Nottingham University Hospitals NHS Trust

Queen's Medical Centre

Inspection report

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Date of inspection visit: 1-4 March 2022
Date of publication: 27/05/2022

Ratings

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

Our findings

Overall summary of services at Queen's Medical Centre

Requires Improvement 

The Queen's Medical Centre is operated by Nottingham University Hospitals NHS Trust. The maternity service sits within the division of family health and provides a range of services from pregnancy, birth and post-natal care. There are inpatient antenatal, intrapartum and postnatal beds available for women. Fetal medicine service is based at both Nottingham City Hospital (NHC) and QMC sites but mainly at the QMC campus.

Maternity services at the QMC are based over two floors. Ward B26 is an 18 bedded antenatal ward. Ward C29 is a 26 bedded postnatal ward which includes transitional care cots. The labour suite is located on the same floor as B26 and has maternity operating theatres, 9 beds for women in labour plus four observation beds, and a bereavement suite. The triage and induction suite are also based in the labour suite, as is the Sanctuary birth centre which is a four bedded midwife led unit.

Data from the trust reported that for the 12 months prior to the inspection, 3559 babies had been delivered at the QMC. Of these 1837 were unassisted deliveries, 511 were assisted deliveries, 535 were elective caesarean deliveries and 676 were emergency caesarean deliveries.

Community maternity services are provided by teams of midwives predominantly commissioned by NHS Nottingham and Nottinghamshire CCG. They offer women a homebirth service and postnatal care. We did not inspect the community services during this inspection.

We inspected the service on the 3 and 4 March 2022. The inspection team comprised two inspectors, one midwife specialist advisor and one consultant specialist advisor. An inspection manager oversaw the inspection.

Our rating of maternity services stayed the same. We rated them as inadequate and have taken enforcement action as a result of this inspection to promote patient safety. We served a warning notice to the trust requiring them to make improvements to their triage services, at both the Nottingham City Hospital and Queens Medical Centre, to address safety concerns in respect of staff deployment and the oversight of risk and performance. The warning notice also requires the trust to make improvements in respect of their processes for observing women across all maternity services.

During our inspection we visited ward C29 (postnatal ward), B26 (antenatal ward) and the labour suite. We spoke with 28 staff including midwives, midwifery support workers, obstetricians, anaesthetists, managers and reception staff. We reviewed 11 patient records and nine patient prescription charts. We spoke with eight women and two fathers about their experience of the trust.

After the inspection we also held focus groups where we spoke with more midwives; some staff also contacted us separately to discuss their experience of working at the hospital.

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

Inadequate ➔➔

Our rating of this location stayed the same. We rated it as inadequate because:

- The service did not have enough staff to care for women and keep them safe. Not all staff had training in key skills. Staff did not always assess all risks to women, and we were not assured staff acted upon concerns in a timely way. Staff did not always keep good care records. Staff did not always receive feedback after they had reported an incident.
- Managers monitored the effectiveness of the service however the outcomes were variable. Not all staff received appraisals.
- People could not always access the service when they needed it. Home births were cancelled due to escalation measures in the acute hospitals and women were delayed for unplanned and planned care and treatment due to capacity issues.
- Not all staff felt respected, supported and valued. Although governance processes had started to improve, there were still further areas of improvement required to ensure effective oversight of the service. Staff at all levels were not always clear about their roles and accountabilities and often did not have regular opportunities to meet, discuss and learn from the performance of the service. Leaders did not always effectively identify and mitigate risks to the service.

However:

- Staff understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Improvements into the overall management of safety incidents had been made.
- Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Staff worked well with others for the benefit of women. Staff advised women on how to lead healthier lives and supported them to make decisions about their care and had access to good information. Key services were available seven days a week.
- Overall, staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service mostly planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were focused on the needs of women receiving care. The service engaged with women and the community to plan and manage services. Staff were becoming re-engaged with improving the service.

Is the service safe?

Inadequate ➔➔

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff had completed it.

Maternity

Not all staff received and kept up to date with their mandatory training. Due to the challenges of the pandemic, compliance rates with this training had dipped. Information received after the inspection showed in February 2022 there was an overall compliance rate of 62% for mandatory training compliance against a trust target of 90%. This covered all maternity staff working across both sites. Data from the trust estimated the division would achieve the 90% trust target by October 2022 as part of a structured recovery plan. However, there was an awareness of the difficulties in being released to complete training. Some staff told us they were able to claim overtime or time back in lieu (TOIL) if they completed their electronic learning in their own time.

Clinical staff completed practical obstetric multi-professional training (PROMPT) electronic learning as part of their mandatory training programme. Compliance rates were recorded as 71% in February 2022. In addition to this, staff completed face to face maternity inter-professional scenario training (MIST) to enhance the learning from PROMPT. Compliance rates were recorded as 87% in February 2022. The trust planned to fully implement PROMPT training through face to face sessions by September 2022, until this is implemented, they intended to continue with the blend of MIST and PROMPT training.

The service recently launched their fetal monitoring competency assessment package in conjunction with the K2 perinatal training package. To support staff undertaking this, the fetal monitoring lead midwife and obstetrician held weekly CTG learning sessions which were open to all staff. Compliance rates with this in-house CTG competency package at the end of January 2022 was recorded as 88% for midwives and 79% for obstetricians. The trust moved to using the Midlands electronic fetal monitoring regional competency assessment document for trusts following NICE guidance in January 2022.

Staff told us the mandatory training they completed was comprehensive and met the needs of women and staff. Staff generally spoke positively of the mandatory training programme. Most training was delivered by e-learning; however staff also attended face to face modules.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Specialist midwives provided additional training to staff on mental health and cognitive impairment.

Some managers monitored mandatory training and alerted staff when they needed to update their training. However, not all staff received reminders.

Safeguarding

Not all staff received training on how to recognise and report abuse. Staff understood how to protect women from abuse and the service worked well with other agencies to do so.

Not all staff received training specific for their role on how to recognise and report abuse. Due to the challenges of the pandemic, compliance rates with this training was low. This training was part of the recovery plan which had been devised by the senior managers of the service. Data provided by the trust for February 2022 showed midwives were 47% compliant with level two safeguarding adults and children, and 47% compliant with level three safeguarding children. Data showed only 43% of consultants had completed the same training. This was against a target of 90%.

Midwifery Support Worker (MSW) grades were 100% compliant with safeguarding adults level two, and 38% compliant with safeguarding children level two and three.

The named midwife also conducted additional training at a safeguarding forum which was well received by the midwives and support workers. This was usually based on incidents or cases that occurred and was refreshed each year.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff provided many examples of where they had escalated their safeguarding concerns or made safeguarding referrals to protect women with complex backgrounds. Specialist midwives had also provided effective support to staff when protecting women.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a named midwife who was the lead for safeguarding within the maternity services. They were also supported by a band six safeguarding nurse. The named midwife was managed by the head of safeguarding for the trust. This ensured there was a more collaborative and coordinated approach to safeguarding. This had been a positive move as there was a lot of cross over with the children's safeguarding team. The named midwife attended most prebirth meetings, especially if they were not known to any of the specialist midwives.

The named midwife worked closely with other specialist midwives due to the complexities found within safeguarding cases. One example of positive proactive work was in relation to ensuring women who were seeking asylum were safe from harm and abuse. The safeguarding midwives and specialist midwife for asylum seekers worked together to ensure they were safe and had supportive plans in place. This included additional measures to provide any existing children support and a safe place to stay whilst the woman was delivering her baby in hospital. The safeguarding team and specialist midwife had worked with local organisations to provide this wrap around care for women and their children.

Staff made safeguarding referrals as standard for pregnant young people under 16.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. All staff we spoke with showed a good understanding of signs and symptoms of potential abuse and were able to describe examples of women and families who had safeguarding referrals in place. We saw staff made referrals for a variety of reasons including female genital mutilation, domestic violence, substance misuse and where women did not have a fixed address. Staff completed body maps for babies born in the labour suite to ensure any new marks or injuries were recorded. We saw this in action where a baby was noted to have bruises which were not present on the body map from birth. Trust processes were followed to ensure this baby was monitored. This was a transparent process involving the mother of the baby.

Staff we spoke with were aware of who the safeguarding leads were who could provide additional advice and support if necessary.

Staff consistently asked women about their experience of domestic abuse, however, they did not always record correctly if they had not been able to ask at an appointment, for example if a women's partner was present. Data from the trust for February 2022 showed that 95.8% of women were asked about domestic abuse, but staff only recorded 'not asked at this time' where appropriate 46.6% of the time.

Staff followed safe procedures for children visiting the ward. However, at the time of our inspection, local restrictions were still in place around visiting due to the COVID-19 outbreak. This meant there was usually no children visiting the services.

Not all staff were aware of the baby abduction policy and staff told us they had not completed baby abduction drills. During the previous inspection in October 2020, we had concerns raised with us about the abduction policy and staff

awareness of this. We recommended the service consider implementing a process. During this inspection we found staff were still not all aware of this policy, which was in draft form at the time of our inspection (dated January 2022). We found the service had not undertaken any formal scenarios around abduction. However, the service had completed informal, in-house awareness training of the policy. This concern had been added to the service risk register as a new risk.

Staff were aware of concealed pregnancies within the region. Although this had previously not been a concern, since the lockdowns from the COVID-19 pandemic this has started to rise. Work was going on regionally to collate data and identify the themes or trends.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean. However not all areas were audited to monitor this.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean and uncluttered. Furniture was wipe clean and conformed to infection prevention and control best practice. Sinks in clinical areas had elbow operated taps to reduce the risk of contamination.

In the labour suite, including the triage and induction suite, we saw single use curtains were used. These were regularly changed. Staff told us where a woman was positive with Covid 19 or had another infectious illness, the curtain was replaced immediately as the area was cleaned.

The service generally performed well for cleanliness; however not all areas were audited. Data from the trust reported that hand hygiene audits were completed every other month. We saw from November to March 2022, ward C29 had not been audited. This meant there was a lack of oversight of performance in this area. Ward B26 was audited in November 2021, January and February 2022. This ward achieved 100% for the first two audits, and 93% for the most recent audit. The labour suite showed 100% compliance against two audits conducted in February and March 2022. We requested cleaning audits from the trust which were sent in May 2022. These showed cleaning audits from all areas within maternity for December 2021. Each area was audited four times within the month. Where concerns were identified in the first and second audits; improvements were made towards the end of the month.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. However, we saw that infection prevention and control in relation to cleaning was added as a new entry to the department risk register due to a lack of domestic cleaners.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbow. We saw staff using PPE as required.

We observed staff cleaning equipment after patient contact. Equipment was not labelled to indicate when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mainly kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

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

Maternity

The design of the environment followed national guidance. Staff told us of changes to the environment since the last inspection. For example, triage and the induction suite had been moved from the ward to the labour suite. This made sure women were closest to where they needed to be should they experience complications.

We checked the resuscitation trolleys in the labour suite. These comprised an adult trolley and a neonatal trolley. We checked six consumable items within the trolley, all were in date. Emergency drugs box was tamperproof and in date. Staff did a daily seal check and a weekly full check of the contents. The resuscitation trolleys were sealed with a quick break tag, however the tag could be undone and reattached without breaking it. This meant someone could tamper with the contents of the trolley and attach the same tag.

The resuscitation trolleys for both neonates and adults on the wards were accessible, tamperproof and checked daily. We checked a sample of consumable products, all of which were in date.

