George Eliot Hospital NHS Trust

George Eliot NHS Hospital

Inspection report

Eliot Way
Nuneaton
CV10 7RF
Tel: 02476351351
www.geh.nhs.uk

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Ratings

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

Our findings

Overall summary of services at George Eliot NHS Hospital

Requires Improvement 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at George Eliot NHS Hospital.

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

George Eliot NHS Hospital provides maternity services to the population of over 300,000.

Maternity services include an early pregnancy unit, outpatient department, maternity assessment unit, combined antenatal and postnatal ward (Drayton Ward), delivery suite and two maternity theatres. Between April 2022 and March 2023 2,153 babies were born at George Eliot NHS Hospital. We will publish a report of our overall findings when we have completed the national inspection programme.

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

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

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

Our reports are here: www.cqc.org.uk/location/RLT01

How we carried out the inspection

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

We visited the maternity day assessment unit, maternity assessment unit (triage), delivery suite and the antenatal / postnatal (Drayton) ward.

We spoke with 9 midwives, 3 support workers, 9 medical staff, 5 women and birthing people and 1 birthing partner and or relative. We reviewed 5 patient care records, 4 Observation and escalation charts and 10 medicines records. We did not receive any responses to our give feedback on care posters which were in place during the inspection.

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

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

Maternity

Good ➔➔

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

- Staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. Training compliance was monitored to ensure staff maintained their skills and knowledge.
- The service had continued to control infection risk well during the ongoing refurbishment work. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well.
- The service managed safety incidents well and learned lessons from them. When appropriate the service completed rapid reviews and action plans following incidents to minimise the risk of recurrence.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. They encouraged staff to take part in secondments and pilot projects to help all staff progress.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities.
- The service engaged well with women and birthing people and the community to plan and manage services. The service worked closely with the local Coventry and Warwickshire Maternity and Neonatal Voices Partnership.
- The service was committed to identifying and reducing health inequalities for women and birthing people. Positive interventions around smoking had been successful and the percentage of women who were current smokers at delivery had reduced. There was ongoing work around poverty proofing, exploring barriers experienced by women on low incomes in accessing maternity care.

However:

- Despite the ongoing management of sickness levels and recruitment, staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- The service could not always demonstrate best practice guidance on consent for planned caesarean sections was being followed.

Is the service safe?

Good ➔➔

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Maternity

The service had a training needs analysis policy which expired in June 2023. The service shared the updated draft policy. The policy outlined all training required to be completed by maternity staff. The training needs analysis linked to national recommendations and showed the compliance required to meet the recommended standards. The service made sure staff received multi-professional simulated obstetric emergency training.

Nursing and midwifery staff received and kept up-to-date with their mandatory training. The service had achieved over 90% compliance for the majority of mandatory training courses above the trust target of 85%. Midwives were below target for neonatal resuscitation level 3 (80%) although 92% had completed level 2. We saw from the training schedule staff had been identified and placed on the schedule to attend level 3 training.

Medical staff received and kept up-to-date with their mandatory training. The service had achieved 90% compliance for the majority of mandatory training courses, with the exception of Practical Obstetric Multi-Professional Training (PROMPT) training, where compliance for anaesthetic staff was 81% due to recent changes in staff personnel and moving and handling training for obstetricians at 77%.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were rostered in advance to attend training days and told us they were usually able to attend. There was an expectation staff completed their eLearning during clinical working hours. However, they told us this was not always possible.

The service took into account the planned routine activity within the unit when organising multidisciplinary training sessions. These training sessions were arranged on Mondays, as there was no planned clinics or theatre lists during the morning. Staff told us this had improved medical staff attendance at these sessions.

Staff received training on emergency evacuation from a birthing pool through medical devices training. The equipment had been risk assessed as moderate, requiring direct competencies undertaken every 24 to 36 months for frequent users and 12 months for infrequent users. The figures for current compliance were 80% for infrequent users and 85% for frequent users. However, the service told us these figures included staff who were not currently at work, and cleansing of the data was in progress. A pool evacuation skills and drills session was planned for October 2023.

The service had introduced informal ‘tea trolley teaching’ initially introduced by the infant feeding team. These were monthly walk rounds facilitating one to one teaching for staff over a cup of tea, providing a safe space for discussion and questions.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Training records showed staff had completed both Level 3 safeguarding adults and safeguarding children training as set out in the trust's policy and in the intercollegiate guidelines. The service had achieved 90% compliance or above in all staff groups for safeguarding adults and safeguarding children training at the level appropriate for their role.

Maternity

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans in place, with input from the safeguarding team.

Staff were supported by two named safeguarding midwives and the Head of Safeguarding for the trust. Staff spoken with shared examples of when they had raised safeguarding concerns with colleagues. Staff told us about the Positive Intervention Parent Solutions (PIPS) team which provided support for women and birthing people under the age of 19 years. The remit of this team was being expanded to include other vulnerable women and birthing people.

