared when required. We saw evidence of an OASI audit completed in July 2023 which showed the service looked at the incidence of OASI and identified potential learning from each occurrence. However, the audit looked at cases that were over a year old which is not recent enough to identify and implement improvements for the benefit of women and birthing people accessing the service.

The audit showed 6 out of 11 questions showed non-compliance. However, there were areas of good compliance for example, the correct type of suture material was used in every case. Documentation compliance was 100% but the audit excluded records where documentation was incomplete and therefore this data could not be seen. Overall, the audit results were non-compliant, and the service planned a re-audit for October 2023, the results of which were not available at the time of publication.

Leaders told us and policies stated that all maternity incidents were reviewed at a weekly incident review meeting. We were not assured the board had full oversight of the themes and trends of all incidents and learning and improvements may not be identified in a timely manner. During the factual accuracy process the service said incidents are reviewed by a central team every 24 hours which focussed on the specifics of the incident and any immediate learning. The service said these reviews informally reviewed the categorisation of incidents, and that this process would be strengthened following inspection feedback.

Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. There was 1 never event in April 2023 in maternity theatres which at the time of the inspection was under investigation by the trust.

We saw themes and trends of incidents discussed at monthly maternity governance meetings.

Maternity

We reviewed Incident review meeting minutes. These minutes looked at all incidents across the trust including maternity. These meetings were attended by senior leaders within the maternity services as well as the maternity governance midwife. It was not always clear from these minutes if appropriate referrals had been made to outside agencies such as Healthcare Safety Investigation Branch (HSIB) now known as Maternity and Newborn Safety Investigation programme (MNSI).

Quality and Safety committee minutes in April 2023 stated there had been 3 new serious incidents raised during the quarter. Each case had been reviewed with any immediate learning taken into pending further serious incidents review.

The service had monthly Maternity Governance meetings where themes and trends of incidents were discussed.

The service had a quarterly Perinatal Quality, Safety and Assurance newsletter. As well as a Perinatal Learning Forum and wider staff forums where learning from incidents was shared with staff.

Due to incidents being rated inappropriate it was not possible to be assured that the staff at the service understood and carried out their duties under duty of candour. For incidents that are graded as moderate or severe there are formal processes to be followed around duty of candour.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service and understood the issues the service faced. However, they did not consistently address them in a timely way. Local leaders had the skills and abilities to run the service.

We saw there were several 'should do' actions from the last CQC report in February 2020 that had not been comprehensively or fully addressed. The trust said some of the delays had been due to changes within the senior management team. However, members of the quadrumvirate had been in post for 20 months. Leaders expanded by saying they said they had wanted to make changes in a way that would ensure staff were onboard with the change, despite the immediate risks which had been identified in 2020. During this inspection, we spoke to leaders and asked them for immediate assurances around the safety of maternity triage services. Following this, changes were made including staff rotas, digital resources, and staff communication emails to ensure a safe triage service was provided, and this was done within 3 working days.

We saw the service had a draft Maternity and Neonatal Services succession planning strategy dated August 2023.

Leaders were not responding to pressures identified by staff during the inspection. We found staffing for the triage area was taken from the substantive labour ward workforce. This was recognised by leaders as a concern but not managed or mitigated against effectively or in a timely way, therefore continued to be problematic for staff and patients within the service.

Maternity

The service was led by a quadrumvirate made up of the Director of Midwifery and Neonatal Services, General Manager, Director of Nursing and Clinical Director. They were supported by the Head of Midwifery and Neonatal services, 2 matrons, and 1 patient safety lead supported by a patient safety and governance midwife, an audit and guidelines midwife and a Patient Safety and Governance neonatal nurse. The service was supported by maternity safety champions and non-executive directors who did regular walk rounds in the service talking to staff and women and birthing people.

The service sits in a large Directorate of Surgery, Women and Children's. We were told that this had impacted when the service looked at improvement projects they would like to engage in whilst resources were also shared in the wider division.