The labour suite had CCTV coverage. The labour suite and the wards required any visitors to be let in and out to maintain security.

We did see an unsecured fire extinguisher in the triage waiting room. We alerted staff to this who provided assurances that this would be secured promptly.

Staff carried out daily safety checks of specialist equipment. Within the labour suite, matrons had developed a daily list to ensure all equipment in areas that required checking throughout the labour suite, induction suite, and triage was undertaken.

The service had enough suitable equipment to help them to safely care for women and babies. Each room within labour suite had their own CTG (cardiotocography) machine, a resuscitaire and equipment to monitor women for deterioration. Staff had their own handheld devices to record electronic observations. The digital team regularly sent newsletters advising any staff member who did not have such a device to contact them to obtain one.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff mostly completed and updated risk assessments for each woman and took action to remove or minimise risks. However, we were not assured staff always identified and quickly acted upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. However, not all observations were carried out in a timely matter. When staff checked women's vital signs as required, these were inputted into an electronic system which automatically calculated the Modified Early Obstetric Warning Score (MEOWS). This was then automatically escalated according to the level of concern, staff told us they would also verbally escalate any concerns to relevant staff members (midwife in charge or medical staff). The score also dictated how often women should be re-monitored to identify or prevent deterioration.

We found that not all women on the wards were reviewed within appropriate timeframes as per the nationally recognised tool used. Midwives and midwifery support workers (MSW) were trained to review women using the MEOWS

tool. Each midwife was responsible for a number of patients which included taking observations; this task was often delegated to MSWs. However, not all MSWs completed these. In addition, there was no system or oversight to identify women who were overdue to have their observations taken. This meant there was a risk of not identifying a deteriorating woman in a timely manner.

We raised this with the trust as an area of risk. Subsequently the trust submitted data showing overdue observations from September 2021 to March 2022. From 6 February 2022 to 20 March 2022, the number of overdue observations ranged between 22 and 29%. Additional data from a dashboard used by the trust showed that the observations undertaken in line with the trust MEOWS policy had shown statistically significant improvement from October 2021 to mid-February 2022. In addition, the trust set actions for midwives to use the available functionality as part of the electronic observation system to oversee outstanding observations.

Staff did not always complete initial assessments on time on admission or arrival. Significant concerns remained in the provision and oversight of triage at the QMC location. The trust had a target that all women should be seen within 15 minutes of arrival at triage. Women were not consistently triaged within 15 minutes of arrival. This was due to a number of factors including staffing; and triage seeing patients who were on a day assessment unit (DAU) pathway. DAU was for non-urgent appointments which were pre booked. Plans were in place to separate DAU from triage; however, this had not happened at the time of our inspection due to low staffing. This concern was added to the divisional risk register. The trust told us they were aiming to separate these areas by April 2022.

Data submitted by the trust showed: in December 2021, 580 women were seen in triage. Of these, 318 were seen within 15 minutes (55%). 204 (35%) women did not have their 'time seen' documented, therefore it was not possible to identify if they were seen within 15 minutes or not. In January 2022; 818 women were seen in triage. 350 were seen within 15 minutes (43%). 468 (57%) did not have their 'time seen' documented. In February 2022, 617 patients were seen in triage. Of these, 390 (63%) were seen within 15 minutes. 227 (37%) did not have their 'time seen' documented. This data excludes those patients seen as part of the DAU or the antenatal clinic overflow.

On the first day of our inspection we saw that 20 women had attended triage. Of these, seven had been seen with 15 minutes, five had not been seen in this timeframe, five did not have the 'time seen' documented and three were being seen at the time of our inspection. This indicated that learning from previous audits had not been embedded.

Data from the trust over the past 12 months showed one incident of severe harm for a woman who was not seen within 15 minutes of triage. This incident was in January 2022 and was being investigated at the time of the inspection.

Upon arrival at triage, staff assessed women according to a trust wide standard. This was an improvement on our previous inspection. Staff identified women as either 'red', 'amber' or 'green' which determined how quickly the women would be seen and by whom. Women who were assessed as 'red' moved straight into the labour suite. All triage staff we spoke with were aware of this categorisation and could describe what action should be taken in the event of a patient who deteriorated during their time in triage. The assessment was clearly displayed in staff areas.

Not all patients had their risk status documented. In December 2021; of the 580 women seen, 262 did not have their status documented (45%). For January 2022, out of 818 patients seen, 437 (53%) did not have their status documented. For February 2022, out of 617 patients, 132 patients did not have their status documented. (21%). Whilst February showed an improved picture, this was not sufficient to demonstrate staff were accurately recording information regarding patient risk. We saw this issue was raised in a triage team meeting in December 2022 to remind staff to complete documentation.

Maternity

Staff compliance with documented standards when undertaking cardiotocography (CTG) monitoring had improved. CTG is a way of monitoring fetal heartbeat. At our last inspection we found women and babies were at significant risk of harm due to a lack of standardised practice and staff not following guidance which recommends a 'fresh eyes' approach (a second review of the monitoring output). During this inspection we found CTGs were well documented within patient notes, and where necessary staff had escalated concerns to the relevant staff. We saw posters promoting the 'fresh eyes' approach displayed in clinical areas and staff we spoke with told us this approach had been instrumental in improving patient safety. Staff used stickers within patient records to show they had initiated CTG monitoring, and separate stickers to denote a 'fresh eyes' review had been completed. We reviewed an audit of CTG for July, August and September 2021 and found that the use of 'fresh eyes' at the two-hour point had deteriorated. In July, 72% of cases reviewed had a 'fresh eyes' review. This dropped to 26% in August 2021. In September 2021 this was 41%.

Staff knew about and dealt with any specific risk issues, however did not always have full support from other specialities. Medical staff reported difficulties in accessing support from other specialities to review women as necessary to mitigate risk.

During the first day of our inspection, we were made aware of a patient who had been referred to the labour suite from ED. The patient was admitted to the labour suite primarily with a suspected head injury and abdominal pains. Staff told us they had difficulties in obtaining reviews for this patient from specialities outside of maternity or support to re-locate this patient to the correct speciality. We discussed this case with senior leaders to ascertain if the patient had been put at risk of deterioration or harm as a result. Managers told us the medical team within the labour suite took appropriate steps to maintain the patients' safety whilst waiting for a transfer to the right department and did receive some input from relevant specialities. On the same day; two women were awaiting a surgical review however surgical medical staff had not responded to this request in a timely manner.

The trust told us from 24 September 2021 to 24 March 2022; staff reported 204 incidents relating to 'delay/ failure to treatment or procedure; Obstetrics'. Of these, two indicated a delay in medical staff attendance for a deteriorating patient.

We requested data to clarify how often women were inappropriately sent to maternity from ED or other specialities. Data from the trust confirmed there had been no reported incidents of this nature within the last three months. However, across the two sites, 13 incidents had been reported specifically regarding inappropriate referrals to triage within the 12 months prior to the inspection. Data from the trust confirmed there were no specific trust guidelines for managing patients who were diverted to labour suite inappropriately. In response to our request the trust were reviewing guidelines used elsewhere to see if these could be adopted. The trust confirmed that pathways for the condition with which the patient presented should be followed and to take into account pregnancy with the exception of chest pain where there was a specific guideline for pregnant patients presenting with this.

Staff described how they would respond to a medical emergency. This was in line with the trust policy. Staff undertook scenario training on a yearly basis. This included midwives, midwifery support workers, obstetricians and anaesthetists.

In addition to yearly training, the consultant obstetric anaesthetists delivered three-monthly simulation sessions. This was open to anaesthetists, consultant obstetricians, trainee doctors, band 5 to 7 midwives, midwifery support workers and students. The scenarios were based on real incidents that happened within the department; and were held in the location where the incident had occurred. This meant the staff training was delivered realistically in the environment they would be working in. Within each session three simulations were undertaken. In the afternoon all the staff involved would return as a group to discuss learning from the incident simulations and from patient feedback letters and incident reports.

Maternity

Staff we spoke with and observed were familiar with signs and symptoms of sepsis. Staff initiated the sepsis bundle when required.

In all patient records we checked; staff completed risk assessments for venous thromboembolism (VTE). The maternity service report for January 22 showed the percentage of completed VTE risk assessments at delivery was 99.1%, against a trust target of 95%.

The service monitored safe care in respect of risk of developing tissue damage whilst an inpatient.

Not all women had a carbon monoxide screening. Data from the trust showed in February 2022, 68.8% of women had received screening. This was, however, an improvement from our previous inspection.

Staff completed safer surgery checklists for women undergoing surgery such as a planned caesarean section. In the five records we looked at where women underwent a procedure, all checklists were completed appropriately apart from one. In one case the 'sign in' part had not been fully completed. We saw swab counts were completed for all applicable cases.

The service last audited compliance to safer surgery checklists in April 2021. Plans were in place to audit this on a monthly basis going forward post inspection.

The trust had a guideline for caring with women who presented as Covid 19 positive. This covered all women regardless of their point of entry to the service.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The mental health provision was provided by a different trust and a policy was in place to support access. In addition to this, there was a specialist mental health midwife who was involved with women known to have significant mental ill health.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff completed specific mental health assessments and recorded any mental health symptoms or diagnosed conditions disclosed by women. We saw evidence staff discussed onward referrals to mental health services for women who indicated they may benefit from this. Data from the trust showed in February 2022, 93.8% of women had their mood assessed for depression or low mood. Ninety-three percent of applicable women completed a generalised anxiety disorder (GAD-2) screening.

Staff shared key information to keep women safe when handing over their care to others. We observed staff completing handovers of specific women to staff who would be taking over their care. These handovers were very detailed with clear information regarding medications, recent observation scores, safeguarding concerns, Covid 19 status, and any general requirements.

Shift changes and handovers included all necessary key information to keep women and babies safe. Labour suite midwife and consultant handovers included all relevant information to keep women safe.

Midwifery and Nurse staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Maternity

The service still did not have enough nursing and midwifery staff to keep women and babies safe. During the inspection in October 2020, we placed conditions on the trust's registration to ensure they actively assessed, reviewed and appropriately escalated any staffing concerns. During this inspection, we still found concerns with staffing. The service used a nationally recognised tool (Birthrate Plus) to calculate the number of midwives required to provide safe care and treatment to women using the service. During the inspection, the Director of Midwifery (DoM) said there was a staffing gap of 35 whole time equivalents (WTE). However, to ensure the service has adequate cover for any staffing absences and training, a paper was due to be presented to the board requesting an uplift of 60-65 WTE midwives.

Each clinical area (both wards and the labour suite) completed the Birthrate Plus tool regularly to accurately measure staffing and acuity. The wards completed this three times per day whereas the labour suite completed this plus acuity every four hours. This information was shared with senior leaders to determine how to best staff each area to keep women safe, when staffing levels were not as planned.

All midwives and midwifery support workers we spoke with told us of the impact the reduced midwife staffing was having. This included looking after a higher number of women than recommended and not having time to undertake duties such as breastfeeding support.

Data from the trust shows that for the three months prior to the inspection, staff had reported 54 incidents regarding staffing. Eight of these were linked to unit diversions, 39 were linked to unit closure and seven were linked to general staffing concerns.

Registered nurses had been introduced to the maternity services to support the midwives and enable them to concentrate on their core skills of helping women to give birth. The nurses were able to concentrate on aspects such as medication rounds and wound dressings which freed the midwives up to care for the women in relation to their maternity needs.