Staff followed safe procedures for children visiting the ward. We saw a selection of children's books and toys were available on the ward and heard positive comments from a mother about staff interaction with visiting children.

When women had their babies taken into care at birth or shortly afterwards by social services the midwives ensured they received 'Hope' boxes which contained early memories of the baby and pregnancy journey.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. We saw the service had taken appropriate action following an incident in July 2022, and changes made to ensure fire doors were alarmed, to alert staff when opened. Staff told us the head of security had also been receptive to security staff receiving training around baby abduction. The service had practised what would happen if a baby was abducted within the 12 months before inspection, on 10 May 2023.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Leaders had recognised the maternity unit was in need of refurbishment and work was ongoing. Although there was ongoing building work in the delivery suite, staff had continued to maintain the cleanliness within the area. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly.

Cleaning audits were completed monthly and reported to the Infection Prevention and Control Committee. The expectation for these audits was a score of 95% or above. We saw between February and August 2023 this had not consistently been achieved, with scores ranging from 82% to 100% where audits were available. Some months audits were not completed due to building work or not submitted. The issues had been highlighted within the report to the Infection Prevention and Control Committee and included in the action plan.

Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas, and for the last 4 months compliance was consistently above 95%.

Monthly audits were completed for peripheral line insertion (cannula) and catheter insertion and ongoing care. The results for peripheral line insertion and catheter insertion ranged from 70% to 100% over the last 7 months. Improvement actions had been identified and included in the action plan and scores had improved. The audits highlighted operating theatre staff had not received training on how to record the information on the electronic patient record. As of the beginning of September 2023, 15 out 35 members of operating theatre staff had received this training.

Compliance with the uniform policy was audited monthly and compliance ranged from 90% to 100%. The uniform policy had been reissued to staff, who had to sign to say they had read the policy.

Maternity staff completed infection prevent training levels 1 and 2, with a compliance rate above 90%. Compliance rates for sepsis training was above 90% for maternity and obstetric staff.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the day assessment unit and it was clear equipment was clean and ready for use. Staff used 'I am clean' stickers to indicate cleaning had taken place.

Environment and equipment

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

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

The maternity unit was located over three floors and fully secure with a monitored entry and exit system. However, the service acknowledged challenges within the unit and at the time of the inspection reconfiguration and refurbishment work was ongoing. Drayton ward (combined antenatal and postnatal ward) had a rolling programme for refurbishment one bay at a time, and the main desk had been moved closer to the ward entrance to assist with monitoring entry. The outpatients area was used for both antenatal and gynaecology clinics. Staff told us that cross over of clinics was kept to a minimum and there were two separate waiting areas. Areas within the outpatients area had been refurbished, and efforts made to create a more homely environment in the room used for sensitive discussions with women, birthing people and families. The maternity day assessment unit was located within the outpatients area, operated a booked appointment system and reviewed women and birthing people referred from antenatal clinic.

The delivery suite was undergoing considerable building and refurbishment work to the theatres to ensure they were fit for purpose. One theatre was currently out of use undergoing refurbishment. In order to maintain two theatres on the unit, the delivery room closest to the theatres had been converted into a fully operational theatre. Staff told us this theatre was predominately used for lower risk procedures, although was fully equipped to carry out caesarean sections. We sought assurance from the service about the procedures undertaken and frequency of use of the second theatre (room 4). They told us between 1 March and 31 August 2023 this theatre had been used 16 times, although only once for an emergency caesarean section.

Triage had been relocated to the delivery suite as part of a pilot. Triage was located close the midwifery station and comprised of an office and two assessment rooms. Staff told us they were able to flex the rooms used for assessment if there was increased activity within the unit.

We noted a number of delivery rooms were not able to accommodate the resuscitaire in the room, and they were kept outside the room. We asked the service to provide assurance they had assessed and mitigated the risk. We saw risk assessments had been completed in August 2023, and were due to be reported to the next governance meeting and added to the risk register.

Processes were in place for staff to carry out daily safety checks of specialist equipment. Records indicated equipment had been checked daily, with the exception of the resuscitaire on Drayton Ward, where there were gaps in the records for two days in July and August 2023.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. There was a dedicated area on delivery suite for bereaved parents. This room was sound proof, had access to an outside court yard and was the first delivery room on entering the delivery suite.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, on the maternity day assessment unit there were cardiotocograph machines and observation monitoring equipment.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