Vision and Strategy

The service did not have its own vision. However, there was a trust vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders, however there was no mention of maternity. The trust vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Not all staff knew how to apply them and monitor progress.

The trust had a quality strategy, people strategy, and an overarching strategy until 2024.The quality strategy (2022-2026) had 4 quality aims: deliver great care, improve staff and volunteer experience, improve population health through better patient outcomes, safety and clinical effectiveness and reducing health inequalities and harm, and to ensure value for money through improvement and efficiency.

These aims were supported by 8 objectives, however, there is no reference to maternity services within the quality strategy. The is no reference to midwifery or obstetrics in the people strategy.

The main strategy talks about performance of services. There is 1 mention of maternity services in the document however, this is focused on the potential building's expansion. This meant there was no credible statement of vision and guiding values for maternity services trust-wide, and therefore, no effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans. This was not in line with recommendations made by the Ockenden reports (2022).

Not all staff could speak about the service vision. One midwifery support worker spoke about ensuring care was the best it could be.

Culture

All staff shared with us that there was a positive sense of teamwork and a willingness to work together, although not all staff felt listened to. The service promoted equality and diversity in daily work. The service had an open culture where women, birthing people, and their families could raise concerns without fear. However, staff did not always articulate this.

Staff we spoke with were positive about the sense of teamwork and there was a willingness to work together. They were happy to work at the trust and whilst staffing was not always ideal, enjoyed their roles and being involved in looking after women, birthing people, and babies.

Maternity

We observed staff working together, being responsive to requests for help and communicating effectively. However, we were told that some senior midwifery staff were reluctant to accept changes that needed to be made within the service and did not always respond well to new roles that had been introduced.

Leaders told us that they had facilitated away days for senior midwives to identify issues and work on the culture within the service in order to progress with change. However, they had still found some resistance to changes that needed to be implemented.

Some staff told us they did not always feel listened to by senior managers. They were aware that senior managers did walk rounds of the service but did not feel they engaged with the staff as much as they could during these walk rounds.

Some staff said that they did not feel supported by senior managers and specialist midwives. They voiced that there was a 'them and us' situation with specialist midwives reducing the hours that they work clinically and often working from home.

The service was actively looking at their community and how they could be working to reduce health inequalities. This included the continuity of care team who were working with women and birthing people who had been identified to have high index of multiple deprivations.

Additionally, the service had accepted an offer from a local university to train up to 10 staff in Black maternity matters leading to the introduction of a Black maternity matters champion role.

Leaders recorded and reported incident data against the ethnicity of women and birthing people. The maternity safety report stated 25% of incidents involved women and birthing people from black, Asian and minority ethnic back grounds and 5% had no ethnicity recorded. The service did not consider this to be a high percentage despite 75% of the local population was white British. The service had an open culture where women and birthing people, their families could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns.

Managers investigated complaints and identified themes these themes were reported in governance meetings and shared feedback with staff.

Governance

Leaders did not always operate effective governance processes and action was not always taken to address risks in a timely way. However, 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.

Leaders did not always operate effective governance processes, throughout the service, for example, incidents were not always graded appropriately, and issues in triage, theatres, and record keeping had not been fully addressed at pace.

Staff and leaders were able to articulate the governance framework for the directorate and how information flowed up to the board. During the factual accuracy process the trust advised However, the service was unable to demonstrate how any action was monitored effectively, as actions and responses taken by leaders were not always documented or timely. However, the service had a governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a series of well-structured governance meetings.

Maternity

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. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. However, some staff said they did not feel information was fed back to them when they raised issues.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies to make sure they were up to date.

Management of risk, issues, and performance

Leaders and teams did not use systems to manage performance effectively. They identified and escalated relevant risks but did not respond to identified risk in a timely way in order to reduce impact.

Leaders identified and escalated relevant risks and issues; the service had a risk register. The risk register did not outline what actions were being taken to mitigate the risk.