Matrons in the labour suite had plans to upgrade the escalation process for staffing so midwives, who did not work clinically, such as clinical educators, would be allocated a day where they could support clinically if required.

The maternity services report for January 2022 showed that 99% of women had one-to-one care in labour. This was against a national target of 100%. This was an improvement on previous months and was the highest percentage of one-to-one care given since April 2021. This showed that despite staffing concerns, almost all women in labour were receiving appropriate care.

Managers accurately calculated and reviewed the number and grade of nurses and midwifery support workers needed for each shift in accordance with national guidance.

The number of midwives and midwifery support workers did not match the planned numbers. On the first day of our inspection staffing was identified as 'red'. We saw the antenatal ward (B26) had three midwives allocated however one of these had been sent to support the labour suite. At this time there were 13 women on the ward. A third midwife was sent to the ward when the ward reached capacity at 18 women. This was a different midwife to the one originally allocated who was moved to labour suite which meant they were not as familiar with the area. On the postnatal ward (C29) there were three midwives, a registered nurse, a transitional care worker and a midwifery support worker. At that time 18 women were on the ward. Three women were due to be admitted to the ward. This ward was deemed safe for

staffing at this point. The triage and assessment unit had limited capacity and was running with two midwives. Two community midwives have been allocated to work on the triage phone line. Planned staffing for the telephone line was one community midwife and one triage midwife. The induction suite had three women who were continuing to wait due to the lack of capacity in the labour suite with three further women waiting to come in to be induced.

The triage advice line had a staffing level of two midwives during the day and one at night. This was covered 24/7. There were not always enough midwives available to staff the face to face triage 24/7. Staff told us that 24 hour coverage was achieved approximately 70% of the time. However, this was not formally monitored by the trust.

Managers could adjust staffing levels daily according to the needs of women. The service had introduced morning multidisciplinary (MDT) meetings to review the acuity of the areas and the staffing. Where pressures were identified, this enabled measures to be put in place to support staff. In addition to this, the service had introduced flow coordinators in the daytime. They were also able to support areas when pressures were felt due to staffing concerns. Senior leaders told us the flow coordinator had been very successful in supporting areas when pressured, they planned to roll this out 24 hours a day.

The flow coordinator worked clinically if required such as if women arrived who were in labour despite the unit being closed to new admissions. Non-clinical staff provided assistance within their competences to support the midwives.

Reception cover for the labour suite was available 24 hours per day.

Transitional care workers supported midwives on the postnatal ward. There were eight transitional care workers to cover this role. Staff told us how midwife staffing could affect the amount of time allocated to transitional care babies.

The service had significant vacancy rates. Senior staff told us there was a constant vacancy rate which they were recruiting into. This was down to already established gaps in the staffing establishment, but also due to ongoing challenges with retention.

The service had reducing turnover rates. Staff told us they had go through a lot of periods where staff were leaving just as fast as new staff were starting. However, data showed this had started to decrease. In September 2021 the turnover rate was approximately 4.3%. Managers told us about work to increase retention rates such as focusing on specialist skills and link midwife roles.

The service had reducing sickness rates. Data showed there was a peak of 8% sickness for midwives in August 2021 but had been reducing since this. There was another small increase in December 2021, but this had now started to reduce again and was currently measured as 6.5%. Staff told us the sickness had been due to a mix of COVID-19 related sickness and also long-term sickness.

The service had ongoing bank and agency nurses working within the service. Managers did not limit their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. Staff told us new agency staff were shown round the department and given support to understand what was expected of them. Agency staff who were new were given a booklet with a checklist to ensure they had covered all essential items such as the IT systems.

Maternity

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. However, there was a plan to improve this. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service was improving the number of medical staff to keep women and babies safe. The service leads completed a gap analysis of the obstetric consultants for the service and identified an additional 13 consultant posts were required. At the time of our inspection an additional six consultants had been recruited into post. Further information supplied by the trust indicated the service were expected to be able to cover all gaps in the rota by December 2022.

The consultant anaesthetist staffing provided 24/7 maternity cover. Recruitment was due in August 2022 to cover a 1.5 whole time equivalent gap.

The medical staff matched the planned number. Information shared with CQC showed in January 2022, the service still had a gap of 50.3 PAs (programmed activities). The impact this had was identified with the split workload of the daytime labour suite consultant who also covered the elective theatres, ward and the triage unit.

Medical staffing cover was not always sufficient to see patients in a timely way. Staff told us that often, junior doctors would be allocated to triage between 9 AM and 5 PM rather than consultant grade staff. Staff described triage running more safely and efficiently when a consultant was allocated as they were able to review higher risk patients without delay and complete scan reviews. We raised this with the trust who submitted data to demonstrate how they were mitigating risk. A template obstetric rota showed an improved process for planning and monitoring medical coverage from previous rotas provided. However as this was not the final document, it was not fully completed. In addition, no dedicated triage cover was allocated. Where a dedicated consultant was not available, the triage area would be supported by the labour suite consultant. The trust submitted a poster for women waiting to be seen which highlighted that if they had not been seen within 15 minutes to speak with a member of staff. This was available in different languages for women who did not speak English. Documentation reviews to be included in audits was increased to gain more oversight of how staff followed processes.

Medical staff we spoke with told us of positive changes to the rota which meant a better coverage for day and night. They told us that when the triage was covered by a consultant this provided a much better service; although due to the staffing was not able to be done consistently at the time of our inspection.

The service had reducing vacancy rates for medical staff. At the time of our inspection there were seven obstetric and gynaecology consultant vacancies. Interviews for these vacancies were scheduled for May 2022. Data from the trust reported one consultant obstetrician and three combined obstetric and gynaecology posts were successfully filled as a result of these interviews. We saw there was one vacancy for a senior house officer grade trainee doctor and one vacancy for a senior registrar.

The service had low turnover rates for medical staff. Data from the trust showed that the rolling turnover for the 12 months preceding February 2022 was zero.

Sickness rates for medical staff were reducing. Senior medical staff told us there had been some challenges over the last few months with sickness, especially amongst the junior doctors, however this was improving. There were some gaps due to long term sickness amongst the medical staffing. As of February 2022, data from the trust showed that sickness rates for medical staff within the family health division were 0.9%.

Managers could access locums when they needed additional medical staff. The service had been reliant upon locums to fill the gaps within the rota. Approximately 25% of registrar shifts were covered by locums due to sickness. Medical staff we spoke with told us that the locums were competent and very experienced.

Managers made sure locums had a full induction to the service before they started work.

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. There was a non-resident on call system to support the resident senior speciality registrars. All consultants providing a non-resident on-call service were required to be within 30 minutes of the location.

Records

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

Women's notes were comprehensive, and all staff could access them easily. During our inspection we reviewed 11 sets of patient records which were in paper and electronic format. We found these were comprehensive and contained information to provide women with their care and treatment.

All records, except one, had entries made in clear handwriting. Entries were dated and timed.

Some information was only kept within electronic records which meant staff had to log into the electronic system to review information as well as reviewing paper notes.

The trust undertook quarterly documentation audits, however due to significant trust pressures these had been paused for quarter three and four of 2021. Results from quarter two (May, June, and July 2022) showed 76% compliance with documentation standards for the postnatal ward (C29) and 85% compliance for the antenatal ward (B26). Labour suite records were not audited at this time. More recent results for January to March 2022 showed C29 ward deteriorated and was now 65% compliant. Ward B26 was not audited. The labour suite records audit showed 84% compliance. Overall issues with the quality of the audit were identified. For example, not all areas were being audited as per the trust process, and managers were not collating and sharing action plans with staff. This meant there was no mechanism to drive improvement within the staff group who competed the records.

When women transferred to a new team, reception staff assisted with managing the transfer of records.

Records were stored securely. Paper records were stored in filing cabinets at the midwives' station. These were kept closed when not in use.

Limited details of the women in the labour suite and on ward was recorded on whiteboards. This was for staff to use at a glance to see where women were. The board in the labour suite could be closed to keep the details private from women and their birthing partners. The matron within the labour suite told us planned improvements to this board were in place to make it more useful to have oversight of all women at a glance.

Medicines

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

Maternity

Staff followed systems and processes to prescribe and administer medicines safely. A pharmacist was allocated to the wards and attended every weekday to give support. They audited the medicine storage and were able to provide support with ordering additional medicines as required. Out of hours pharmacist support was available if required. A pharmacy technician role had been allocated to the wards. They organised the prescribed medicines which women take home with them to minimise discharge delays. The pharmacy technician also explained to women how they should administer their medicines.

Staff recorded allergies including medicine allergies in patient records.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines. Pharmacy support was available. Staff told us that pharmacists would provide advice and support if required to support regular reviewing of women's medicines and prescriptions.

Medicine allergies or sensitivities were recorded on all medicine charts seen. This ensured staff were aware and alerted to prevent the prescribing and administration of medicines causing allergic reactions.

Staff completed medicines records accurately and kept them up-to-date. We reviewed nine prescription charts for women on the wards and found that these were, in the main, accurate and up to date. All prescriptions were signed and dated with legible writing used throughout. We found one instance where an omitted medicine did not have a reason documented. We saw two occasions out of nine where the patient's weight had not been recorded.

Staff stored and managed all medicines and prescribing documents safely. We reviewed the drug storage room on labour suite. A sample check of routine medicines and IV fluids showed these were in date, labelled and placed in a way that avoided confusion or would potentially allow medicine to be mistaken for a similar one.

We checked the controlled drugs and found that the trust had stickers to attach to liquid forms of medicines such as morphine which enabled staff to write when these had been opened. However, we saw on one bottle, that had been opened, this label had not been filled in therefore it was not possible to identify how long it had been open for. This meant staff may be using open bottles of medicines for longer than recommended. Data from the trust showed this finding was replicated in all areas which held liquid medicines as per an audit conducted in February 2022.

We reviewed the medicine storage on both wards and found this was compliant with the trust medicine management policy.

Staff checked the temperature of medicine fridges daily.

We saw evidence the pharmacy team audited medicines safety and storage regularly. Following an audit in September 2021, issues were identified for the labour suite, ward C29 and ward B26. Pharmacy technicians began delivering these audits in February 2022 as part of an action plan to increase pharmacy support to the maternity unit. In addition, a pharmacy action plan was in place to mitigate risks caused by poor environmental factors such as a lack of space on wards C29 and B26.

Staff followed national practice to check women had the correct medicines when they were admitted or they moved between services. A Patient Group Directions (PGD) policy was available. PGDs allow certain healthcare professionals such as midwives to supply and administer prescription only medicines without an individual prescription.

Maternity

Staff learned from safety alerts and incidents to improve practice. We saw when medicine incidents and errors had occurred, the staff involved were spoken with to ensure improved practice.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients 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 described incidents they would report and were familiar with the electronic reporting system used by the trust.

Staff raised concerns and reported serious incidents and near misses in line with trust policy.

The service had reported no never events in any of the areas between March 2021 to February 2022.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Staff gave examples of where they had been open with women throughout their day-to-day work; and had offered apologies when the care had not been provided as staff would have liked. For example, if staff were delayed going to see a patient.

One member of staff told us they felt duty of candour was not undertaken when mistakes were made. However, we saw evidence within incident reports that duty of candour was considered and undertaken. Further data from the trust provided three examples where duty of candour was undertaken post inspection.

Not all staff received feedback from investigation of incidents. Staff told us of a variable approach to receiving feedback following incidents. Some staff told us if they had experienced a serious incident, they were offered time to reflect with their manager and identify learning. Some staff told us they were not aware of being expressly informed of learning following incidents. However, all staff did say they received emails and other communication with general updates within these. However not all staff had time to read this information thoroughly, meaning some learning may be missed.