The service had identified and responded to the risk presented by triage and the maternity day assessment unit being co-located. Consequently, triage had been relocated to the delivery suite and was staffed separately. Staff working in both triage and the maternity day assessment unit told us the changes had been beneficial and allowed them to provide a better service to women and birthing people. Staff used the principles of an evidence-based, standardised risk assessment tool for maternity triage. They aimed to review all women and birthing people within 15 minutes of arrival and complete a risk assessment. Women and birthing people were triaged on arrival to the hospital when they were not attending for a planned birth. The service implemented clear guidance to help midwives and medical staff determine the clinical urgency in which women need to be seen. The service audited the use of their triage tool monthly. We looked at audits for the last 3 months and found on average women were triaged within 15 minutes of arrival in over 90% of cases. The service identified factors which affected time to initial triage assessment. This included space capacity, if the rooms were in use long term; unpredictability of acuity and patients arriving all at once and staffing levels. Planned staffing levels for triage were two midwives across 24 hours but this was not always possible, and delivery suite staff provided supported for triage.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 4 MEOWS records and found staff had correctly completed them. An internal audit in

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June 2023 reviewed 20 records from April 2023 demonstrated an overall MEOWS compliance of 86%, with 100% compliance in antenatal and postnatal care and 73% in intrapartum care. Following the audit an action plan was put in place around intrapartum care. For ongoing assurance the monthly MEOWS audit had been added to the safety champions meeting monitoring table for oversight. The audit data from September 2023 and review of the action plan will be presented at the next safety champions meeting.

Staff knew about and dealt with any specific risk issues. The service provided training and competency based assessments on the use of cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Midwifery staff compliance was 97% and obstetric staff compliance was 100%. The service told us monthly multidisciplinary CTG training was delivered jointly by the fetal monitoring midwife and labour ward lead consultant. All staff were required to complete a competency test before they were rostered to work on delivery suite. There was an expectation staff used a 'fresh eyes' or buddy approach for regular review of CTGs during labour. The recent audit highlighted 'fresh eyes' had only been completed every hour in 85% of cases, and two hourly fresh eyes completed in 98% of cases. However, the peer review hourly recorded in the electronic records was 79% and peer review two hourly was 94%. We reviewed eight patients where CTGs had been completed. We saw 'fresh eyes' had been completed appropriately.

Staff in theatres used the World Health Organisation (WHO) Surgical Safety Checklist which was a tool aimed at decreasing errors and adverse events in theatres and to improve communication and teamwork. The service used monthly Local Safety Standards for Invasive Procedures (LocSSIP) checklist reports to check compliance in all theatres. Compliance in August 2023 was 96% although recurring themes included clinicians not fully engaging in the process and talking over theatre staff whilst they are trying to complete the WHO checklist.

Staff completed risk assessments for each woman antenatally, on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring at the point of booking. Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of deteriorating mental health during pregnancy. Staff screened women for depression using the 'Whooley

questions.' The questions are a screening tool designed to try and identify symptoms that may be present in depression. There was a referral process to ensure support was accessible for women who identified with possible mental health needs.

The service recognised the percentage of women who were current smokers at delivery was higher than the national average of 8% and had been proactive in addressing this issue. Staff received training on risk perception to assist them to engage with women who smoked. A tobacco dependency advisor had been in post since March 2023, and a standard operating procedure for referral for nicotine replacement therapy developed. The public health midwife told us smoking status and carbon monoxide assessments were recorded at booking and rechecked at every contact. Women and birthing people who wished to stop smoking were referred to the smoking cessation team, to access nicotine replacement therapy and support. Women and birthing people were also referred to the specialist community midwifery team. Women could request a home visit from the fire service, and on average, 5 visits a month were undertaken. Data included in the maternity dashboard demonstrated the interventions had been successful and the percentage of women who were current smokers at delivery had reduced from 12.9% in May 2023 to 8% in August 2023.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. The newborn early warning trigger and track (NEWTT) tool is designed to be used by healthcare professionals working in areas caring for newborns in the early and ongoing postnatal period to identify babies at risk of clinical deterioration and provide a standardised observation tool to monitor clinical progress. The service had carried out a NEWTT audit on

9 cases in August 2023. The audit demonstrated improvements were required as 66% had the appropriate frequency of observations in line with the Neonatal Early Warning Score Observation policy. In addition, 55% of cases had observations not completed or late timings. The full observations pathway had not been completed and documentation needed to be improved to clearly reflect the reasons for missing or incomplete observations. However, 100% of cases were managed appropriately in terms of escalation to the paediatric team. No referrals were missed or late.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

The neonatal and delivery suite team attended a daily virtual call 'WebEx' with the two local hospitals in the Coventry and Warwickshire Local Maternity and Neonatal System. This facilitated open discussion about staffing and acuity and support available across all three units as required. Staff also shared information and updates, for example the challenges around supplies of vitamin K injections. We observed this meeting and the interactions between staff and concluded the three units felt integrated.

