Sheffield Teaching Hospitals NHS Foundation Trust

Jessop Wing

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inadequate**

Our findings

Overall summary of services at Jessop Wing

Inadequate

The Jessop Wing opened in 2001 and is a purpose-built maternity unit with approximately 6,200 babies born at the trust every year.

In addition to a 22-bed labour ward, there are two postnatal wards, one antenatal ward, an admission triage area and an advanced obstetric care unit One of the postnatal wards specialises in caring for women who have had a caesarean section. In addition, the Jessop Wing community midwifery service supports approximately 200 homebirths per year.

The Jessop Wing also provides neonatal intensive care and special care for sick and premature babies born in Sheffield and those transferred from other units who require this service.

The antenatal clinic and gynaecology outpatient clinic are on the ground floor of the Jessop Wing. The gynaecology service also includes two wards on G Floor of the Royal Hallamshire Hospital. At the time of the inspection one ward of G Floor was closed due to COVID-19. The Jessop Wing has an assisted conception unit for women who require this specialist treatment. We did not inspect this service.

We carried out this unannounced focused inspection because we received information that highlighted concerns about the safety and quality of the services.

During the inspection we inspected the labour ward, two postnatal wards, antenatal ward, admission triage area, advanced obstetric care unit. We spoke with 22 staff, including senior leaders, service leads, matrons, midwives, medical staff, maternity care support workers and student midwives. We reviewed 11 sets of records and observed staff providing care and treatment to women.

Focused inspections can result in an updated rating for any key questions that were inspected. This can be if we inspect the key question in full across the service and/or where we had identified a breach of a regulation, and issued a requirement notice or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we imposed urgent conditions on the registration of the provider in respect to the regulated activity; Maternity and midwifery services. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to the maternity units at Sheffield Teaching Hospital NHS Foundation Trust's Jessop Wing.

We rated maternity services as inadequate. Overall, we rated safe, and well-led as inadequate. The ratings for effective went down to requires improvement and responsive was not rated and stayed the same.

Our rating of services went down. We rated them as inadequate because:

Our findings

- We were not assured the trust always had effective systems in place to ensure that medical and midwifery staff had the skills, competence, knowledge and experience to safely care for and meet the needs of women and babies within all areas of the maternity service.
- Staff did not always complete and update risk assessments for each patient and did not always take timely action to minimise and mitigate risks.
- The service did not always manage patient safety incidents well. There were delays in the investigation of incidents and lessons learned were not always shared amongst the whole team and the wider service. When things went wrong, there were concerns that there was a lack of openness and transparency.
- We were not assured the leaders had the skills, knowledge and experience to run the service. We were concerned that leaders within the service were not effective at implementing changes that improved the quality and safety of care delivered.
- Leaders did not operate effective governance processes to continually improve the quality of the service and safeguard the standards of care.
- There was mixed performance on patient outcomes, but they didn't always use findings to make improvements and achieve good outcomes for women.
- We were not assured that the service collected reliable data and analysed it effectively. Data was not always in easily accessible formats due to the multiple systems in use. Data or notifications were consistently submitted to external organisations as required, but recommendations were not always shared or implemented in a timely manner.

However:

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Doctors, midwives and other healthcare professionals worked together as a team to benefit women.

Maternity

Inadequate

Our rating of services went down. We rated them as inadequate because:

- We were not assured the trust always had effective systems in place to ensure that medical and midwifery staff had the qualifications, competence, skills and experience to safely care for and meet the needs of women and babies within all areas of the maternity service, including any area where women were waiting to be seen. This may expose women to the risk of harm.
- Staffing challenges also resulted in staff not always completing and updating risk assessments, undertaking 'fresh eyes' or CTG monitoring for each patient and did not always remove or minimise risks.
- We were not assured the service made sure all staff were competent for their roles.
- The service did not always manage patient safety incidents well. There were delays in the investigation of incidents and lessons learned were not always shared amongst the whole team and the wider service. When things went wrong, there were concerns that there was a lack of transparency.
- We were not assured the leaders had the skills, knowledge and experience to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety.
- Leaders did not operate effective governance processes to continually improve the quality of the service and safeguard the standards of care.
- We were not assured that the service collected reliable data and analysed it effectively. Data was not always in easily accessible formats due to the multiple systems in use. Data or notifications were consistently submitted to external organisations as required, but recommendations were not always shared or implemented in a timely manner.
- Resuscitaire checks on Norfolk ward showed that the resuscitaire had not been checked for the whole first half of February 2021 and for previous months there were regularly missing days.

However:

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Doctors, midwives and other healthcare professionals worked together as a team to benefit women.

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

Mandatory training

We were not assured the trust always had effective systems in place to ensure that medical and midwifery staff had the qualifications, competence, skills and experience to safely care for and meet the needs of women and babies within all areas of the maternity service, including any area where women were waiting to be seen. This may expose women to the risk of harm.

Maternity

- Data provided by the trust showed only 73% of midwifery staff had completed mandatory training against a trust target of 90%. We asked the trust what impact COVID-19 had on training schedules and were told that all training had been changed to virtual training.
- Multi-disciplinary training stopped during the pandemic. Evidence showed they had been providing virtual practical obstetric multi-professional training (PROMPT) since January 2021. However, some staff groups could not recall being part of MDT training pre-pandemic for example, anaesthetists. Therefore, at the time of inspection, there was no multidisciplinary team (MDT) training being delivered within the service in line with best practice guidance.
- Through our routine monitoring, and prior to the inspection, we identified concerns around cardiotocograph (CTG) training (fetal monitoring), monitoring and implementing the 'fresh eyes' approach in line with best practice. This was also identified as a breach in regulation at our previous inspection in 2015. We found this continued to be a concern during our inspection. We were told the 'fresh eyes' approach had been fully implemented in December 2020 but was not yet embedded. This was not due to be audited until April 2021.
- Our review of incident reports and Health Safety Investigation Branch (HSIB) recommendations showed that staff were not interpreting, classifying or escalating CTG appropriately. Documentation on CTG was poor and not in line with NICE guidelines [CG190]: Intrapartum care for healthy women and babies (2017).
- Staff informed us that training was not reflective of any recommendations from serious incidents or HSIB recommendations. Staff, managers and senior leaders could not articulate any of the themes from the HSIB reports or any actions they had put in place to mitigate the risks of them occurring again. In addition to this, when interviewing staff there was confusion about what CTG training package the trust used.
- Despite fetal monitoring being identified previously in our 2015 inspection, recommendations from national guidance and the findings from the HSIB investigation the service and trust had not identified this as a significant concern. They had lacked urgency and pace in implementing actions to mitigate these risks therefore exposing patients to risk of harm.