Staff on the wards reported that learning from incidents was not routinely shared as compared to staff within the labour suite.

Staff told us of a lack of a structured debrief following any serious incidents. Staff told us this was due to a lack of time and a lack of staff to provide such debriefs.

Medical staff we spoke with reported a positive safety culture with a good standard of shared information about learning from incidents.

Staff did not always meet to discuss the feedback and look at improvements to patient care. We saw handovers at shift handover times did not include information such as learning from incidents or any changes to practice. Not all staff had access to team meetings. Following inquests or significant events, the senior leadership team organised information sharing meetings. However, not all staff were able to attend these.

Maternity

The governance team oversaw and investigated incidents thoroughly. For the three months prior to our inspection, staff reported 299 incidents. Of these, five were severe and seven were categorised as catastrophic. The catastrophic and severe incidents were reviewed to ensure they had been graded accurately. The governance and risk team identified these were appropriate gradings and investigated them accordingly.

Managers supported staff after any serious incident although debriefs were not consistent. Data from the trust showed a formal referral process for managers to refer staff to the Professional Midwifery Advocates (PMA) after any serious incident. This was a newer initiative implemented by the trust.

Is the service effective?

Requires Improvement 

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. All staff had access to National Institute for Health and Care Excellence (NICE) guidance on their mobile phones via an app. This enabled quick access to updated guidance. When guidance was updated managers produced posters and sent emails to alert staff. However, not all staff reviewed these communications therefore not all updates were actively received.

We reviewed a sample of maternity policies and found these were in date and referenced appropriate guidance. However, the governance team identified that some guidance was out of date and therefore had a planned review of these. Both the midwife lead for guidelines and the midwife lead for audits positions were vacant at the time of our inspection. Staff at the trust told us there were plans to recruit to both these positions.

Staff had access to guidelines to follow should a pregnant woman present at the emergency department (ED) with a non-obstetric medical concern.

Medical staff attended weekly cardiotocography (CTG) meetings to ensure staff were adhering to agreed practice. The trust worked to NICE guidance for CTG interpretation. Baby lifeline training was also being used to support the understanding of the physiology behind the fetal heart rate patterns seen. A midwife trained in administering aromatherapy shared their learning with other midwives to offer this option to women giving birth. Research suggests that the use of aromatherapy in labour can reduce pain and, in some cases, encourage spontaneous labour.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We observed shift change handovers and individual patient handovers between staff. We saw staff discussed women's mental health needs when they required additional support.

Maternity

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Women could choose food from a menu which catered for a variety of dietary requirements and choices. In addition to this, staff provided additional provisions, such as tea and toast in between set mealtimes when women required this.

Staff supported women with their feeding choice for their baby. On the postnatal ward, there was a milk kitchen where formula milk was stored for women who decided to provide this for their baby. The milk kitchen also stored expressed breast milk for women who were breast feeding their babies. As at the end of January 2022, the breastfeeding initiation rates was recorded at 71% which was slightly above the trusts own target of 70%. This was on a decline after a peak was observed in October 2021. Staff told us they felt they were not always able to provide additional support to women in relation to breastfeeding due to demand, capacity and low staffing levels at times.

Women in the triage area had access to a drinks station and biscuits. As women could wait for several hours depending on staffing, staff told us they had organised delivery of more substantial food such as sandwiches.

Women and their families in the induction suite could access a drink and snack station as and when they chose.

Staff fully and accurately completed women's fluid and nutrition charts where needed. We reviewed women and baby records and saw fluid and food charts were completed.

Staff used a nationally recognised screening tool to monitor women at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists (SALT) was available for women who needed it. We saw SALT attend the postnatal ward during our inspection to support a baby's feeding regime.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women we spoke with told us they were asked about pain levels and received medicine for this. We saw pain levels were recorded within patient records. Consultant anaesthetists undertook audits regarding women's experience of pain relief during procedures.

Women received pain relief soon after requesting it. Patients we asked told us they received pain relief when required.

Patients had access to booklets about pain management and pain relief. These were available in a variety of languages including Hindu, Slovakian, Romanian, Cantonese, and French.

Staff prescribed, administered and recorded pain relief accurately. We reviewed women's prescription charts and found this was completed well.

Maternity

Patient outcomes

Staff monitored the effectiveness of care and treatment. They did not always use the findings to make improvements and achieve good outcomes for women.

Outcomes for women and their babies remained mixed, inconsistent and did not always meet expectations, such as national standards. Where areas for improvement were identified, staff used the results to try and drive improvement in women's outcomes. The service maintained a maternity quality dashboard which recorded outcomes on a range of measures including (but not limited to) numbers of elective caesarean sections, numbers of emergency caesarean sections, number of still births (and rolling number of still births), numbers of 3rd and 4th degree tears and post-partum haemorrhage of over 1500mls. The senior leaders of the service ensured this data was regularly reviewed at governance meetings using the maternity services report and improvement measures were implemented to try and improve where the service had concerns.

The maternity services report for January 2022 showed the service were performing worse than set targets for certain metrics. Planned home births was 0.6% compared to the trust target of 3% and a national average of approximately 1%. The percentage of third and fourth degree tears for assisted deliveries was 6.4% which was slightly above the trust target of 6%. The percentage of post-partum haemorrhage greater than 1500 millilitres of blood loss was 4.2%, against a target of 2.8%. Maternal admissions to the intensive care unit was four women in January 2022 as compared to the trust target of one. The stillbirth rate per 1000 was 4.9 against a target of 3.8 for a rolling 12 months. This was a whole trust figure. Avoidable term neonatal unit admission rate was 18.8% against a target of 5%.

One area which had been highlighted as a concern by the service was around the rolling number of still births. We discussed this with the head of service who was sighted on this but had not yet identified any themes or potential rationale behind this. One factor which had been identified in some cases was around congenital abnormalities and early gestational births, however this was not considered to be the only factor and further review of this was required. In addition to this, there had been a drive to improve the rates of post-partum haemorrhages (PPH) at the service. The service had previously been an outlier for this and had initiated a lot of work and 'deep dives' into the incidents which had occurred. Although the management of PPH had improved locally at the service, there had been no reduction in the number of PPHs which occurred.

The same report showed where the service was performing at or positively against certain targets. For example, third and fourth degree tears for unassisted deliveries was 2.6% against a target of 2.9%. Completed venous thromboembolism risk assessments at the antenatal booking was 98.8% against a target of 95% and the number of the VTE risk assessments at delivery was 99.1% against a target of 95%. The number of neonatal deaths where the baby was born in hospital within 28 days of birth per 1000 births was slightly below the target at 2.7% against a target of 2.8%. Maternal readmissions within 42 days of delivery was 1.3% against a target of 3%. The friends and family test results showing very good and good was 98.8% against a target of 90%. The percentage of women screened for sickle cell/ thalassaemia by 10 weeks was 99.9% against a target of 75%. The percentage of NIPE performed within 72 hours was 96.5% against a target of 95%. The number of women initiating breastfeeding was 70.7% against a target of 70%.

The service participated in relevant national clinical audits. The service participated in the National Neonatal Audit Programme 2020 (data submitted between 1 January to 31 December 2020). Results for the two measures relevant to the service showed:

- Are mothers who deliver babies from 23 to 33 weeks gestation inclusive given any dose of antenatal steroids? (gestation range was 24 to 34 weeks on previous audit in 2017).

Maternity

97% of mothers were given a complete course of antenatal steroids. This was higher than the national average (90.8%) and the East Midlands network of 92.3%.

- Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

90% of mothers were given magnesium sulphate in the 24 hours prior to delivery. This was higher than both the national average (84.6%) and the East Midlands network of 85.1%.

The service also participated in the MBRACE perinatal mortality surveillance. The report published by MBRACE in 2020 was based on births in 2018. This showed the case mix adjusted perinatal mortality rate per 1,000 births was up to 5% higher than the average. The case mix adjusted perinatal mortality rate per 1,000 births excluding congenital abnormalities was 5% higher than the average; but was comparable to local tertiary units. The trust's own data, which was recorded on their maternity dashboard, had also indicated this was a concern with an upwards trend observed for 2021.

Medical staff met regularly to discuss specific cases to identify learning and service improvements. Midwives also formed an integral part of these meetings.

Medical staff took part in audits to identify ways to improve practice. Consultant anaesthetists had reviewed the Covid-19 vaccine uptake in pregnant women as compared to earlier in the pandemic. Findings showed a vaccination rate of 76%, from a sample of 50 participants, which was an improvement. Next steps following these findings were to identify areas of lower uptake and provide support.

Consultants had completed audits for anaesthetic pain relief to identify if anaesthetists were following guidance including following women up after giving birth. Audits completed in 2021 showed not all women had a follow up to check the effectiveness of their anaesthesia. A lead consultant anaesthetist had started a quality improvement initiative linked to this to specifically audit headache rates after an epidural. Improvements had been made to the after care of patients; all women who had any anaesthetic were followed up to gain feedback and learn about the effects.

The service had a lower than expected risk of readmission for elective and non-elective care than the trust target. Information submitted by the service showed at the end of November 2021, the percentage of women readmitted within 42 days of giving birth was 1.3%. The trust had set the target at 3%.

Managers and staff had a comprehensive audit strategy for 2022, which was to check improvement over time. This strategy mapped out the national audits which they must participate in as well as those locally, which were considered a must to identify where any shortcomings were or any positive outcomes to be celebrated and shared amongst other maternity services. Within this strategy was a strict timetable for the audits which were to be completed over the year.

The service completed the maternity incentive scheme (MIS) which was launched by the Clinical Negligence Scheme for Trusts (CNST). This was a self-assessment against the ten safety standards which aims to support services to deliver safer care in maternity. The most recent assessment showed the service was compliant with seven out of ten standards. The three which the service needed to improve on was avoiding term admissions into neonatal units (ATAIN), Saving Babies Lives and safety champions. An action plan on how they were to address this had been developed and was discussed at governance meetings including the Quality, Risk and Safety (QRS) meeting.

The service was working on how to achieve the safety standard from the MIS in relation to SBL. Information reviewed in a QRS meeting showed the service had identified a potential opportunity to develop a separate tool, however there was some discussion on whether the information was already being collated within other audits set out in the audit strategy. A gap analysis of data collection for each of the elements of SBL had been completed to establish if there were new data collection tools required or whether the data was already available, but just required bringing together for this standard.

Improvement was not always checked and monitored. We found staff audited the triage standard of 15 minutes each month, however there appeared to be no oversight and monitoring of this data and we did not find evidence of where improvement plans were discussed in relation to this. We raised this with senior members of staff who confirmed the oversight of this part of the service was not as strong as other areas and therefore the drive for improvement may not have been in place for this.

Managers audited the observations undertaken on women to identify deterioration; however this had not driven improvement in the oversight of this area.

Competent staff

Not all staff received an appraisal or supervision of their work. The service provided specialist training to make sure staff were competent for their roles. However, not all staff felt competent in all aspects of their role.

Staff were mostly experienced, qualified and had the right skills and knowledge to meet the needs of women. Newly qualified band five midwives all had a preceptorship which was a period of time for them to complete a set list of competencies. These midwives were required to rotate around different areas to ensure they were competent in all settings. There were future plans for every band five midwife to work one day per week in the labour suite regardless of where they were allocated, to maintain skills and confidence in this setting. Upon completion of the competencies to a good standard, these midwives were promoted to band six.