The service's risk management strategy outlined that there were weekly incident review meetings. Evidence provided as part of this inspection showed the incident review meetings had not acted when incidents were identified, and incidents were not graded correctly in accordance with The NHS policy guidance on recording patient safety. This meant that incidents which should have been graded as moderate harm may not have been investigated in line with the trust's incident management (including SI) policy and formal duty of candour processes may not have been enacted.

Assurance meetings and safety meetings recognised that recording was low for some known incidents. Despite this acknowledgement meeting minutes did not state what action the service would put in place to rectify this.

The trust did not have effective oversight, nor had they recognised that incidents reported to the NHS National Reporting and Learning System were not always categorised correctly. When we reviewed these incidents, we found that some maternity incidents were recorded as either mental health or community care.

The service participated in relevant national clinical audits.

Managers and staff carried out a programme of repeated audits to check improvement over time. However, repeat audits were not always undertaken even when the outcome of the audit was that the service was not compliant. For example, the service carried out an audit of the use of Situation Background Assessment Recommendation (SBAR) when handing over care in May 2023, this had shown the service was compliant in 2 of the 20 items in the audit. Following the audit managers identified areas for improvement and an engagement session was facilitated, and information on baby labelling was disseminated to the team. However, we were informed that due to a change in ward manager there had been a delay in reauditing to see if improvements were effective.

The Maternity Incentive Scheme is a national programme that rewards trusts which meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services.

The service met all 10 safety actions in Year 4 and had a delivery plan to comply with 7 out of 10 actions in Year 5. Progress was reported monthly in maternity governance meetings.

Maternity

The service had an NHSE assurance visit in October 2022 to assess compliance with the 7 immediate and essential actions from the interim Ockenden report. The visit findings included 7 recommendations for the trust to consider making improvements; this recommendation included Listening to staff's concerns regarding information technology, making the Maternity and Neonatal Voices Partnership (MNVP) an integral part of the team, as well as ensuring MNVP promotional material was more visible.

Service leaders told us the risk register was reviewed every month with the governance leads, we reviewed governance meeting minutes which supported this. However, we were not assured that the risk register was effective or that leaders effectively managed the risk entries and actions taken to mitigate risk. It was not always easy to identify or understand where action had been taken to address or mitigate an identified risk, a number of risks were old. We saw limited evidence that appropriate action had been taken to reduce the risk ratings in all entries.

Ventilation in treatment room often used as a 2nd theatre had been identified as a risk in July 2017. Leaders had tried unsuccessfully to sign off on work that would mitigate this risk, and there was a start stop approach with leaders chasing information on why the project had been stopped. Safeguarding training was identified as a risk in October 2020, there was an action tracker in place. However, the pace of action was slow and there continued to be missed opportunities when recognising the need for further support for some vulnerable women and birthing people.

The service was developing their approach to Patient Safety Incident Response Framework (PSIRF) which sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The service had an escalation policy in place to proactively manage activity and acuity across the trust. They followed a standard escalation policy across the local area.

Information Management

The service collected data and analysed it, to understand performance. It was not always clear if this data was effectively used to make improvements. The information systems at the service were secure but were not always integrated. Data or notifications were not consistently submitted to external organisations as required.

The service had their own comprehensive maternity dashboard where they could see women and birthing people's and babies' outcomes at a glance. However, this dashboard did not benchmark against national outcomes. The service also inputted into regional and national dashboard where the service could benchmark and compare their outcomes against the region as a whole.

Staff told us they could not always find the data they needed, in easily accessible formats, due to the service using more than one system to record data. This was also recognised on the service risk register since 2019. There was a plan in place for a digital maternity records system to be implemented, although the pace in which the service had moved to implement this change and mitigate the risk to women and birthing people was slow.

The information systems at the service were secure but were not always integrated; the continued use of multiple paper and electronic systems posed a risk of inconsistency, inaccurate, and out-of-date information used to provide care.