Safeguarding

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

- Midwifery and medical staff received training specific to their role around how to recognise and report abuse. Obstetrics, gynaecology and neonatology safeguarding training 2020-21 for safeguarding adults training compliance rates were 98.7% and for children were 97.3% with a target of 90%.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The trust followed the Family Common Assessment Framework (FCAF) (incorporating threshold of need guidance) and referral to the local safeguarding hub. The trust aimed to commence the FCAF at approximately 16 weeks gestation and set targets of assessment completion within 35 working days. However, recognised further assessment may be identified.
- Safeguarding adult and children policies were in place in line with intercollegiate guidelines, up to date and due for review in July 2021 and January 2023.
- Staff had access to practice guidelines such as, but not limited to, female genital mutilation, domestic abuse, referral to the local safeguarding hub, management of substance misuse in pregnancy: identification and provision of care and substance misuse in maternity: care of the baby.

Maternity

Cleanliness, infection control and hygiene

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

- Hand hygiene audits for January and February were 100% for all areas except Norfolk ward which had achieved 93.9% in January 2021.
- Infection, prevention and control reviews were undertaken across the maternity department in 2020. In January 2020 the labour ward achieved 96% compliance, the neonatal follow-up clinic achieved 96% compliance and the antenatal & feto-maternal services compliance rates were 92% in September 2020.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. 'I am clean' stickers were visible on all freestanding equipment, doors etc.
- Staff followed the infection control principles including the use of personal protective equipment (PPE). Staff had good access to PPE, and all staff were wearing appropriate PPE at the time of the inspection. All were bare below the elbows and observed hand hygiene procedures. We observed adequate supplies of hand gel and sinks available.
- Furnishings were clean and well-maintained. Cleaning and decontamination of equipment audits showed that checks were continued throughout the pandemic (2020).
- Cleaning records were not up to date at the time of the inspection, and records provided demonstrated that all areas were not audited for cleanliness between 10 March 2020 and 17 August 2020. However, audit scores that were completed and provided showed an average of 97.15%. Following the inspection, the trust told us during this time period, cleaning audits were stopped to prevent the transmission of COVID-19 during the pandemic.

Environment and equipment

Staff were trained to use equipment, but it was not always readily available or checked as often as required. Staff managed clinical waste well.

- There were challenges with the layout of the delivery suite in complying with Health Building Note 09-02 – Maternity care facilities (2013). The guidance states that "The reception desk should be located to enable all visitors entering or leaving the unit to be monitored."
- We found there were two entrances to the labour ward and only one was monitored by a 24-hour reception desk. Access to the ward was by a call system, however, to exit the labour ward women and visitors could press a button to leave unchallenged from either door. There was no direct line of sight from the reception desk or midwives' station to the second entrance.
- There was an Abduction or Suspected Abduction of a Baby from the Jessop Wing policy in place since 2020. There had not been a baby abduction drill carried out prior to the inspection and staff on the labour ward could not recall when this was last tested. During our staff interviews we were told the tagging system had not recently been tested and the security tag would be placed on the baby prior to leaving the labour ward. Therefore, there remained an opportunity for an untagged baby to be taken from the labour ward and staff could be unaware that the baby had been removed from the ward. Information provided by the trust showed the tagging system had not been tested on the labour ward.
- During inspection we noted that on Norfolk ward, the resuscitation trolley had been checked on 16 occasions between 15 August 2020 and 8 March 2021 out of a possible 190 occasions. On Whirlow ward, the resuscitation trolley also had missing days where checks had not been completed.

Maternity

- Resuscitaire checks on Norfolk ward showed that the resuscitaire had not been checked for the whole first half of February 2021 and for previous months there were regularly missing days. For example, 12 checks completed out of a possible 30 in November 2020, 12 checks completed out of a possible 31 in December 2020 and 20 checks completed out of a possible 31 in January 2021. The resuscitaire on Whirlow ward checks were mostly undertaken with minimal daily checks missed in February 2021 (three occasions over four-week period). We were unable to look back further during the on-site inspection.
- We saw evidence on inspection that emergency equipment was shared between two wards. The emergency equipment was located in the middle of the two wards (apart from the resuscitaire – there were two, one on each side). This may place women at risk if both wards require the emergency equipment at the same time.
- The resuscitaire on Whirlow ward was past the due date for portable appliance testing (PAT) testing in February 2021 but the resuscitaire on Norfolk was in date until June 2021. Some other electrical items where the PAT test date was October 2019 had no next test date given.
- There was an adult resus trolley on the postnatal wards, boxes for post-partum haemorrhage (PPH), cord prolapse, and anaphylaxis were available. Adult resus trolleys were checked and observed to have everything present, equipment was working, and nothing had exceeded its expiry date. Monthly checklists were all present and fully completed. There were no issues with tag ID checks.
- There were not enough resuscitaires on the labour ward. All of the tom thumb resuscitaires in the midwifery led unit (MLU) had been decommissioned, however, staff were unaware if this had been risk assessed. Therefore, there were two Draeger resuscitaires in the corridor. There was one in each of the consultant led care rooms, AOCU and Theatre, however, if there was more than one set of multiple births there would be a shortage of equipment.
- The corridors were cluttered posing a risk if women needed to be transferred from the MLU to consultant beds.
- We observed women waiting for lengthy periods of time on chairs in the corridor outside the labour ward assessment area awaiting clinical assessment due to fetal concerns, which posed a risk to patients due to lack of space, poor environment, lack of equipment in an emergency and indicated lengthy delays. The Trust explained that the use of the corridor was necessary to appropriately socially distance women during the COVID-19 pandemic.
- There were missing checks on the labour ward resuscitation trolley, which meant that staff could not be assured that emergency equipment would be available when required. There were no checks in place for the post-partum haemorrhage trolley on labour ward to ensure it was fully stocked. Staff stated that this was because ‘it was used so often’.
- The neonatal resuscitation trolley was checked by the neonatal team, however, there was no assurance for the labour ward staff had it been checked.
- Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and did not always remove or minimise risks.