Some band six ward staff were concerned when they were asked to move to cover the labour suite, especially if they had not worked in labour suite for a significant period. Senior leaders were in the process of moving towards a rotation programme for all staff members to enable a more flexible and skilled workforce who would be able to cover any areas when staffing challenges were experienced. This was also seen as a potential to strengthen the skills staff already possessed as well as potentially developing their skills further.

Managers gave all new staff a full induction tailored to their role before they started work. Matrons within labour suite had identified there was no induction pack for band seven midwives starting this role. Therefore, they planned to create one which included clinical skills, Birthrate Plus knowledge and other competences to be completed. There was space within the workbook to identify and reflect upon issues during the supernumerary. A similar workbook for new band six midwives was in construction.

Not all staff received a yearly appraisal. Data from the trust for February 2022 showed that across the trust, appraisal rates were at 60.3% and the overall staff rate was 62.8%. However, performance at the QMC site was significantly lower. Within the labour suite, 29.5% of staff had received an appraisal. This was out of a total of 95 staff. On the antenatal ward (B 26), 24.2% of staff had received appraisals. On the postnatal ward (C 29), 21.7% of staff had received appraisals.

Where staff did receive appraisals, they told us these happened as planned and allowed a meaningful conversation about continued professional development, as development in terms of progressing through management could be limited at times.

Maternity

Managers told us about how they were working on retention rates by focusing on developing other specialist skills and creating link midwife roles.

Not all staff received regular, constructive clinical supervision of their work. Sickness among ward management meant not all staff had the opportunity to meet regularly with managers.

Staff told us that the clinical educators were not always visible in clinical areas to provide regular support. The clinical educators did provide training days following monitoring training compliance, but staff told us this could be more dynamic to address training needs in a more contemporaneous way. A new matron was due to join this team following our inspection. Staff hoped this would encourage a more direct, hands-on approach to providing support and training with competency-based skills.

Labour suite management had changed the template used for staff one-to-one meetings. The purpose of the change was to encourage a more meaningful career discussion.

Non-clinical support staff described not always having the same training opportunities as clinical staff.

Not all staff had regular team meetings. Some managers held these more regularly than others. For example, staff within the triage team had access to a team meeting every other month whereby the manager shared updates such as incident themes, performance and ideas for improvement. Other staff told us they did not have team meetings, particularly on the wards. We saw staff received a monthly update relating to ward C29 in lieu of a team meeting. This information included audit results and reminders for staff.

Some managers held a “10 at 10” meeting to review staff workload and to share any necessary learning. Staff told us that attendance could be difficult if staffing levels were low and workloads were high.

Staff attended a yearly forum where they were told about updates to the service.

Staff had access to a closed social media group where maternity information, updates, learning, bite sized training and messages were shared. The director of midwifery shared regular updates via this platform.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Two staff within the labour suite were on a degree top up programme at the time of our inspection.

Managers made sure there were opportunities for staff to receive specialist training for their role. All clinical staff attended routine yearly scenario training for medical emergencies which was held at City Hospital in a specially designed ward area.

Midwifery support workers undertook training specific to their roles which included breastfeeding support, managing an unwell baby, and expressing milk. Transitional care workers were required to undertake specialist training for this role.

One midwife had undertaken specialist training in aromatherapy and shared this learning with other midwives.

We spoke with the lead consultant and lead midwife for fetal monitoring. They told us how staff training had progressed from being fragmented, to using a regionally standardised training package. Since our last inspection, where this was identified as a serious concern, all staff who required this were re-trained and had their competency reassessed. At the time of our inspection, staff were 97.4% compliant with this training.

Maternity

Managers identified poor staff performance promptly and supported staff to improve. The senior leaders gave examples of where they had worked collaboratively with staff to improve performance where concerns had been identified.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed staff working together to provide care and treatment for women. During our inspection we saw a speech and language therapist had attended to provide feeding support at the request of staff.

Staff worked across health care disciplines and with other agencies when required to care for patients. However, some staff told us they did not always receive timely support from other specialities when needed, as discussed in 'Safe'.

Staff referred women for mental health assessments when they showed signs of mental ill health and/or depression. Women were routinely asked about their mental health to support any ongoing needs.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. This had improved due to an uplift in consultant staffing.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. However, the response from other specialities was not always timely.

The triage advice line was staffed 24/7, 7 days a week. This enabled patients to contact the triage service with any concerns or queries at any time.

Staff told us triage was run on a 24-hour basis approximately 70% of the time; the aim was for this to be a 24/7 service however due to staffing was not always feasible. However, it was open 7am to 7pm, 7 days per week.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. We saw a large amount of information and literature which women could access in order to promote a healthier lifestyle.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. We reviewed patient records and saw staff undertook assessments and measures to identify risk factors relating to a healthy lifestyle. For example, staff recorded women's alcohol intake, smoking status and BMI. Staff offered support to women who indicated they may benefit from advice about becoming healthier.

Maternity

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Due to the nature of the service, staff did not regularly work with women who did not have capacity to consent to care and treatment. However, if and when this was the case, relevant women were discussed at handover and by the clinicians treating her.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw within patient records that medical staff gained consent for any surgical procedures using a trust consent form. These were appropriately completed.

We saw evidence that midwives asked for consent to undertake routine care and treatment.

Staff mostly made sure women consented to treatment based on all the information available. Staff told us about identified learning following an audit about consent to caesarean sections. Medical staff identified that consent was generally sought in line with good practice; however more information about high risk consequences could have been discussed more thoroughly with women to ensure the women had all the information required. Actions to improve this were in place.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff could access a specialist teenage pregnancy midwifery team to support them when working with young pregnant women.

Not all staff were up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Due to the challenges of the pandemic, compliance rates with this training had dipped. This training was part of the recovery plan which had been devised by the senior managers of the service.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff had access to trust policies and processes electronically via handheld devices.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff mostly treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Maternity

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. We observed staff treating women kindly and with compassion.

Women said staff treated them well and with kindness. We spoke with eight women and two partners during our inspection. All told us they had received very good care and staff had been responsive to requests.

Staff followed policy to keep women's care and treatment confidential. Staff held handovers away from where women or their families could hear discussions.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. Staff gave examples of where they had worked with women who had exhibited symptoms of mental health illnesses or who were diagnosed with mental health illnesses. Staff generally promoted a caring and considerate approach to engaging with women who are experiencing difficulty with mental health.

Most staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Most staff we spoke with presented as non-judgemental and open towards all patients regardless of their personal, cultural, social or religious needs. We were told of some examples where specific staff chose not to work with certain women due to their own personal beliefs. We asked the trust about this and they reported they did not have a policy but follow the NMC guidance in relation to midwives demonstrating moral objections to working with women or patients with specific social backgrounds.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. A partner told us the limited visiting times had impacted on their bonding process with their new baby, however, they understood the reasons for this and felt the service overall was caring and safe. We saw feedback from women which highlighted staff had provided emotional support and advice as required when women were at the hospital.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. Staff gave us examples of where they had supported women at times of emotional distress. For example, when women were required to have emergency surgery. Staff spoke of the importance of keeping partners, family members or other birthing partners updated with news.

The trust bereavement midwives worked cross site and provided practical and emotional support to parents who had lost their child. This support was available long term after the parents had been discharged from the service. We spoke with the trust bereavement service who gave us many examples of where they had supported women and their families in extremely distressing times.

A second midwife was available in the delivery suite when women were giving birth to provide emotional support whilst the first midwife aided the delivery of the baby. Theatre staff were kind and caring to the women and their birthing partners.

The professional midwifery advocates (PMA) had started to hold birth reflection clinics and birth planning clinics to provide additional support to women who required this. For example, the PMAs had helped women in the birth planning

clinic who previously lost a baby. Due to the situation which surrounded this, they felt like they would never have another baby. The women attended this clinic with one of the PMAs and felt they would be able to have another baby due to the support they had provided. An additional example was where women had previously had traumatic birth experiences and had anxiety about giving birth again.

Staff did not undertake specific training on breaking bad news but demonstrated empathy when having difficult conversations. The bereavement midwives were able to support staff to break bad news to women and their families.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The chaplaincy service could provide spiritual or religious support at the request of women and their families.

Understanding and involvement of women and those close to them

Staff mostly supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff mostly made sure women and those close to them understood their care and treatment. All women we spoke with, except two, told us staff had communicated clearly with them about what to expect. Two women told us they felt medical staff did not give consistent information and it felt as if the medical staff had not taken the time to read the patient record prior to seeing them.

Staff spoke with women, families and carers in a way they could understand, using communication aids where necessary. We observed interactions with staff and women and saw that staff communicated clearly. Staff had access to communication aids if needed to facilitate a better understanding.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Women had a variety of options for providing feedback which were clearly advertised in patient areas. Data from the trust showed many women had left feedback, both positive and suggestions for improvement.

Staff supported women to make advanced and informed decisions about their care. Staff supported women to make decisions about their pregnancy during antenatal appointments and recorded this within their records. Specialist midwives were also involved with some women to enable them to make informed decisions about their care and treatment.

Women gave positive feedback about the service. We saw numerous thank you cards displayed within the labour suite. Themes within the comments in these cards included "support", "above and beyond", "I felt at ease and safe" and "empowered and safe".

Staff could be nominated for awards where women, their family and other staff felt they had gone over and above. Daisy awards were specific to nurses, nursing associates and midwives and Tulip awards encompassed other staff such as support workers and support staff. We saw and heard examples of where staff had won or been nominated for awards after providing a caring approach above and beyond what was expected. Four midwives had won awards at QMC during 2021.

Staff told us of an improvement to family and friends test (FFT) results. A total of 28 responses had been received in the month prior to our inspection. In January 2022, 98.8% of respondents to the FFT reported the service was very good or good.

Maternity

The trust performed similarly to other trusts for 46 questions in the CQC maternity survey 2021. However, they performed somewhat worse than other trusts for one question and worse than expected for three questions. Information from the survey showed that statistically, women giving birth at the trust in February 2021 had a worse experience than when giving birth in February 2019. However, it was noted there had been a national decline in women's experiences nationwide due to the pandemic.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service planned care in a way that met the needs of local people and the communities served. However, it was not always able to provide care as planned. The service also worked with others in the wider system and local organisations to plan care.

Managers planned services so they met the needs of the local population. However due to staffing challenges and the pandemic, not all services were available to all women. For example, a midwifery led unit; the Sanctuary Birth Centre provided midwifery led care to women who were deemed as low risk within the labour suite. However, at the time of our inspection this was being used to isolate women who were Covid-19 positive.

Women having home births was below the trust target. This was impacted by staffing as community midwives were required to come into the hospital to provide support there. The current service ran from 8am to 8pm; and overnight where staffing allowed. The homebirth rate nationally was approximately 1% at the time of the inspection. Data from the trust showed in January 2022, the homebirth rate was 0.6%. Data from the trust showed in the six months prior to the inspection, one woman was unable to have a home birth due to escalation of capacity within the hospital sites. Twenty-five women had a hospital birth as opposed to a home birth due to staff sickness and vacancies. Three women were unable to have home births as midwives were already with other women. In total, 22 home births were completed.

The service engaged with the local maternity network to deliver services. A meeting was held every weekday to review capacity and demand; where necessary the various external organisations and stakeholders were involved to support with this; such as the maternity network, local trusts and the clinical commissioning group.