Consent procedures for planned caesarean sections did not always follow best practice guidelines. Guidance indicates the information should be provided during the antenatal period and ideally well in advance of admission to hospital. After provision and discussion of all available information, women should be offered the time and opportunity to clarify any concerns they may have, before seeking their written consent. We were told this wasn't the case as women and birthing people usually consented for planned caesarean sections on the day of delivery. We requested additional assurance from the service around compliance with consent procedures. The service told us following discussion with medical staff they were assured women and birthing people were given information during the antenatal period and usually consented on the day of the procedure. However, their audit indicated this discussion was not always recorded. As a consequence, they had updated their policy and advised medical staff of the correct procedure. There were plans to reaudit on a monthly basis. There was no evidence women and birthing people had not given consent for procedures. In addition, medical staff had received training specific to consent (Montgomery Training). This training was being delivered every three months. One session had been delivered in July 2023 and 50% of consultants and 56% of registrars had completed this training.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support staff needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in January 2021, which was due to be repeated in October 2023. This review recommended 101.44 whole-time equivalent (WTE) Band 3 to 8 compared to the funded staffing of 98.13 WTE, a shortfall of 3.31 WTE staff. The service provided additional assurance around staffing following the inspection. The service had increased

staffing to 101.64 WTE band 5 -7 midwives and 28.93 WTE band 2 and 3 support workers. We saw from the monthly Birth Rate Plus Acuity reports shortfalls were usually due to short term sickness, unable to fulfil vacant shifts and midwives scrubbed in theatre. Staff spoken with told us there were occasions when they were short staffed, as staff were redeployed from the ward to cover shortfalls on delivery suite.

The service had taken action to mitigate some of the staffing challenges. For example: the introduction of a dedicated theatre team to support the elective caesarean section list, although midwives still scrubbed for theatre at night. There were plans for the dedicated theatre team to be available 24 hours a day. The service told us this had been approved in principle by the Business Review group and would be presented to Trust Management Board in the near future.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign something may be wrong with midwifery staffing. There had been 37 red flag incidents between February and July 2023. In July 2023 there were 11 red flag incidents; 8 incidences when the labour ward coordinator was unable to maintain their supernumerary status, but not providing 1:1 care. There were 3 incidences recorded as labour ward coordinator not being able to maintain their supernumerary status and were required to give 1:1 care. The on call staff were not utilised during these occasions. There were plans to investigate why and share any identified learning.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Managers moved staff according to the number of women and birthing people in clinical areas and staff told us they were more likely to be short staffed on the ward than in other areas. We saw from the monthly staffing reports and during the inspection the staffing escalation policy was generally utilised when required, and additional support provided by on call community midwives and on call manager.

The service monitored and reported on vacancy rates, turnover rates, sickness rates and use of bank staff. At the end of July 2023, the service had a vacancy rate for bands 5 – 7 of 10.7 WTE staff, and during the month there had been 2.8 WTE new starters and 3.2 WTE leavers. There were 4.38 WTE band 5-7 midwives on maternity leave, whose shifts were covered by bank and agency staff where possible. The service had over recruited to band 7 specialist roles to offer secondment opportunities to cover maternity leave. In addition, 5.37 WTE band 5 newly qualified midwives have been recruited to commence in October 2023. Sickness rates had decreased in July 2023 to 4.74 WTE, although this was still above the trust target rate.

The service provided assurance around staff vacancies following the inspection. The current vacancy rate for band 5 to 7 midwives was 10.11 WTE with a sickness rate 5.45 WTE. Agency and bank staff continued to cover any shortfalls. The service had recruited 4.76 WTE newly qualified midwives to commence in October 2023, resulting in a trajectory of 1.38 WTE vacancy remaining.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided by the service indicated 85% of midwives had received an appraisal, in line with the trust target. Any outstanding appraisals had been scheduled. The service did not have a practice development midwife in post. The vacancy had been recruited to, with a start date of 25 September 2023.

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We spoke with the lead professional midwifery advocate (PMA). They told us the leaders were committed to developing the support for midwifery staff and had trained additional staff to become sessional PMAs to work alongside the lead PMA. The lead PMA worked 30 hours a week and each sessional PMA offered 7.5 hours a month. Both group and one to one supervision was provided, as well as more informal support whilst walking around the unit.

Several staff we spoke with told us they were on secondment and how they valued these opportunities to develop their skill and knowledge in different aspects of maternity care.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff.

The service had 8 WTE consultants in post, 10 WTE Specialist Registrars, and 10 lower grade doctors. The service had a vacancy for one specialist registrar due to vacancies within the local medical deanery.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they felt very well supported and enjoyed working at the trust. The teaching environment was promoted through rostered weekly Monday morning department teaching sessions and/or quality of care meetings. Cardiotocographs (CTG) from the previous week were presented at these meetings by the fetal monitoring midwife to improve junior doctors knowledge around this aspect of care. Data provided by the service indicated 95% of medical staff had received an appraisal.