- There were no criteria for the labour ward assessment unit to prioritise women or patient risk. Women were not risk assessed to enable those deemed at the highest risk to be seen first, rather than women being seen in order of attendance. Whilst on inspection we saw some women waiting in excess of two hours to be seen. There was a lack of ‘wait time’ monitoring in the assessment unit with no specific assessment criteria. As such staff were unable to articulate how women were referred into this unit.

Maternity

- Data supplied by the trust showed the rate of post-partum haemorrhage at Jessop Wing for January 2021 was 67 per 1000 births, which was significantly higher than the national average of 25 per 1000 births, including other tertiary units. When we spoke with leaders in the service, it was not clear if they had identified this, and subsequently what actions they were taking to reduce this.

Midwifery staffing

The service did not have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.

- The trust had a nursing and midwifery staffing escalation policy in place. The policy detailed how to address any shortfalls in staffing, for example, unexpected absence. An escalation approach via the senior nurses and midwives on duty or relevant on-call teams was clearly defined. Ultimately, if a significant nursing / midwifery problem remained unresolved; the chief nurse would be contacted. There was a series of systems and processes in place that operated 24 hours per day, 365 days per year to ensure safer staffing levels. A daily nurse staffing meeting was said to be embedded; the meeting was chaired by a nurse director, deputy nurse director, matron and considered the plans for staffing over the next 24-hour period.
- We found that the chief nurse, the nurse director, and head of midwifery had not followed the Birth Rate Plus report staffing recommendations of an average of 90% registered midwives to 10% maternity support worker (MSW) for maternity. Information provided by the trust demonstrates they were working towards an average of 85% registered midwives to 15% maternity support worker (MSW) for maternity However, we found that these figures had not been achieved.
- The Jessop Wing had been using Birth Rate Plus and Intrapartum Acuity to capture real time data of labour ward acuity since 2016. Within the live acuity tool was the use of red flags which had been embedded for a number of years and reported on a four hourly basis as recommended by Birth Rate Plus and National Institute for Health and Care Excellence (NICE) guidelines. Once a red flag incident had been triggered, the responsive action taken was recorded in real time. A midwifery red flag event was a warning sign that there may be concerns with midwifery staffing levels. If a midwifery red flag event occurred, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing was the cause, and the action that was needed. We discussed the red flag system with ward staff and found that most struggled to verbalise the processes. We lacked assurance that the process was robust and embedded.
- The Birth Rate Plus refresh assessment in 2020 recommended a further eight whole time equivalent (WTE) midwives above the trusts previous establishment figure for clinical midwives, taking the trust to a vacancy figure of 15 midwives (previously seven vacancies). However, at the time of our inspection leaders within the service could not articulate what the assessment had identified.
- The trust advertised midwifery positions in February 2021 to which they interviewed in March and recruited to four posts. The trust had a total of 41 midwives that held ‘as and when contracts’ within the Jessop Wing.
- Between January to March 2021, 7,054 hours had been paid for on a ‘as and when’ basis this equated to 587 maternity shifts breaking down to 195 per month, averaging at 48 shifts per week. The trust advised that the 15 vacancies the trust had currently equalled a maximum of 45 shifts per week. Therefore, the ‘as and when staff’ were utilised to increase the staffing to meet the recommended figure as per Birth Rate Plus.
- We were told that Birth Rate Plus data was reviewed weekly and triangulated with staffing and incident reports via the trust’s incident reporting system and that the responses to red flags were monitored to ensure safety was maintained.

- However, the number of actual midwives and care staff did not match the planned numbers. We saw evidence provided by the trust the unit as a whole was consistently short on care hours per patient. Labour ward minutes highlighted an audit undertaken over a four-week period regarding staffing levels on the advanced obstetric care unit (AOCU) which was completed mid December 2020. The audit split a day into four shifts (six hr shifts). During the shifts the acuity of each patient was assessed using Birth Rate Plus Intrapartum Acuity Tool (one to one, one to two care, etc.) versus the recorded staffing level.
- The audit highlighted that out of the 79% of shifts audited by the trust, 33% of women needed one to one care. After looking at the level of patient acuity, the senior midwife established that 52% were not staffed appropriately. Minutes highlighted that most women were usually well enough for a 'one nurse to two women' level of care, but the minutes highlighted the unit was not staffed enough to care for one to one level women.
- Labour ward minutes from December 2020 go on to state that 26% of shifts did not have appropriate staffing levels. Twenty-two percent were overstaffed by one or more midwives. However, these figures were not clear as nurses in AOCU had been counted as midwives, even though they don't undertake key tasks such as cardiotocography (CTG) and antenatal (AN) examination.
- The Birth Rate Plus Intrapartum Acuity tool example screenshot provided by the trust was for the period April-June 2020. As the screenshot was not the most recent, it did not provide assurance on current staffing levels as this was nine months prior to the inspection. However, following inspection the trust provided us with figures for 2020/21 which demonstrated continued shortfalls in staffing.
- Data reviewed following our inspection showed that between 01 August 2020 and 01 March 2021 a total of 11 patient safety incidents had been raised due to staff shortage issues, an example in relation to midwifery staffing was*:*
  - Data highlighted a woman who was reported to have a pressure sore to her right buttock, which was sore to touch. This patient had been encouraged to lay on her left side whilst awaiting suturing which had been delayed due to staffing and doctors being in theatre.
  - Insufficient staffing was reported where there had been two postnatal woman awaiting ward beds with no beds available and two women requiring the advanced obstetric care unit (AOCU). There were further unwell women, including women with post-partum haemorrhage (PPH) and high-risk neonate and a diabetic lady on variable rate intravenous insulin infusion. There was a further admission with lower (uterine) segment caesarean section (LSCS) for haematoma requiring a septic screen. There was reported to be only one midwife and one clinical support worker on duty to provide care for these patients.
  - The coordinator on the labour ward was not always supernumerary, however, this was dependent on which coordinator was on site. They were counted in the numbers for the floor which gave an inaccurate picture of the staffing on duty.
  - During our inspection on 09 March 2021, we found there were eleven midwives on shift to cover the midwifery led unit, consultant led unit, advanced obstetric care unit and triage. The midwifery coordinator was counted in the staffing numbers, this was not deemed to be adequate against the number of patients or level of acuity.
- The service was one of the first maternity units in the country to successfully implement an apprenticeship scheme for maternity support workers (MSWs). A cohort of 11 MSWs completed the 18-month senior healthcare support worker level three apprenticeship. Combining practical hospital experience with learning at a local college, the apprenticeship offered the opportunity to gain skills and knowledge specific to maternity care. The scheme was supported by the Royal College of Midwives.