Facilities and premises were appropriate for the services being delivered. At the time of our inspection the maternity service had made several upgrades to the environment to improve this for patients. For example, the labour suite had been refurbished. Triage and the inductions suite had moved from the wards to the labour suite to facilitate prompt support if women needed this whilst in either of these two locations. Upgrades were still being made on ward C29 (postnatal ward) at the time of our inspection. We arrived at the ward at 7am and noticed contractors were drilling around the main front doors to the ward which may have affected some women and babies' sleep.

Further plans were in place to improve the facilities and environment for women. As a result of feedback, the theatre area was being expanded in July 2023, to become a more appropriate space for the women and birth partners who used it. The day assessment unit was due to be moved out of triage.

Staff in the labour suite had access to essential oils to use with women who would like these. One midwife had undertaken specialist training in aromatherapy and shared this learning with other midwives. Data from the trust showed positive feedback from women about this service.

The labour suite staff could access portable mood lights and lamps to use within theatre or within the sanctuary birth unit. Staff could access bariatric equipment within the trust if this was required for women.

Staff had access to equipment boxes to support the recording of births where requested. For example, there was a general anaesthetic caesarean section box which had an instant print camera to take pictures of the birth to give to the mother after recovery. Staff told us they had received positive feedback from using this.

The service had suitable facilities to meet the needs of women's families. Families could use the bereavement suite if they experienced the loss of their baby. This was decorated appropriately and had facilities for the family to stay and be with their baby. A cold cot was available for use where required.

Birthing partners had sleeping facilities in the labour suite such as pull out beds in the induction suites.

Drink and snack trollies were in areas where family could be waiting for a long time.

The service had systems to help care for women in need of additional support or specialist intervention. The service was due to launch 'Rainbow clinics' from April 2022. These were for women who had experienced a pregnancy loss and were planning future pregnancies. It was recognised by staff, that women who had experienced a pregnancy loss had greater anxiety and required additional support and monitoring. The clinics were due to be ran by a consultant obstetrician and specialist bereavement midwives.

Managers monitored and took action to minimise missed appointments. Managers ensured that women who did not attend appointments were contacted. Data from the trust reported staff followed trust guidance to follow up with women who did not attend scheduled appointments.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff made sure women living with mental health problems, dementia and learning disabilities, received the necessary care to meet all their needs. The trust had a comprehensive guideline for staff to follow when working with women who had a learning disability. However, we noted this guidance was due for review in 2020 and was therefore out of date at the time of our inspection.

Staff told us it was rare to provide care and treatment for a woman who was living with dementia and there were no women admitted at the time of our inspection.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. Staff had access to communication aids to help women become partners in their care and treatment. Women who required this could request information leaflets in Braille, font enlargement or audio transcripts. This was facilitated using a third-party provider. Patients could also use a 'ReciteMe' tool on the trust website which could read screens out loud, magnify screens, change the colour of the screen and highlight aspects of the screen. The trust had adapted the format of patient leaflets on the website in order to work better with screen reading technology.

The trust did not have a specific policy on the Accessible Information Standards (AIS) however this was covered within the 'Equality, Diversity and Inclusion' policy.

The service had information leaflets available in languages spoken by the women and local community. For example, we saw pain management leaflets in the labour suite in a range of languages.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. The service used a third-party telephone-based interpretation service for women who did not speak English. Whilst this supported the translation of important information, staff told us this could be a time-consuming process if they did not have access to a telephone with a speaker capacity. Staff told us they could access British Sign Language (BSL) interpreters as required, and there were a number of staff within the trust who were trained as BSL interpreters.

Women were given a choice of food and drink to meet their cultural and religious preferences. The trust had a menu which catered to a range of diets and choices including halal, vegan, gluten free and vegetarian.

Staff shared examples of working with LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer, Plus) patients. Senior leaders told us of upcoming training for staff around supporting non-binary and transgender patients.

Specialist midwives were in place to support specific groups of women including asylum seekers, women who used substances and domestic violence.

Staff could provide relevant partners with a booklet explaining all aspect of becoming a father. This included topics relating to managing stress and domestic abuse and contained information about local services who could provide support.

Access and flow

People could not always access the service when they needed it or received the right care promptly.

Data from the trust reported that for the 12 months prior to the inspection, 3559 babies had been delivered at the Queen Medical Centre. Of these 1837 were unassisted deliveries, 511 were assisted deliveries, 535 were elective caesarean deliveries and 676 were emergency caesarean deliveries.

Not all women could access services within agreed timeframes. A multidisciplinary team (MDT) meeting was held every day, including weekends and bank holidays, to review capacity and demand. This was led by the senior leadership team. On day one of our inspection, the service moved into 'purple state' which meant there was no capacity on either site. Instead women were being diverted to a maternity service at a local trust.

The maternity services report for January 2022 showed 19 total unit diversions and nine total unit closures. We reviewed previous data for total unit diversions and saw in December 2021 there were 21 diversions which was the highest number since January 2020. With regards to unit closures, the January 2022 figure was the highest since January 2020.

Data from the trust showed that no women had complained about being diverted from the QMC to City Hospital. We saw evidence that where women had been moved to the opposite site of their choice, women were still happy with the care they received.

Data from the trust showed that in the last 12 months the triage service had diverted patients from the QMC to the City Hospital on one occasion which was in February 2022 and due to capacity.

Maternity

Managers did not always effectively monitor waiting times and did not always make sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Women who had concerns about their pregnancy were signposted to the telephone triage service which ran 24 hours, seven days a week. Staff provided a telephone assessment and signposted to appropriate services. For example; attending the triage service in person or speaking with the community midwife.

As reported in 'safe', not all women were triaged within the 15-minute target when they attended the triage service. Additionally, waiting times were not consistently reported which meant a lack of oversight of the performance of this service. Although the trust monitored this through audits, the audits were not effective for driving change.

On the first day of our inspection we saw that 20 women had attended triage. Of these, seven had been seen with 15 minutes, five had not been seen in this timeframe, five did not have the "time seen" documented and three were being seen at the time of this review. This indicated that learning from previous audits had not been embedded.

Data from the trust over the past 12 months showed one incident of severe harm for a woman who was not seen within 15 minutes of triage. This incident was in January 2022 and was being investigated at the time of the inspection.

We raised our concerns about the triage service and their responsiveness to women's needs, alongside the safety concerns of the triage assessment unit, with the senior leadership team.

Managers and staff worked to make sure women did not stay longer than they needed to. Staff discussed women who could potentially be discharged at handovers and ward rounds. This was also discussed at the morning MDT meeting. Managers and staff started planning each woman's discharge as early as possible. New-born and infant physical examinations (NIPE) were conducted as early as possible to help with the flow on the wards. The service had a NIPE specialist who undertook these examinations. Data showed these examinations were performed within 72 hours of birth for 96.5% of babies who were born in January 2022.

Managers worked to keep the number of cancelled appointments to a minimum, however this was not always possible. When women had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. On the first day of our inspection, the induction suite had three women who had started the induction of labour (IOL) process but who were continuing to wait due to the lack of capacity. Three further women were waiting to come in to be induced. We spoke with one woman and their partner who had started their IOL, but this had been paused. They told us staff updated them regularly and they understood the delay.

Managers monitored patient moves between wards and ensured they were kept to a minimum. Staff avoided moving women between wards at night. However, we were told about a complaint whereby a woman was transferred from the labour suite to the ward at night. The women subsequently had a seizure. Staff were aware that tiredness was a trigger for the woman's seizures.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Where women had additional needs and were waiting for support to be put in place, staff enabled them to remain as an inpatient for longer.

Managers did not monitor the number of women leaving the service before being seen at triage or the day assessment unit (DAU). Data from the trust reported that although this was not monitored, they believed the numbers were very low.

Maternity

Managers monitored the number of women whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Any potential delays in discharge was escalated during the morning MDT call. This enabled staff to dedicate any resources to help with discharges.

Staff supported women and babies when they were referred or transferred between services. Managers monitored transfers and followed national standards. Staff worked with community midwives to ensure women were supported.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them but did not always share lessons learned with all staff.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patient feedback boards were displayed clearly in all patient areas. This included information about how to raise concerns or make a complaint and also provided information about changes that have been made as a result of feedback.

Staff understood the policy on complaints and knew how to handle them. Staff were familiar with how to manage a complaint made to them. Staff referred women to the complaints or feedback process if required.

Managers investigated complaints and identified themes. The service had received 71 complaints between March 2021 to February 2022. Common themes arising from the complaints and concerns raised included staff behaviour and attitude and delayed elective procedures (induction of labour and caesarean sections). During the pandemic the service extended the time for investigating complaints to six months. However, since April 2021, the service started to triage the new complaints submitted and adhered to their usual response rates of 25, 40, 60 and 80 days. Staff told us that common complaints they heard about were about referral issues, complaints about the birth process and complaints about breastfeeding support.

Not all managers shared feedback from complaints with staff but learning was used to improve the service. Staff were variable in their experiences of receiving feedback from complaints. Some staff reported that managers did not share these with them. However, all staff we spoke with reported that compliments and positive feedback were shared.

Staff were unable to give examples of how they used women's feedback to improve daily practice. Information shared after the inspection showed this was an area of concern which had been identified by the senior managers. Complaints had been managed in a different way due to staff depletion. However, this meant there had been minimal information shared amongst the staff within the service.

Is the service well-led?

Inadequate 

Our rating of well-led stayed the same. We rated it as inadequate.

Maternity

Leadership

Leaders had the skills and abilities to run the service. They mostly understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However; the pace of change to make improvements was not supportive of safe care.

Overseeing local leadership were the director of midwifery, head of midwifery, and the director of midwifery governance. A director of maternity improvement had also been appointed since our last inspection to drive improvements across maternity services. Staff we spoke with about the senior leadership team spoke positively about the changes within this. For example, some staff told us of a no blame approach when reviewing incidents at senior leadership level. However, some staff still felt there was a blame culture following incidents. Staff told us the director of midwifery was visible and effectively used a closed social media page. The director of midwifery was familiar with every attendees' name at the multidisciplinary meeting we observed. They demonstrated compassion regarding a maternal death to the staff who supported the family. During interviews, the senior leadership team members demonstrated a passion to improve the service for the women who chose to have their babies at the trust, and for the staff who enabled this. However, despite positive changes since our last inspection; the pace of overall change did not support safe care.

The leadership within the labour suite had recently seen new members join. This included two intrapartum matrons, who made up one whole time equivalent role. They oversaw managers including a triage manager, and labour suite managers. In addition, band seven labour suite flow co-ordinators oversaw shifts across all areas within maternity to ensure staffing and acuity were monitored to keep patients safe. Staff we spoke with in the labour suite told us managers were visible, supportive and the new management team had been proactive at leading the service. Staff told us that local leaders supported them to develop skills and take on new roles. Leaders undertook clinical work to support staff. The leaders we spoke with, although mostly new in these posts, had clear action plans to drive improvement.

Each ward had a ward manager allocated; however, these were away from work at the time of our inspection. Therefore, a temporary ward manager covered both wards. They were supported by the flow coordinators, and by band six shift co-ordinators (midwives in charge of each shift). Staff we spoke with spoke positively of the temporary manager cover and this was reiterated in a shared governance council newsletter, however, they highlighted the difficulties of having a lack of consistency in ward management. Staff on wards told us about the lack of team meetings, a lack of learning from incidents or sharing of updates, a lack of learning from complaints and a lack of support when escalating concerns.