The service had invested in ‘midwives for medical education’ following less favourable feedback from the national trainee survey. These midwives provide support on the wards for medical staff with teaching and practice skills and knowledge. As a consequence, the survey results had improved in the 2023 survey.

Records

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

Women and birthing people's notes were comprehensive and all staff could access them easily. The trust used a combination of paper and electronic records. The majority of information was recorded electronically although paper records were used for medicine charts. We reviewed 5 electronic patient records and found records were clear and complete.

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

Records were stored securely. Staff locked computers when not in use.

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The service had undertaken an audit of patient records in April 2023, having migrated to digital patient records in June 2022. The audit reviewed both digital and paper records for completeness. The audit identified a number of areas for improvement, including countersigning student shifts, completing handovers as a minimum when transferring between areas, sharing information to involve patients in their care, completing intrapartum management plans and improving the information required on the partogram. An action plan had been developed following the audit, with plans to reaudit records in September 2023.

Medicines

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

Midwifery and medical staff were provided with medicines management training. The service had systems in place to check staff competency when using medicines was in line with trust policy and national guidelines. Midwifery staff compliance with medicines management training was 96%, which met the trust target. Medical staff overall compliance with medicines management training was 80%, which did not meet the trust target. Midwifery staff were assessed for competency in intravenous administration and oral administration and medicines management. Competency rates were above the 85% target, with 87% for intravenous administration and 99% for oral administration.

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

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. Staff completed medicines records accurately and kept them up-to-date. Medicines records were clear and up-to-date. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system.

Incidents were investigated and responded to in a timely way; there were 15 incidents open over 60 days.

Maternity

There were no reported ‘never’ events at this service.

We saw the service had investigated and taken action following incidents. We saw the service had completed an immediate action plan following an incident and taken steps to minimise a recurrence. We found that specific actions had been completed, including the introduction of specific maternity focused training by the Venous thromboembolism (VTE) specialist nurse as part of PROMPT training. (Venous thromboembolism (VTE) refers to blood clots in the veins). Compliance rates were above 90% for both midwifery and medical staff.

Staff reported serious incidents clearly and in line with trust policy. Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. We saw that incidents and risks were reported and discussed at board level through a variety for meetings.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

Managers debriefed and supported staff after any serious incident. Both ‘hot’ and ‘cold’ debriefs were held, and the Professional Maternity Advocates (PMAs) were available to support any member of staff working within the maternity unit.

Is the service well-led?

Good 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

There had been a period of instability within the maternity leadership. The Director of Midwifery (DoM) shared a joint role with South Warwickshire Foundation Trust. The senior midwifery post at the service had been vacant for a period of time and the DoM had taken operational oversight of the unit. The service provided additional information following the inspection. The service had previously been overseen by an Associate Director of Midwifery and Nursing (ADOM) for the Women’s and Children’s Directorate. This post became vacant in October 2022, and a member of staff was seconded to this role between January and the end of March 2023. The service then reviewed and restructured the leadership within the Women’s and Children’s Directorate and midwifery team to strengthen the leadership team. This included the addition of 3 matron's posts, as well as additional band 7 posts added to the Governance team to provide additional support. This resulted in the role and responsibilities of the senior midwifery post been redefined and the post of Head of Midwifery (HoM) readvertised in July 2023. The post had been appointed to, with plans for the new HOM to the join the service in December 2023. Staff spoke about the positive impact of the DOM on the maternity unit since taking operational oversight.

Maternity

Maternity service was part of the Women's and Children's Directorate. A clearly defined management and leadership structure was in place. The service was led by a triumvirate made up of the service manager, head of midwifery (DoM at present) and clinical director. The head of midwifery's role was supported by a risk and governance manager, matron for maternity inpatients and intra-partum care, matron maternity outpatients and community and maternity superintendent.

There was clear oversight of the service with appropriate lines of reporting to various meetings, to ensure a clear line of communication between the ward and the board and any agreed actions or developments.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. They described the ongoing work to improve the facilities, including ongoing refurbishment and upgrading of theatres, workforce gaps in the leadership team and management of high risk women and birthing people.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service was supported by maternity safety champions (Chief Nursing Officer / Chief Medical Officer) and non-executive director. They completed a walk around on a monthly basis and spoke with staff and women and families using the service. They told us staff were very open and shared their concerns, for example, staffing levels, triage and lack of space for breaks. Wherever possible, action was taken such as providing a separate area for staff breaks. The non-executive director told us they also completed walk rounds in different directorates within the hospital to understand the safety focus for those staff and how safety concerns were being addressed.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in secondments and pilot projects to help all staff progress. For example, staff had been seconded to specialist midwife roles, and to manage the triage project.

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. Leaders and staff understood and knew how to apply them and monitor progress.

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 for maternity services was aligned to the trust vision, which was 'EXCEL at Patient Care' with 5 strands;'Effective open communication; EXcellence and safety in everything we do; Challenge but support; Expect respect and dignity and Local healthcare that inspires confidence.'