Medical staffing

Maternity

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

- The service had enough medical staff to keep women and babies safe. There were 6180 births between March 2020 and February 2021 with 16 obstetricians in post. The ratio of consultant to births was 1545.4. This falls within national guidelines.
- There was a resident consultant anaesthetist presence Monday to Friday 8am to 6pm. Outside of these times there was a non-resident consultant on-call. There was night cover Monday to Friday 6pm to 8pm and at the weekend was 8am to 8am. No gaps in the on-call rotas were identified between 30 December 2019 to 09 March 2021.
- The service always had a consultant on call during evenings and weekends. Labour ward rotas for obstetrics and gynaecology consultant cover from April 2020 to March 2021 were reviewed and minimal gaps were identified at trainee two and three levels only. Within the service there was 132 hours of resident consultant labour ward cover. This was achieved by four days of 24-hour cover and three days of 12-hour cover. We reviewed rotas provided and were assured that appropriate medical staffing was provided seven days per weeks, 24 hours per day.
- There was an operational process to cover absence. We were told that from Monday to Friday the clinical administration team used the 'How to manage client activity standard operating procedure (SOP)' to ensure the emergency services, including the elective sections, were prioritised if an absence was reported.
- The theatre staffing figures showed actual funded establishment for both obstetrics and gynaecology was 47.21 whole time equivalent (WTE). The current staff in post at the time of inspection was 49.40 WTE.
- We asked the trust what impact COVID-19 had on training schedules and were told that training had all been moved to virtual training. However, at the time of inspection, there was no multidisciplinary team (MDT) training being delivered within the service, including virtual sessions.

Records

Staff did not always keep detailed records of women's care and treatment. There were multiple systems in place for staff to document in, which led to reduced oversight of patient care. However, records were stored securely, and most were available to staff providing care.

- We reviewed women's notes during the inspection and found that records were held on multiple systems which didn't flow effectively. To have a full overview of a woman's notes staff had to access different systems, for example, there was an electronic prescribing system, however, fluid records were paper based, and other information held elsewhere.
- When women transferred to a new team, we found that antenatal notes had not always been incorporated within post-natal notes. It was highlighted in HSIB reports 1905-697 (August 2020) that there has been occasion where 'There does not appear to have been a dynamic approach to capturing and managing the risks relevant to the mother across the maternity pathway. Risks from previous pregnancies, antenatal and intrapartum care … [were] documented in different formats. The clinicians caring for the mother were not aware of the full clinical picture'.
- Further HSIB recommendations (1908-1116: March 2020) stated 'the trust to ensure that all antenatal assessments and identified risk factors are fully documented in the patient notes in line with the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) standard'. We did not see evidence to provide assurance that the trust had acted on this recommendation.

- Despite these recommendations being highlighted within these reports we found little or no improvement in this at the time of our inspection.
- We observed that the application of the 'fresh eyes' approach had newly commenced, the process was not embedded, there was no continuity in practice, and not all records had 'fresh eyes' noted in records.
- We reviewed NRLS and found that, between June 2019 and December 2020, 81 incidents had been recorded relating to documentation (including electronic and paper records, identification and drug charts).
- Maternity records were stored securely within the maternity unit.

Medicines

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

- There was one HSIB report which made two recommendations stating that the trust should ensure that there is a robust system in place for the safe prescribing and administration of all ongoing medicines for maternity in-patients. However, we saw no evidence that the trust had acted on this.
- Staff followed systems and processes when prescribing, administering, and recording medicines. However, we observed several missing daily fridge temperature checks on Norfolk ward (eight), Whirlow ward (13), the midwifery led unit (28) and consultant led labour ward (53) from January to 9 March 2021.
- Drugs occasionally lacked a double signature (as per trust process) both on Norfolk and Whirlow wards (5) and there was evidence of missing boxes of iron tablets on Whirlow ward. These were escalated to the appropriate staff member during the inspection.
- We found missing controlled drug checks on the midwifery led unit (17) and consultant led unit (8) from January to 9 March 2021. In addition, we found epidural infusion bags had been signed for with no patient name (2). This was escalated with this trust at the time of the inspection and dealt with by the ward manager.
- We reviewed the expiry dates of medicines on all areas we inspected and found that all medicines were in date as required. We were told there were three monthly pharmacy audits undertaken.
- Emergency medicines were stored centrally with ease of access for staff. During the inspection we reviewed the PPH box and found no concerns. All drugs according to checklist were in the box, in date, tags checked, and matched check sheet.

Incidents

The service did not always manage patient safety incidents well. There were delays in the investigations of incidents and lessons learned were not always shared amongst the whole team and the wider service. When things went wrong, there was concerns that there was a lack of transparency.

- Prior to inspection, we had been informed of five maternal deaths, only three of which had been reported via the National Reporting and Learning System (NRLS) system and investigated as serious incidents.
- The trust had reported five deaths of women who met the criteria for a maternal death between October 2019 and December 2020. Three of the cases relate to women receiving their maternity care at the trust due to complexity which couldn't be managed at their local maternity unit. The other two cases related to deaths at a very early stage of the pregnancy, eight weeks and 13 weeks gestation respectively.