Specialist midwives supported local leadership. For example; there was a band eight quality and risk matron and a safeguarding matron.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, the service faced delays to implementing aspects of this due to capacity and demand pressures.

The service had a vision and strategy in place. The Nottingham University Hospitals, Professional Midwifery strategic plan was a five-year plan which started in 2021 and aimed to drive improvement across the service. The strategy had five ambitions which it aimed to achieve:

- Leadership at all levels.
- Inclusive talent management and lifelong learning.

- Highest quality relationship centred care.
- Research and innovation.
- Pride recognition and reward.

The service had a long-term vision to bring the trust wide maternity service onto one site. In the meantime, improvements to maternity and neonates were ongoing as part of the neonatal design programme. This had started with neonates and had progressed into some areas of the QMC maternity department. Newsletters were produced for staff to inform of upcoming alerts and changes, and to invite staff to engagement activities.

The senior leadership team had a focus on many areas in order to drive sustainability and improvements in care. For example, plans regarding band six midwife rotation were in early progress at the time of our inspection. The outcome was to have a three-monthly rotation for midwives and for staff to know exactly where they would be located for up to 2 years in advance. This meant all midwives who took part in the rotation would build and maintain competency to work in any area of the maternity department.

Another vision was in place for a 24-hour dedicated homebirth team. Currently community midwives provided the service however they were often pulled into the hospital site to provide support.

Culture

Not all staff felt respected, supported and valued. Staff were mostly focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. Staff felt they could raise concerns; however not all staff felt these would be listened to.

Staff experience of the culture of the service varied. Most of the staff we spoke with felt valued, supported and engaged with the service.

Some staff described cultural issues between ward staff and labour suite staff. Some ward staff felt pressured to work in the labour suite when they did not feel confident or competent; and felt pressured by some labour suite staff. Labour suite staff felt that some ward staff refused to rotate to the labour suite despite support being available for this. This meant that a certain number of staff would regularly rotate to different areas and some staff did not rotate at all. As a result of this, the labour suite had been closed to new admissions on a number of occasions due to staffing despite having staff on the wards who potentially could have rotated. We requested further information from the trust who told us 218 incidents were reported from 24 March 2021 to 24 March 2022 relating to unit closures or diversions. There were no incidents where the labour suite specifically had to close due to staff refusals, however there were incidents where staff refusal or other concerns about being redeployed were a factor.

Upon further exploration, we found that band six midwives were not routinely rotated to different areas and had not been for some years. In order to address this, the director of maternity had a structured plan to reintroduce routine rotation to ensure all midwives were able to work within all areas of the maternity unit. At the time of inspection, a survey had been undertaken to gather midwives' views on this plan. The planned introduction of rotation was due to start towards the end of 2022. Managers were aware of the cultural issues around rotating to different areas within maternity. Managers told us they tried to inform staff in advance where possible that they were being moved from their usual area, however often short notice changes need to be made to support the safety of the women.

As discussed in caring, we found not all staff were willing to work with all patients. Some staff chose to re-assign particular patients to colleagues if they objected to treating them due to certain health issues such as substance misuse. Senior leaders were not aware of this at the time of the inspection but reported they would address this with staff.

Maternity

Staff we spoke with told us that midwives were leaving the trust for a number of different reasons and reported this was often related to the staffing levels and the subsequent heavy workloads. Staff told us they would regularly miss breaks in order to complete work. Staff felt there was a culture of trying to go the extra mile, however, being blamed when things went wrong or if aspects of the job were not completed.

Several staff spoke of bullying occurring; either experiencing this themselves or having witnessed it and reported this was impacting upon their health and well-being at work. Data from the trust reported six concerns raised about bullying over the year preceding the inspection, and one concern about racial discrimination. One additional complaint of racial discrimination was made over 12 months ago but was still being addressed at the time of the inspection. All allegations of bullying were addressed via an informal process. A new resolution of employment concerns (REC) policy and procedure had been introduced in 2021 which the trust reported had been well received by staff and managers.

Staff had recently participated in the staff survey. We requested the information from the trust in relation to results for maternity services, however this was unavailable at the time of our inspection.

Staff were aware of the Freedom to Speak Up Guardians (FTSUG) in the trust and had started to use them regularly to escalate their concerns. The service recorded the number of contacts staff had on the maternity dashboard. There were 18 contacts with the FTSUG recorded between February 2021 and January 2022.

Staff we spoke with felt confident to make complaints or raise incidents if they witnessed poor care or cultural concerns. However, some of these staff felt that concerns would not be taken seriously. For example; concerns raised regarding the culture between areas or where poor care had been identified. Leaders were working to address this and promote a blame free approach to incident management.

Some staff told us that communication could be improved between areas in order to enable effective administration and record-keeping processes as well as to promote information sharing, such as changes to processes.

Medical staff we spoke with reported an open culture within the medical team with no hierarchical issues. They reported a positive safety culture with a good standard of shared information about learning from incidents.

Midwives had access to Professional Midwifery Advocates (PMA). Staff we spoke to provided varied details in respect of how much they had used this service.

Staff had access to wellbeing support. Staff told us there were services to support staff well-being such as an employee assistance scheme which enabled counselling from a third-party provider and access to physiotherapy. Some staff told us that managers were able to support flexible working to increase a positive work-life balance. Labour suite managers told us of initiatives to promote staff well-being such as creating a ‘wobble room’ and having a star jar where a positive comment about a member of staff will be placed into the jar and discussed at governance review meetings.

We saw in minutes, from the intrapartum forum meeting held in March 2022, specific staff within maternity were being trained in Trauma Related Incident Management (TRIM) which was a structured process to review the ongoing impact after staff experience a traumatic incident.

Governance

Leaders had implemented a governance structure for the service however we were not assured this was fully effective. Not all staff at all levels were clear about their roles and accountabilities and they did not regularly meet to discuss and learn from the performance of the service.

Maternity

The service had made some improvements to the governance structure. The service has now introduced a governance process which aimed to improve the quality of care and patient experience within the maternity service. There was a policy to support the new governance structure to ensure this was implemented effectively. The structure was based on splitting out the areas for governance into quality, risk and safety (known as QRS). However, the cascade of information did not always reach staff at all levels. Not all areas in the service had team meetings where this information would be discussed, and we did not observe any key information being discussed during handovers or huddles. During our interview with the DOM, we discussed the current governance structure and process. It was identified that this was still within the pilot phase until April 2022. After this, it was expected that there would be modifications and improvements to make it more effective.

We had identified some improvements to the governance process, but we found there was a lack of oversight within the current governance structure for the triage assessment unit. We raised our concerns about the triage assessment unit with the leadership team who acknowledged the oversight was lacking. We were told this would be immediately rectified. We wrote to the trust after our inspection to highlight our concerns with them. The service responded to our letter with further information on how they planned to improve the oversight of this service by aligning this to the current governance structure. This provided some reassurance that triage assessment would have the required oversight going forward, however we were aware this was not embedded practice.

The maternity service had board representation which was an improvement from our previous inspections. The chief nurse was the general safety representative and a non-executive director held this role for maternity. Senior leaders within maternity told us the board was engaged with the maternity improvement plan.

The DOM had the overall responsibility for ensuring there was an effective governance process. Due to vacancies in key leadership roles the DOM had to take on more operational oversight as well as the strategic oversight. However, they had the support from the associate director of maternity governance. Below the senior leadership team, not all staff were clear about their roles and responsibilities within the governance structure.

Some staff did describe some difficulties in obtaining support from other divisions and specialities when required; however, it was reported this was improving. The medical director for the trust was aware of this. Senior leaders told us the department felt more integrated into the trust and they were routinely invited to trust wide governance meetings to present information.

The incidents within the service continued to be monitored through the QRS governance framework. During our previous inspection in October 2020, we found the service had a large number of incidents which had built up which had no initial review of them and therefore was unaware of what level of harm had occurred or the risks faced by women using the service. We found during this inspection that there were 414 incidents which were still awaiting investigation. These had been broken down into severity (276 no harm, 80 low harm, 54 moderate, three severe and one catastrophic) however no additional information other than the category of the incident and date of the incident was recorded. The longest recorded incident awaiting investigation was 493 days at the time of our request for this information. This therefore demonstrated there were still concerns with the management and oversight of incidents within the service.

There was a maternity improvement plan in place which captured all the improvements identified by CQC, HSIB reports (healthcare safety investigation branch) and other external reviews. The leadership team met regularly as part of their governance framework to review this plan and documented actions made against this. We observed there were several items on this plan which were coming up to the dates identified to be compliant/have actions in place. However, it was evident the item on the plan was ongoing as it was rated either red or amber on the ‘RAG’ rating (red, amber, green) with alternative dates suggested to be compliant by.

The department had shared governance councils which were run and attended by staff within the department. At the time of our inspection there were five members of the governance council. The council met regularly to discuss staff concerns and to share ideas. They provided newsletters and worked to improve areas which were not working effectively within maternity. The DOM had been invited to the next meeting which fell after our inspection.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They did not always identify and escalate relevant risks and issues and did not always have plans to cope with unexpected events.

Systems were in place to review performance and risks, but these were not always used effectively to mitigate risks. We reviewed the maternity services risk register report for QMC, although many of the risks were cross site. All risks on this report were clearly defined in terms of the risk and the impact if not mitigated. A risk meeting had been held in February 2022 and two new risks were added to the report following the meeting. These included; the risk to women if triage and the day assessment unit (DAU) were not separated, and a risk around infection prevention and control due to a reduced number of domestic cleaners. Both risks had actions allocated to them. The risk around the separation of triage and the DAU had a higher risk rating in terms of impact and likelihood and actions focussed around obtaining reception staff to support this process and ensuring staff were adequality trained to follow the trust triage pathway. Senior leaders told us the risk, safety and performance of the triage assessment unit was not adequately monitored within current governance processes.

At the time of our inspection, there were 31 risks recorded on the risk register ranging from three (very low risk) to 20 (significant risk). There were four risks graded as significant on the risk register, these were:

- Poor patient experience and regulatory activity.
- Poor care delivery linked to Medway issues.
- Midwifery recruitment (specifically within the community)
- Lack of training will lead to potential patient harm and non-compliance with regulatory requirements.

We found the risk register did not fully align with the top risks which staff told us about. We also identified additional risks during our inspection which the service had not identified themselves. All staff without exception told us staffing was the biggest risk to the service.

We had also escalated our concerns around the risk to women within the triage assessment unit who were not being triaged within 15 minutes. This was not identified as a risk prior to our escalation of concerns, despite the service completing an audit of performance in the triage assessment unit over the last three months. We wrote to the service after our inspection to highlight our concerns about the risks within the triage assessment unit and the failure to triage women within 15 minutes. In response to our letter, the service produced further information to demonstrate this had now been added to the risk register.

Although local managers knew the top risks, midwives within the department were not familiar with these. There were no mechanisms for sharing the clinical risks with relevant areas. The matrons in labour suite had an action to update the performance board within the department which would include the top risks for staff to see during their shifts. This was to be undertaken post inspection.

Performance was monitored through a dashboard. Managers could access this, but it was not shared more widely with all clinical teams which meant those working with women were not aware of how they were performing against targets. However, where poor compliance was identified, managers discussed this with the relevant team or individual.

The dashboard captured a lot of relevant data, but it was identified there were some missing metrics including triage, percentage of shifts covered by temporary staff and the number of uncovered shifts.