The maternity vision further focused on 'Family is at the centre of everything we do'. The service had identified 7 key areas to achieve this. These were service improvements; national compliance; wellbeing; development; accountability; culture and leadership. The leadership team had delivered a presentation to the trust board in April 2023 outlining the vision and progress towards achieving each strand and future plans.

Maternity

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The service was working with the local system to improve pelvic health.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

The culture within maternity services supported staff to develop and fostered a culture of learning and improvement. Staff were proud to work for the trust and felt valued and respected by management. Staff were positive about the unit and spoke highly about the changes made to the leadership and felt able to speak to leaders about difficult issues and when things went wrong.

Staff were focused on the needs of women and birthing people receiving care, ensuring their needs and voices were heard in all aspects of their birthing journey. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. Verbal feedback from women and birthing people supported they were very happy with the care and support they had received whilst on the unit.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. We spoke with the public health midwife who described the work being undertaken to identify and reduce health inequalities. Key issues included smoking, vaccinations, risks associated with obesity and poverty including digital poverty. Positive interventions around smoking had been successful and the percentage of women who were current smokers at delivery had reduced from 12.9% in May 2023 to 8% in August 2023.

The service was actively involved in poverty proofing, exploring barriers experienced by women on low incomes in accessing maternity care. Transport was a key factor in women not attending or disengaging from the service, so women were provided with information about bus routes, reimbursement schemes as well as free parking on site. The service worked with a supermarket to provide non-perishable foods on Drayton Ward for partners, reducing the need for time away from the ward to purchase food or the additional expense. The charity Growbaby, supported women and birthing people with packs of baby supplies if required. The community outreach worker worked with the infant feeding team to encourage women to consider breast feeding and had a meeting planned for October 2023 with a Syrian community group for further discussion and advice.

From October 2023 there were plans to implement a health and wellbeing clinic for women with the body mass index over 45. The aim of the clinic was to provide advice and guidance, as well as risk assess the needs of these women, for example, ensuring they were on the correct medication and birthing in the most appropriate facility. As part of the refurbishment of the ground floor within the unit, there were plans to create an internet café. This would support women and birthing people to access their maternity records whilst on site.

The service monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes. They had identified they were an outlier for vaccination rates within the local maternity and neonatal

system (LMNS). Antenatal clinic midwives offered vaccinations during clinics on Monday afternoon and Saturday mornings which was not equitable for all women. Other trusts within the LMNS had dedicated vaccination staff in all clinics. The service had put in a bid for monies to improve the service and also planned to explore the reasons why women declined vaccinations to identify any specific groups or barriers to uptake.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The results of the Maternity Survey 2022 showed when compared to other trusts, the results were about the same. Six questions had a statistically significant increase when compared to 2021. Women and birthing people complemented the quality of care and staff interactions throughout all stages of the maternity pathway. Many comments showed appreciation for how the staff across the service were supportive, kind, caring and helpful, and midwives were singled out for their attitude and kindness. However, not all respondents were pleased with their experience of dealings with staff. Many respondents were disappointed with the lack of psychological and physical support, particularly around the restrictions with visiting at the time. Some respondents did not feel listened to or their concerns and wishes not taken seriously, or that medical concerns were missed, ignored or not competently dealt with and not always given correct information or advice at the appropriate time.

We reviewed the service's NHS Staff Survey from 2022. The results of the survey were measured against the 7 People Promise elements and against two of the themes reported in the previous years (staff engagement and morale). For all areas, scores at the trust were similar to the average of comparable trusts. The service had developed its own action plan from the survey results around workforce and culture.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. The service had received one complaint in the 3 months prior to the inspection. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. Staff understood the policy on complaints and knew how to handle them. Complaints were reported monthly to the Quality Assurance Group and the Public Trust Board.

The maternity and neonatal safety champions met bi-weekly and reviewed data once a month. They carried out a monthly walk round to speak with staff, students, women and families, as well as meeting with the safety leads. They discussed maternity governance and safety improvement activity / action. Data was compared month on month to identify any trends.

Governance

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

The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

Maternity

The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders were clear on the links to trust wide groups and committees to escalate risks and issues.

Oversight of safety in maternity services was reported to the Divisional Quality Assurance Committee through the monthly Maternity Assurance Reports, compiled by the DoM, Clinical Director for Women's and Children's and the Divisional Risk and Governance Manager. We reviewed the last 3 reports and found that the service reported on their challenges and successes The reports highlighted key areas including performance, staffing and incidents.

Staff and leaders could clearly articulate the governance framework for the directorate and how information flowed between maternity services and the board, and from the board back to the ward.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Clinical governance meetings were held monthly. We looked at meeting minutes for the last 3 months, standing agenda items included Ockenden, CNST, risk register, policy updates, maternity dashboard reports, incidents, safeguarding, training, audits, complaints, friends and family test and pharmacy updates.