Maternity

- NHS Improvement (2017) Learning from Deaths states “Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly”. However, all cases had been considered by the trust’s internal serious incident group as potential serious incidents, but none had been declared as a serious incident. Two of these deaths had been considered by a Coroner, two deaths were still within the coronial process and the final case did not progress to an inquest.
- We reviewed serious incident (SI) process for maternity services. There were 13 serious incidents reported by the trust between June 2019 and December 2020. All but two incidents were reported outside the serious incident timelines. Serious incidents were events in health care where there was potential for learning, or the consequences were so significant that they warranted using additional resources to mount a comprehensive response.
- On inspection, we were informed all incidents were reviewed at the rapid review meeting prior to escalation at the trust serious incident group (SIG). There were no terms of reference for the rapid review group, and there was no identification of when the meeting was quorate.
- The SIG would then decide if an incident would be declared as an SI or not, then reported to the National Reporting and Learning System (NRLS) system. We found there was no obstetric representation on this group. To report a serious incident the team were required to submit a paper explaining the incident but were not invited to present or discuss the incident in person. This delayed the incident reporting process, which was contrary to the serious incident framework requirements and in reporting within two working days.
- We reviewed NRLS and found between June 2019 and December 2020 there were 768 incidents reported of which eight were reported as moderate harm, 148 low harm and 608 no harm. We were not assured that patient outcomes and the grading of incidents matched the impact or potential impact of harm to the patient or staff member. After speaking with staff, we were aware of two further incidents that could not be found on the NRLS system.
- Therefore, this prevented some incidents/ serious incidents from being investigated, the root cause identified, and lesson being learnt. During a review of recent HSIB incidents, we were not assured that managers shared learning, with their staff or shared learning in a timely manner.
- Staff said they understood the duty of candour process and would apologise to women if there had been an error in care. However, due to the inconsistency of the grading of incidents we could not assured that there was an open and transparent method which gave women and families a full explanation when things went wrong in all cases.
- There were zero never events within obstetrics in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. We were not assured managers shared learning with their staff about never events that happened elsewhere. Staff were not aware of any never events which had occurred within the trust and were unable to recall any such incident in the past which was discussed with them.
- Following the inspection, the trust updated the escalation process within Trust wide ‘Incident Management Policy- including the Management of Serious Incidents and Never Events’. The policy now reflects any actual or suspected serious incidents or never event to be escalated to the Healthcare Governance Team within one working day of identification.

Safety Thermometer

- The trust stopped collecting the generic safety thermometer from June 2019 following the introduction of the Nursing and Midwifery Quality Dashboard. The data relating to patient pressure ulcers and falls was automatically extracted

from the trust report system and presented on the nursing and midwifery dashboard. We reviewed the dashboard provided by the trust which covered a period from April 2018 to March 2021 and found there had been 17 Falls (11 insignificant, six minor) and 10 pressure ulcers (two were grade three, and one ungradable). We found that the management team had not highlighted pressure ulcers as an area requiring improvement.

- MRSA was identified on 17 occasions within the maternity department from April 2018 to March 2021. All of these were identified as a result of routine screening and none were bacteraemias.

Is the service effective?

Requires Improvement

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

Patient outcomes

Staff monitored the effectiveness of care and treatment. Timeliness of reviews and implementation of change was variable, which delayed improved outcomes for women.

- Managers and staff carried out a programme of repeated audits to check improvement over time. Several audits and projects were undertaken by the obstetrics, gynaecology and neonatology directorate audit programmes. The trust told us all projects had been through the trust's clinical effectiveness committee and subsequent actions identified from the projects had been followed up to completion. All projects were now considered 'complete' and appropriate re-audits set or already in progress. We were told the pandemic had meant some aspects of the audit cycle had been interrupted and national guidance meant that some audit processes suspended.
- We were not assured that managers shared and made sure staff understood learning and improvements identified from the audits.
- The service had a higher than expected risk of readmission for elective care than the England average. There was 4.3% of unplanned maternal readmission within 42 days against a national average of 3.3%. However, the service had a lower than expected risk of readmission for non-elective care than the England average.

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

- The service maintained a maternity quality dashboard. However, the dashboard did not benchmark against national indicators, nor did it provide target figures to achieve. There were no balances or checks for comparison and displayed more as facts of information than a dashboard or benchmarking tool. Regional post-partum haemorrhage comparison figures were provided but we were not assured that action was taken as a result of the information.
- The dashboard was maintained monthly and 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 (cot acuity, preterm delivery), public health information and stats analysis. However, this did not cover all data in regional or national dashboards.

Maternity

- The service participated in relevant national clinical audits. The service had contributed to the National Neonatal Audit Programme, MBRRACE UK (mother and baby: reducing risk through audits and confidential enquiries) maternal, newborn and infant clinical outcome review programme, National Maternity and Perinatal Audit and ATAIN (avoiding term admissions into neonatal unit) since the previous inspection.

National Neonatal Audit Programme

In the 2019 National Neonatal Audit Sheffield Teaching Hospitals NHS Foundation Trust's performance in the two measures relevant to maternity services was as follows:

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).

- There were 159 eligible mothers identified for inclusion in this audit measure for your unit. Of the mothers with a recorded outcome, 96.9% were given a complete or incomplete course of antenatal steroids; this was above the national average, where 91.3% of eligible mothers were given at least one dose of antenatal steroids.

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

- There were 53 eligible mothers identified for inclusion in this audit measure for your unit. Of the mothers with a recorded outcome, 88.7% were given magnesium sulphate in the 24 hours prior to delivery; this was above the national average, where 82.1% of eligible mothers were given magnesium sulphate.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

- For perinatal mortality, the latest MBRRACE UK data was published in December 2020 and is based on births in 2018. Based on this the perinatal mortality rate (per 1000 births) was more than 5% higher than the comparator group, and the rate excluding congenital anomalies was up to 5% higher than the comparator group.
- The trust told us that data reported to MBRRACE UK at the time of inspection showed Sheffield Teaching Hospital NHS Foundation Trust had better than expected notifications for perinatal mortality. The trust had reported 3.65 (per 1000 births) notifications for perinatal deaths (still births and neonatal deaths) against an expected rate of 6.9 (per 1000 births) notifications.
- The trust submitted information post inspection which showed that there were 329 instances of obstetric haemorrhage of 1500mls or more between March 2020 and March 2021. This was double the regional average.