Following feedback from the CQC inspection in February 2020, the service purchased equipment to ensure the security of records.

We were not assured that data or notifications were consistently submitted to external organisations as required. We found that not all incidents were submitted to external organisations in a timely manner or categorised correctly when they were.

Engagement

Leaders and staff engaged with women and birthing people, the public and local organisations to plan and manage services. The service did not always collaborate with partner organisations in a timely way to improve services for women and birthing people

Leaders worked with the local Maternity and neonatal Voices Partnership (MNVP) However, more could be done to ensure the MNVP were involved and felt the service acted when they shared concerns. A NHSE assurance visit in October 2022 recommended the MNVP were an integral part of the team. However, during the process of this inspection it became apparent that the MNVP were not aware of nor had been involved in recent improvements regarding maternity triage at the service. The MNVP representatives told us concerns they raised were not always acted upon in a timely manner. However, work had been done following negative feedback about cultural sensitivity and the service showed a timely response to learn from and prevent future mistakes.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity.

Leaders engaged with staff, there was a quarterly newsletter and monthly staff forums. Leaders also used posters to feedback to staff. Information that needed to be disseminated more frequently was sent out by email and discussed at daily safety briefings.

Leaders understood the needs of the local population.

Learning, continuous improvement and innovation

Most staff were committed to 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, however we found a lack of pace.

Leaders shared with us that they had been on an improvement journey over the last 3 years. This had started by looking into concerns raised by staff who said they had not always felt listened to, and they did not feel staffing levels were safe. Safety Champions had received feedback from staff that communication and engagement with leaders had improved.

There had been a targeted recruitment and retention campaign leading to a reduction in vacancies in inpatient areas. There continued to be vacancies for community midwifery teams and this was continuously monitored and managed by the service. Leaders had also implemented an introduction of an acute on-call rota to support in times of escalation which reduced the need for community staff to bolster staff numbers within the hospital.

Most staff were committed to learning and improving services. Some staff had not understood or bought-in to changes at the service and did not see that these improvements would benefit women, birthing people and babies. For example, not all staff at band 7 level saw the benefit of allocating staff to triage despite away days with senior leaders.

Maternity

The service used a methodology called “Improving together”; this aimed to empower staff to own improvements in their own areas and to be part of the solutions. The service had used this methodology to improve their fresh eyes compliance from 60% to over 95%. However, due to being part of a large division progress was slow. The divisional leadership team reported a different improvement project to the executive team each month, and in June 2023 reported on maternity triage services. Some staff told us they did not always feel changes were made quickly enough.

Outstanding practice

We found the following outstanding practice:

- The service was working in collaboration with a local university to train staff in “Black maternity matters”.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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:

Great Western Hospital Maternity

- The service must ensure staff are up to date with maternity mandatory training modules. Including safeguarding training level 3 for both adults and children Regulation 12(1)(2) (c)
- The service must ensure that triage processes are safe, risk assessments are carried out, and women and birthing people have access to parity of service at any time of day or night. (Regulation 12 (2) (a) (b))
- The service must ensure non-compliant audits are acted upon and improvement plans put in place. (Regulation 17 (2) (a))
- The service must ensure incidents are managed well, including but not limited to effective sharing of learning, using learning to effect change and improvement in practice, ensuring incidents are categorised, harm rated, investigated, referred for external review and reported accurately and appropriately. (Regulation 17 (2) (a) (b))
- The service must ensure that adequate documentation takes place including but not limited to triage arrival times and assessments, consistent use of SBAR, consistency and accuracy over several record-keeping systems. (Regulation 17 (2))

Action the trust SHOULD take to improve:

Great Western Hospital Maternity

- The service should ensure that staff are compliant with MEOWS and ensure effective audit programme is in place.
- The service should ensure all incidents are monitored by ethnicity. In order to identify potential health inequalities.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 1 other CQC inspector, and senior specialist and 3 specialist advisors with expertise in maternity. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care