Senior leaders managed workforce planning plans well. The service had commissioned an updated staffing and acuity review, which was due to take place in October 2023. The service produced a monthly maternity workforce quality assurance report, which provided a comprehensive overview of the current staffing level, the staffing trajectory and action taken to manage any identified risks.

Senior leaders in maternity met monthly. The triumvirate meeting followed a standing agenda but did not minute meetings.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We saw updates to policies were discussed at the directorate governance meetings. Two of the policies we reviewed required amending due to recent changes within the service. These were the triage guideline, as it did not reflect the change in location and dedicated staffing, and the labour ward consultant cover guidelines, appendix 1, as the consultants worked 'hot weeks', Monday to Thursday or Friday to Sunday. We noted policies often had a review date of 5 years, which was a long period of time given the frequency with which national guidance can change. The service told us following the inspection that routine review of guidelines was undertaken 5 yearly in line with the trust requirements for document review, however all relevant documents were reviewed and updated following the publication of any new national guidance in between routine reviews.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Maternity

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes.

The service had an audit programme linked to national clinical audits but also included audits identified through incidents as well as ongoing routine audits around patient notes, swab counts and training compliance. The audit plan also included the reporting structure for the findings and recommendations. The service was in the process of updating their audit programme.

The service used a maternity quality dashboard to benchmark against national indicators and provide target figures to achieve. The dashboard reported on clinical outcomes such as level of activity, maternal clinical indicators (mode of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators, public health information and

statistical analysis. It also covered data in regional and national dashboards such as the monitoring of induction of labour. Data from the dashboard indicated an increase in the rate of 3rd or 4th degree perineal tears and post-partum haemorrhages and audits were planned to investigate these issues further.

We saw the service shared relevant information with staff via the monthly 'Maternity – Risky Business' newsletter. The newsletter covered key messages, the top 3 reported incident themes, high risks on the maternity risk register, learning from incidents, updated policies, guidance and leaflets, and most importantly, positive feedback received about staff. Important messages were also shared at the daily safety huddle attended by all staff. The daily brief form was completed at the beginning of each week, added to as required and handed over from one shift to the next. This ensured the consistency of messaging across all shifts.

There was an effective system in place to review and monitor actions from HSIB (Healthcare Safety Investigation Branch). There had been no new HSIB cases in last 6 months. We reviewed 1 report dated July 2023 and saw actions were in place to address the recommendations and had been monitored regularly. In addition, we saw that an immediate action plan had been put in place following the incident in January 2023, and all the actions had been completed.

The service reviewed all neonatal deaths by a multidisciplinary group who used the Perinatal Mortality Review Tool. We reviewed 1 perinatal mortality tool, and saw it had been completed appropriately, and that families were involved, and information shared appropriately. We saw the service reported quarterly to the Mortality and Deteriorating Patient Group, to provide assurance the process was being followed correctly.

The service was accredited by the NHS Resolution clinical negligence scheme for trusts (CNST). The service complied with 6 out of 10 safety initiatives for Year 4. An action plan and a bid for funding had been put forward to help increase support for the CNST requirements. We saw the service had provided sufficient evidence of their current compliance to the trust board in September 2023. The service had updated their assessment tool and action plan to reflect the changes for Year 5.

The service complied with 3 out of 5 saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care.

Maternity

The service had an Ockenden assurance visit in February 2023. The service reviewed their action plan in June 2023 and shared the evidence with the LMNS. The LMNS confirmed there had been an improvement with compliance with 63% compliance with all the sub-elements of the 7 immediate essential actions. We saw progress was monitored through the monthly directorate quality assurance meeting.

The service provided up to date data to the national MBBRACE survey 2021. The service had previously been identified as an outlier for stillbirths and neonatal deaths. The service had reviewed the data, identified themes and developed an action plan, which was presented to the Quality Assurance Committee in November 2022. Current data on the dashboard indicated the current rates had significantly reduced and the service was no longer an outlier.

We reviewed the service's risk register and saw the service had recorded relevant risks rated as high risk. The planned actions to address the risk were not always clear, although action taken could be seen through the reviewer's comments. The register stated clear ownership of the risk, timescales for review and completion.

The service had an escalation policy in place to proactively manage activity and acuity across the trust. They followed a standard escalation policy across the local area. In the last 12 months, the unit had not been closed. The neonatal and delivery suite team attended a daily virtual call 'WebEx' with the two local hospitals in the Coventry and Warwickshire Local Maternity and Neonatal System. This facilitated open discussion about staffing and acuity and support available across all three units as required.

Information Management

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

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. We saw leaders used information in the dashboard to highlight areas for improvement, for example, smoking rates at birth.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated and secure**.**

Data or notifications were consistently submitted to external organisations as required.