National Maternity and Perinatal Audit.

- The service has a higher than the national average rate for caesarean births overall, caesarean births (emergency), unplanned maternal readmission within 42 days and term babies with a five - minute Apgar score of less than seven.
- The services at Sheffield Teaching Hospital recorded 21.7% of labour was induced against a national average of 30.6%.
- The services at Sheffield Teaching Hospital recorded 38.1% obstetric haemorrhages of 500mls or more against a national average of 32.1%.
- The services at Sheffield Teaching Hospital recorded 1.9% obstetric haemorrhages of 1500mls or more against a national average of 2.9%.

Maternity

- The services at Sheffield Teaching hospital recorded 29.7% of caesarean sections overall against a national average of 26.7%.
- The services at Sheffield Teaching Hospital recorded 16.9% of caesarean sections performed as an emergency against a national average of 15.0%.
- The services at Sheffield Teaching Hospital recorded 4.3% of unplanned maternal readmission within 42 days against a national average of 3.3%
- The services at Sheffield Teaching Hospital recorded 1.6% of Term babies with a five - minute Apgar score of less than seven against a national average of 1.2%.

Competent staff

We were not assured the service made sure all staff were competent for their roles.

- In addition to this, when interviewing staff there was confusion about what CTG training package the trust used. Despite fetal monitoring being identified previously in our 2015 inspection, recommendations from national guidance and the findings from the HSIB investigation the service and trust had not identified this as a significant concern. They had lacked urgency and pace in implementing actions to mitigate these risks therefore exposing patients to risk of harm.
- A training plan had been implemented to address training delays resulting from COVID-19. However, recognition of issues and implementation of action plans was not prompt or timely. No dates were recorded in relation to when concerns were identified, and no actions documented to mitigate the risk until training implementation.
- In line with national policy the trust had implemented the Advocating and Educating for Quality Improvement (A-EQUIP) system.
- There were no live skills and drills training, such as pool evacuation or simulations undertaken within the maternity unit.
- Staff were supported by the team of practice educators to support staff in developing and building their midwifery skills. Competency forms, supervision and assessments were in place for specialist tasks such as perineal suturing, and the administration of intravenous (IV) medicines.
- However, we were told that no additional training was provided for staff working in the AOCU, which would be best practice. Midwives had not received additional accredited training in relation to seriously ill women in the AOCU, it was staffed by either the registered nurse (RN) or an experienced midwife. This meant, more junior staff did not have the senior support to develop their midwifery skills.
- Managers gave all new staff a full induction tailored to their role before they started work. Staff were provided with a comprehensive induction and preceptorship logbook which provided information in relation to the preceptorship programme, what was expected of the staff member, linked strategies, each training element of the programme, and final sign off induction and preceptorship. However, there was no timeline or targets to achieve the competencies attached to the programme.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women.

Maternity

- Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. The trust provided evidence to support a collaborative working culture within the service which supported changes to pathways of care. Some of the improvements occurred formally through a number of well-established forums i.e. labour ward forum, following publication of new guidance i.e. The Royal College of Anaesthetists Enhance Maternal Care Guidelines (2018) and following incidents in practice for example, joint working around neonatal hypoglycaemia and keeping babies warm in obstetric theatre.
- A second example provided by the trust highlighted improvement as a result of an RCM labour ward leaders workshop 'working together for safer care'. Members of the multi-disciplinary team (consultant anaesthetist, obstetrician, obstetric trainee, two labour ward co-ordinators and the consultant midwife) discussed and developed a standardised handover designed to maximise and embed a patient safety culture, as recommended by National Patient Safety Agency (2004). 'Focus 15' was developed, this was a set of key principles, including team introductions and a process for a protected 15 minutes of handover. All members of the multi-disciplinary team (MDT) had signed up to the principles and values. To embed this a banner was developed which informs everyone that a protected handover was occurring.
- The trust stated that staff held regular and effective multidisciplinary meetings to discuss women and improve their care. However, we reviewed minutes provided by the trust. The review highlighted a variability in the quality and quantity of discussions held within each meeting for example, some agendas were very minimal, items on the agenda were inconsistent and not followed up at the next meeting, and actions were not consistently reviewed and updated at every meeting.
- Staff worked across health care disciplines when required to care for women. We saw evidence of cross agency working by means of the Yorkshire and Humber (Y&H) maternity focus group which ensured the core set of indicators relevant to maternity services in the Y&H region were reviewed. It provided a forum for identifying themes and cross networking.
- During the inspection and in the data reviewed, we saw no evidence of staff referring women for mental health assessments when they showed signs of mental ill health, including depression. However, following inspection the trust stated they did provide a dedicated mental health nurse who works in the service and carries out perinatal mental health clinics.
- An incident was reported where the unit had experienced challenges around staffing a second obstetric theatre for a category one caesarean section There was already a category one crash call in theatre one but was reportedly insufficient staff to fully staff the second theatre. The COVID-19 status of the second patient was unknown. Therefore, staff from both theatres had to go in and out of zones in order to provide the emergency care required for the women. The second patient had been a placental abruption where the placenta had subsequently become severely stuck and certain drugs and equipment was required. Staff were required to retrieve items for the women and had they not breached the zones; the patient was at a high risk of haemorrhaging.

Is the service responsive?

Inspected but not rated

Our rating of responsive stayed the same.

Access and flow

Maternity

People could not always access the service when they needed it or receive the right care promptly. Waiting times were not always monitored in line with national standards.