Not all audit results were used to drive improvement. For example, the trust undertook quarterly documentation audits, however due to significant trust pressures these had been paused for quarter three and four of 2021. Concerns with the quality of the audit were identified. For example, not all areas being audited as per the trust process, and managers were not collating and sharing action plans with staff. This meant there was no mechanism to drive improvement within the staff group who competed the records.

The trust did not monitor the number of women who left triage without being seen. Data from the trust told us this number wasn't formally monitored but they believed it to be a low figure and usually related to childcare.

Senior midwives planned a weekly senior team meeting, but these did not always go ahead. The trust sent the minutes from the last three meetings, we saw that of these three scheduled meetings, two were cancelled due to service pressures and escalations. Where one meeting did go ahead, we saw the agenda contained items including visitors from pharmacy to update on actions, staffing concerns, the maternity improvement programme and discussions about staff and women engagement. Items such as the risk register, incident reviews, complaints and learning were not included as agenda items.

The governance team oversaw and undertook incident investigations. Senior leaders told us this team had been re-structured since the previous inspection which included a review of all risks on the risk register and strengthening of the maternity risk meeting whereby clinical staff were invited to come and present incidents. Midwives were included within this team which was an improvement from our previous inspections.

Senior leaders within maternity told us staff were supported through Health and Safety Investigation Branch (HSIB) investigations and high-profile coroner cases. Specific learning was shared with relevant individuals; and more general learning was shared with the wider staff group. Pastoral support was in place for staff throughout this process. Support included the senior leadership team, clinical educators and the professional midwife advocates (PMA).

As previously highlighted, a multidisciplinary team meeting (MDT) was held every morning to discuss capacity, staffing, risk and performance. This meeting included medical staff, midwife managers, labour suite coordinators, flow coordinators and the director of midwifery. Both QMC and the City site were discussed. We attended this meeting on day one of our inspection and saw both sites were in 'purple state' which meant there was no capacity on either site. Therefore, the trust had communicated with the site team and silver command, and other trusts to identify where women could be diverted to. Staffing was identified as 'red' which meant actual staffing did not match what was required according to the Birthrate Plus tool. Actions were set such as to focus on discharging where appropriate, liaising with stakeholders regarding the 'purple' status of the maternity service, have a further meeting in the afternoon and to maintain regular updates from each department.

A regional maternity team completed daily situation reports for all of the regions' maternity services as lack of capacity was affecting a number of trusts.

Managers described changes since the last inspection. For example, recruitment processes were quicker, ordering equipment was a quicker process and staff on long-term sickness had reduced.

Two intrapartum matrons overseeing the labour suite had been recruited to one whole time equivalent position. Whilst new in post, they had developed an action plan to address concerns raised in the previous CQC inspections. One example of an action that had started in practice was a daily checklist to ensure oversight of all checks; including safety and mandatory checks such as resus checks, tap flushing and temperature monitoring. This enabled clear oversight of compliance checks. The matrons had also worked as part of a team to clear a backlog of incident reports that required investigations.

Information Management

The service collected data and analysed it but we were not assured this was always reliable. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not completely integrated but they were secure. Data or notifications were submitted to external organisations as required.

The service used a programme of audit to collect data and analyse this. The trust used a digital platform to collect and review data to monitor performance and risk. This platform supported the completion of audits. The trust told us all audits except for infection prevention and control were paused during quarter three and four of 2021 due to significant service pressures. This was agreed by divisional leads.

Not all audits led to direct improvements. For example, as discussed in the 'safe' domain, audits of the triage department identified it was not possible to accurately gauge how many women were seen within the 15-minute target as this information was not recorded consistently. This had been identified through audits but at the time of our inspection there were no specific actions to mitigate this or drive improvement. We requested consultant triage audits post inspection. The trust sent information in a spreadsheet which provided the factual details of women who attended triage on a specific date post inspection. For example, information included was time of arrival, time first seen, time observations were done. This information was not presented as an audit. No conclusions or results were drawn from this and no actions to improve were identified.

The trust told us that completed documentation audits did not always have a robust data collection procedure. This meant results may not be able to be generalised to all areas.

The service had a specialist digital midwife who worked alongside the trust's digital team. The specialist digital midwife also continued to work clinically so was aware of any issues which staff faced and endeavoured to continue work to improve the systems staff used. One area which had been addressed was the access to systems in the community. Staff regularly escalated the accessibility to systems due to their inability to log on to wireless internet services. The team had addressed this, and staff told us they had relatively fewer issues with this now than previously, which had improved their work. This was a continual process and staff from the digital team continued to check to ensure staff had the best access they could get.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Maternity

The service made effort to engage with staff, patients and local communities. The trust had recently completed their staff survey. We requested information from the staff survey during this inspection, however the details from the survey were under embargo until the end of March 2022. Staff told us they were more engaged than during our previous inspection and had participated in the recent staff survey.

Data from the trust reported on the Nottingham University Hospitals GMC National Training Survey results from April 2021 for obstetrics and gynaecology. We saw that where responses indicated a poor experience by trainees, the trust had provided a response to NHS Education. For example, support for trainees and educational governance both scored lower. This result was also reflected in the previous CQC inspection report. We saw actions had been taken such as improving routes of communication for trainees to escalate concerns.

Staff within specialist roles and managers engaged with staff in different ways to ensure they were up to date with some key information. Examples of this was the newsletter which the community matron produced for staff, the digital newsletter from the specialist midwife and digital team and the maternity and neonatal redesign newsletter.

An intra-partum forum had recently restarted. This included labour suite matrons, consultant leads, the fetal heartbeat monitoring lead and when available and representatives from the Maternal Voices Partnership (MVP). The forum was used to ensure women's voices were included. We saw in March 2022; MVP representatives were absent; therefore, an action was to ensure the meeting minutes were circulated.

Data from the trust showed throughout 2021, the service engaged regularly with MVP. The MVP is an organisation which engages with women to ensure their voices are heard. However, within a senior midwife meeting, held in February 2022, attendees discussed maximising engagement with the MVP. We saw that the MVP for Nottinghamshire currently had a vacancy in the chair position. Therefore, staff were considering the best way to engage with the MVP in conjunction with another local trust.

Managers within the labour suite told us of how they had improved women's response rate for the Friends and Family Test (FFT), whereby women indicated if they would recommend the service to their friends or family. The trust created business cards to give to women with a QR code which had resulted in a slight improvement in the response rate. The manager then started to go onto the postnatal ward to talk to women and asked them to share their feedback, which showed improved compliance. Women fed back that they liked this approach and that a manager had taken the time to come and speak with them about their experience.

The service had commissioned a specific survey for women in the four most deprived areas within Nottingham.

Within Nottinghamshire, a family nurse partnership had been set up which comprised nurses and midwives. This was a two-year programme to support families through pregnancy until the baby was two.

The service had a patient experience and engagement steering group which oversaw patient experience. This group fed into the trust board to ensure maternal and birth partner voices were heard.

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.

Following our previous inspection in October 2020, we identified several concerns which required immediate improvement. During this inspection, we identified the service had started to make improvements in some areas. Areas

where we had noticed an improvement since the previous inspection was in relation to the staff competence in cardiotocography (CTG) monitoring. The fetal monitoring leads had been instrumental in driving this forward, although they acknowledged they had further improvements to make in relation to the fresh eyes review. Antenatal risk assessments had improved overall, especially in relation to VTE (venous thromboembolism) assessments, However, there was still some rooms for improvement with other risk assessments (CO monitoring).

After the previous inspection, there was a lot of change which impacted on the service and opportunities to be involved in any quality improvement projects. There were changes in leadership which impacted on staff and their engagement. However, now the leadership team was more stable, staff were becoming re-engaged and opportunities to contribute to improvement and learning was an area where some staff wanted to participate.

Changes had been made to the estate to improve services for women. For example, the induction suite and triage had both been moved to the labour suite.

The medical staff undertook regular audits of clinical interventions and supporting activities to identify improvements.

In addition to yearly training, the consultant obstetric anaesthetists delivered quarterly simulation sessions. This was open to anaesthetists, consultant obstetricians, trainee doctors, band 5 to 7 midwives, midwifery support workers and students. The scenarios were based on real incidents that happened within the department; and were held in the location where the incident had occurred. This meant the staff training was delivered realistically in the environment they would be working in. Within each morning three simulations were undertaken. In the afternoon all the staff involved would return as a group to discuss learning from the incidents, simulations and from patient feedback letters and incident reports.

As discussed above, intrapartum matrons had developed an action plan to address concerns raised in the previous CQC inspection in order to facilitate improvement, continued learning and innovation.

Outstanding practice

We found the following outstanding practice:

In addition to yearly training, the consultant obstetric anaesthetists delivered a three-monthly simulation morning. This was open to anaesthetists, consultant obstetricians, band seven midwives and students. The scenarios were based on real incidents that happened within the department; and were held in the location where the incident had occurred. This meant the staff training was delivered realistically in the environment they would be working in. Within each morning three simulations were undertaken. In the afternoon all the staff involved would return as a group to discuss learning from the incidents, simulations and from patient feedback letters and incident reports.

The specialist midwives went above and beyond to help the women they care for. Staff engaged with external organisations to ensure women received holistic care throughout their journey. For example, staff supported pregnant women who were also seeking asylum in the UK. When these women came to give birth, where they already had children living with them but no other support, the specialist midwives organised buddy families to ensure the children were cared for.

Maternity

Areas for improvement

MUSTS

The maternity service at QMC:

- The service must ensure that systems are put into place to ensure midwifery and medical staffing is actively assessed, reviewed and escalated appropriately in the triage assessment unit to prevent exposing women and babies to the risk of harm. **Regulation 18 Staffing.**
- The service must ensure that all staff receive appropriate support, training, professional development, supervision and appraisal as necessary to enable them to provide safe and effective care to women and babies. This must include safeguarding training. **Regulation 18 Staffing.**
- The service must ensure there is an effective triage process in place for women attending the triage assessment unit which is in line with nationally recognised targets, to prevent exposing women and babies to the risk of harm. **Regulation 12 Safe care and treatment.**
- The service must ensure all women receive timely observations to identify deterioration. This must include oversight of this system. **Regulation 12 Safe care and treatment.**
- The trust must ensure the abduction policy is embedded and abduction drills are carried out. **Regulation 13 Safeguarding service users from abuse and improper treatment.**
- The service must ensure there is an effective risk and governance system in place that identified, assess and mitigates risks when identified. **Regulation 17 Good governance.**
- The service must ensure there is an effective risk and governance system in place that supports safe, quality care for all areas in the service and is in line with the conditions placed upon their registration. **Regulation 17 Good governance.**

SHOULDS

The maternity service at QMC:

- The service should ensure there is a process in place to ensure the tamperproof devices on the resuscitation trolleys, are tamperproof. **Regulation 12 Safe care and treatment.**
- The service should ensure medicines are properly and safely managed, including safe administration and storing of medicines. **Regulation 12 Safe care and treatment.**
- The trust should explore cultural themes affecting staff; and consider these alongside complaint themes such as staff behaviour and attitudes to identify how to develop a more inclusive, non-judgemental approach. **Regulation 17 Good governance.**
- The trust should consider that staff consistently record when they did not ask about domestic abuse.
- The service should consider how to improve their carbon monoxide screening.
- The service should consider updating its guidance for caring for women with a learning disability.

Our inspection team

The onsite inspection team consisted of a CQC inspector and two specialist advisors. The team was supported offsite by an inspection manager.

You can find 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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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