Engagement

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

Leaders worked with the local Coventry and Warwickshire Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The service worked closely with their MNVP champion as well

as the wider MNVP. Maternity and Neonatal voices partnership engagement meetings were scheduled bi-monthly and covered feedback, ongoing projects, or developments within maternity, along with new initiatives and community work. Both the service and the MNVP were positive about their relationship and valued each other's support and input with improvement work.

The MNVP completed a 15 steps review in July 2022. The team included women using both the maternity and neonatal service, a father and a health visitor. This quality tool reviewed the service from the perspective of people who used maternity services. The major feedback point was the décor of the unit did not feel welcoming and didn't reflect the good rapport they received from staff. In addition, it was noted there was not enough support or information for fathers, especially around breast feeding.

The MNVP champion told us the service was open to feedback and made improvements whenever they could. They said feedback was well managed, and staff listened and resolved issues quickly. They told us the service was leading the way with support for fathers and birthing partners. The service with support from 'Dad Matters' (community project) was hosting drop in breast feeding sessions for dads / birthing partners. Dad Matters also provided support with attachment and bonding, mental health, and access to services. In addition, the service had launched 'DadPad,' an evidence based app free of charge. The app was designed to reduce anxieties, create a strong bond and healthy attachment with baby, build stronger family relationships and recognise when mental health support might be needed.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. The MNVP said the service was responsive to providing information in different languages.

The service encouraged feedback from staff. Staff told us they felt able to raise any concerns with their line managers. Staff spoken with were aware of the Freedom to Speak Up Guardian and the service was committed to providing Freedom to Speak Up to all staff. The service had developed an action plan to address issues raised by staff and we saw action had been taken or was ongoing. The Professional Maternity Advocate newsletter contained a section on 'You said, We did' following comments and suggestions from staff. For example: allocation of breaks and preference for particular shift patterns.

We did not receive any responses to our give feedback on care posters which were in place during the inspection.

Learning, continuous improvement and innovation

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

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. We saw the serviced incorporate case studies into training for both midwifery and medical staff, to encourage discussion and shared learning. We saw learning had been shared with midwifery staff through the monthly Safety Champions learning presentations around 'never events, obstetric haemorrhages, and changes to the incident reporting process. Medical staff attended the weekly training sessions where obstetric cases were discussed and learning identified.

Maternity

The service was committed to developing staff. Staff spoke with told us about their secondment opportunities and the support to develop their skills and knowledge. Staff and leaders discussed the support on offer to maternity support workers to assist them to develop their skills through the national framework.

Outstanding practice

We found the following outstanding practice:

- The service was committed to identifying and reducing health inequalities for women and birthing people. The public health midwife described the work being undertaken to identify and reduce health inequalities. Key issues included smoking, vaccinations, risks associated with obesity and poverty including digital poverty. Positive interventions around smoking had been successful and the percentage of women who were current smokers at delivery had reduced from 12.9% in May 2023 to 8% in August 2023.
- The service was actively involved in poverty proofing, exploring barriers experienced by women on low incomes in accessing maternity care. Transport was a key factor in women not attending or disengaging from the service, so women were provided with information about bus routes, reimbursement schemes as well as free parking on site. The service worked with a supermarket to provide non-perishable foods on Drayton Ward for partners, reducing the need for time away from the ward to purchase food or the additional expense. The charity Growbaby, supported women and birthing people with packs of baby supplies if required. The community outreach worker worked with the infant feeding team to encourage women to consider breast feeding and had a meeting planned for October 2023 with a Syrian community group for further discussion and advice.
- The service was proactive in providing support for fathers and birthing partners. With support from 'Dad Matters' the service was hosting drop-in breast-feeding sessions for dads / birthing partners. Dad Matters also provided support with attachment and bonding, mental health, and access to services. In addition, the service had launched 'DadPad,' an evidence-based app free of charge. The app was designed to reduce anxieties, create a strong bond and healthy attachment with baby, build stronger family relationships and recognise when mental health support might be needed.

Areas for improvement

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

Action the trust SHOULD take to improve:

George Eliot NHS Hospital:

- The service should continue to ensure staffing levels meet the needs of women and birthing people.
- The service should ensure best practice guidance on consent for planned caesarean sections is followed and clearly documented with patient records.
- The service should continue to monitor compliance with best practice guidance on consent for planned caesarean sections.

Maternity

- The service should continue to deliver Montgomery training to clinicians within the unit.
- The service should continue to monitor and ensure all mandatory training meet's the trust's targets.
- The service should maintain the cleanliness of the unit and ensure monthly cleaning audits are completed as required.
- The service should ensure daily checks are completed and recorded for the resuscitaire on Drayton Ward.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 other CQC inspectors, 2 midwifery specialist advisors and an obstetrician specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.