- We were not assured that managers monitored waiting times in the labour ward assessment unit. However, there was no evidence to suggest that women could not access services or emergency services when needed or that treatment was out with agreed timeframes and national targets.
- Managers worked to keep the number of delays to a minimum by using the red flag system. If a midwifery red flag event occurred the midwife in charge of the service or shift would be notified. We observed that red flags were recorded. A red flag event would be one of the following, for example, if there was a delayed or cancelled time critical activity, missed or delayed care, missed medication during an admission, delay of more than 30 minutes in providing pain relief, delay of 30 minutes or more between presentation and triage, full clinical examination not carried out when presenting in labour, delay of 2 hours or more between admission for induction and beginning of process, delayed recognition of and action on abnormal vital signs, or any occasion when one midwife was not able to provide continuous one-to-one care and support to a woman during established labour.
- Information provided by the trust showed between September 2020 and February 2021 there were 21 occasions where a red flag event was declared for a delay in commencing or continuing the induction of labour process. We also looked at incidents reported where we saw significant numbers of women were waiting for induction of labour which ranged from six to 20 women at any one point in time.
- Managers monitored that patient moves between wards were kept to a minimum. Managers monitored transfers and followed national standards.
- Staff supported women and babies when they were referred or transferred between services.
- Managers and staff worked to make sure women did not stay longer than they needed to. Staff told us that women were signed off as safe for midwifery led care by doctors before discharge. Any paediatric reviews were completed as required and information was shared with women about safe sleeping, feeding, things to look out for in baby and also things to watch out for in themselves, prior to discharge. During pre-discharge talks with women, leaflets with emergency contact numbers were provided.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate because:

Leadership

We were not assured the leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective in implementing meaningful changes that improved safety.

- The maternity service was a tertiary service covering Sheffield, South Yorkshire and Bassetlaw (and some North East of Derbyshire). For some highly specialised services such as fetal medicine and primary pulmonary hypertension in pregnancy the catchment population extends considerably beyond that described. The trust experienced a change in several senior posts in 2020. The service was led by an operations director, head of midwifery, deputy head of midwifery and clinical director for obstetrics, gynaecology and neonatal.

Maternity

- The triumvirate were supported through clear professional arrangements. The operations director and nurse director / head of midwifery were line managed by the clinical director and have professional reporting lines respectively to the chief operating officer and chief nurse. the clinical director was directly managed by the chief executive and has professional reporting responsibilities to the medical director (operations).
- There was a governance group in place which consisted of an 8a matron, two band 7 midwives, three band 6 midwives, one gynaecology lead, one anaesthetic lead, and one obstetric lead.
- Leaders lacked knowledge of national serious incident processes by following in-house methods, thus delaying investigatory processes which was contrary to the national serious incident framework requirements of reporting a serious incident within two working days. There were concerns that some serious incidents may have been missed, not appropriately investigated, the root cause identified, or correct lesson identified, learned and shared.

Vision and strategy

- The trust corporate strategy was in the process of being updated during the time of the inspection. We were told it had been delayed due to the COVID-19 pandemic. We were also told that the maternity safety strategy would be updated once the trust corporate strategy became available. As a result, the maternity safety strategy was also out of date at the time of the inspection.

Culture

The service had a culture where staff could raise concerns without fear. However, we were not assured concerns were progressed appropriately. Most staff felt respected, valued and supported. Staff were focused on the needs of the women receiving care, and the service promoted equality and diversity in daily work.

- Information from the service national medical staff survey 2019, published 2020 highlighted that 88% (17% improvement since 2018) of staff often / always looked forward to going to work; 93% (decline of 1% since 2018) agreed / strongly agreed that they knew what their responsibilities were; and 83% (9% improvement since 2018) were personally pleased with the standard they were able to perform their work.
- When asked, in the last 12 months had you personally experienced discrimination at work from a manager / team leader or other colleagues, the 'Jessop Wing national medical staff survey 2019' showed a 93% response rate for no discrimination. When asked, if the organisation treated staff who were involved in an error, near miss or incident fairly, the survey showed a response rate of 61% against agree or strongly agreed.
- Information from the 'Jessop Wing national nursing and midwifery staff survey 2019', published 2020 highlighted that 58% (7% improvement since 2018) of staff often / always looked forward to going to work; 90% (same as 2018) agreed / strongly agreed they knew their responsibilities; and 72% (12% improvement since 2018) were pleased with the standard they were able to perform their work.
- When asked, in the last 12 months had you personally experienced discrimination at work from a manager, team leader or other colleagues, the survey 2019 showed a 90% response rate for no discrimination. When asked, if the organisation treated staff who were involved in an error, near miss or incident fairly, the survey showed a response rate of 46% against agree or strongly agreed.
- Following the inspection, the trust provided evidence they have a process in place to review the staff survey results and action plans.

Governance

Maternity

Leaders did not operate effective governance processes to continually improve the quality of the service and safeguard the standards of care.

- We found there was limited oversight of maternity services by the trust board and there was unclear process of how ward to board assurances were gained about the quality and safety of services. Staff including some senior leaders could not clearly articulate the governance framework for the directorate and how this should happen.
- We were not assured that the trust had an effective risk and governance system that supported safe and quality care. This exposed women to the risk of harm. We talked to members of the senior team and were told there was 'no way to compare or assure that [maternity services] were comparable to other trusts'
- We found there was a lack of robust governance systems and processes. Staff, including senior leaders, could not clearly articulate how risks were being managed or what the identified risks in the department were.
- The maternity risk register supplied was not robust, lacked evidence and significant detail, including the date the risk was added to the register or evidence of when it was last reviewed. Some of the risks had been on the register since 2017. This included non-compliance of CTG annotation guidelines standards.
- We were informed that rapid review meetings were held three times per week, with clinical attendance which provided challenge. However, we were informed during the inspection that this alternated between, every 72hrs, to twice a week depending on the level of reviews there was to discuss. Attendance included the governance team, obstetric consultants, a consultant neonatologist, governance for neonatal, matron, anaesthetist, junior doctors, midwives, and deputy head of midwifery. However, it was established that the meeting had been running for 18 months with no clear terms of reference and did not identify when the meeting was quorate. This meant we could not be assured that appropriate scrutiny was given to the rapid review process. In addition, although a proforma was completed, the meeting didn't commence taking minutes until December 2020.
- Following the inspection and as part of the requirements of the urgent conditions of registration, the trust produced a terms of reference for the rapid review meeting which included details of when the meeting is quorate.
- Following review of three months labour ward forum meeting minutes (Dec 2020 to Feb 2021), although governance was identified as a standing agenda item, there were no occasions where there were any governance issues raised, shared or discussed. On one occasion it was documented 'nobody in attendance to represent department'. The trust provided evidence of a labour ward forum meeting minutes (Nov 2020), where governance was discussed, however, this did not include a review of the risk register or the maternity dashboard for example.
- Immediately after the inspection CQC took enforcement action using our urgent powers whereby we imposed conditions under section 31 on the trust's registration as people may or will be exposed to the risk of harm. These included: -
  - The provider must implement an effective system to manage and respond to patient risk.
  - The provider must implement an effective risk and governance system
  - The registered provider must implement an effective system to ensure that medical and midwifery staff have the qualifications, competence, skills and experience to care for and meet the needs of women and babies safely
- Following the inspection, the trust has provided information on the immediate actions they had taken to mitigate the risks we had identified at the inspection. The trust has since produced a detailed action plan, focusing of the conditions of registration and will be providing regular reports to CQC on the actions taken to improve the quality and safety of services. CQC will continue to monitor these actions through our routine engagement.

Managing risks, issues and performance

Maternity

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and actions to reduce their impact were not timely.

- The previous maternity safety strategy (2017-2020) outlined the trust's key priorities, measures and associated work-streams to deliver a safe and sustainable service to women and their families. It provided a framework within the trust's existing governance infrastructure and outlined the enabling conditions required to deliver the strategy for the period 2017-2020. The safety strategy was discussed at bimonthly meetings at board level and action plans were drawn from this and presented through governance meetings.
- On review of the action plan provided, it was evident that the plan with 12 outstanding amber actions had not been reviewed or updated since October 2018. Items on the plan had not progressed since and included actions such as, increasing neonatal nurse staffing, medical staffing, environmental refurbishment, NNAP standard temperature monitoring, and numerous external recommendations in relation to early pregnancy emergency access to services and the role out of electronic maternity records to name a few.
- A business continuity and internal incident plan was in place, and up to date. The plan described the procedures used by the trust to respond to a business continuity or critical incident. However, the plan was generic and did not provide specific instruction or guidance for the maternity unit staff in the protection of labouring mothers, newborns or babies requiring neonatal care, in the event of a major emergency.

Managing information

We were not assured that the service collected reliable data and analysed it effectively. Data was not always in easily accessible formats due to the multiple systems in use. Data or notifications were consistently submitted to external organisations as required, but recommendations were not always shared or implemented in a timely manner.

- Prior to inspection we reviewed the findings and recommendations from 18 Healthcare Safety Investigation Branch (HSIB) reports. Sixteen of the reports had recommendations for actions to be taken pertaining to the trust. The reports provided showed that there were 44 themes and five recurring themes. We were not assured that sufficient consideration had been given to address these concerns. The recommendations included:
  - undertaking a 'fresh eyes' review (seven separate reports),
  - placentas sent for pathological examination including histology (12 separate reports),
  - CTG monitoring (nine separate reports),
  - robust system for safe prescribing of all ongoing medicines (two separate reports)
  - risk assessments/monitoring (14 separate reports).
- Following the Ockenden Review, the trust introduced a new benchmarking process in January 2021. Following further meetings of the senior midwifery team a bench-marking flowchart was agreed (February 2021) to ensure that a clear and transparent process was followed, regarding who was responsible for the benchmarking and contributing to the monitoring subsequent action plans.
- Recent examples of how practice has changed following benchmarking, include (one) HSIB report into neonatal collapse alongside skin-to-skin contact (HSIB 2020) and (two) MBRRACE UK rapid review into SARS-CoV-2-related and associated maternal deaths. For example:

New work stream identified:

Maternity

- Collaboration between the multidisciplinary teams to take forward a programme of work, called 'Skin to Skin Check-in'. Its combined efforts to reduce term admissions to the neonatal unit through attention to key principles and evidences around:
  - Thermoregulation
  - Skin to skin contact
  - Safer holding and sleeping for babies

Outstanding practice

N/A

Areas for improvement

MUSTS

- The trust must ensure systems are put into place to ensure staffing is actively assessed, reviewed and escalated appropriately to prevent exposing women and babies to the risk of harm. **Regulation 18 Staffing.**
- The trust must ensure systems are put in place to ensure that midwifery staff were suitably qualified, skilled and competent to care for and meet the needs of women and babies within all areas of the maternity services, including areas where women were waiting to be seen. **Regulation 18 Staffing**.
- The trust must ensure effective risk and governance systems are implemented that supports safe, quality care. **Regulation 17 Good governance**.
- The trust must improve the monitoring of the effectiveness of care and treatment. Timeliness of reviews and implementation of change. **Regulation 17 Good governance**.
- The trust must ensure risk assessments and risk management plans are completed in accordance with national guidance and local trust policy and documented appropriately. **Regulation 12 Safe care and treatment.**
- The trust must ensure correct processes are in place for investigating serious incidents that reduce delays and accuracy of investigations. **Regulation 12 Safe care and treatment.**
- The trust must improve lessons learned and the sharing of lessons learned amongst the whole team and the wider service. **Regulation 12 Safe care and treatment.**
- The trust must ensure that all staff are competent for their roles. **Regulation 12 Safe care and treatment.**
- The trust must ensure improved infection control. **Regulation 12 Safe care and treatment.**
- The trust must ensure safe systems and processes to prescribe, administer, record and store medicines are in place and applied. **Regulation 12 Safe care and treatment.**

SHOULDS

- The trust should implement electronic recording as per MBRRACE UK guidance.
- The trust should ensure fridge monitoring is undertaken as per the trust policy

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two inspection managers, two team inspectors and two specialist professional advisors. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

How we carried out the inspection

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

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.

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

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

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