Barnsley Hospital NHS Foundation Trust

Barnsley Hospital

Inspection report

Gawber Road
Barnsley
S75 2EP
Tel: 01226730000
www.barnsleyhospital.nhs.uk

Date of inspection visit: 20-21 April 2023
Date of publication: 01/09/2023

Ratings

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

Our findings

Overall summary of services at Barnsley Hospital

Good 

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 Barnsley Hospital.

We inspected the maternity service at Barnsley 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.

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

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

We previously inspected maternity jointly with the gynaecology service, so we cannot compare our new ratings directly with previous ratings from the last inspection in 2016.

Our rating of this hospital stayed the same.

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

How we carried out the inspection

During our inspection of maternity services at Barnsley Hospital NHS Teaching Foundation Trust we spoke with staff including leaders, obstetricians, anaesthetists, midwives, theatre staff, maternity support workers and women and birthing people.

We visited all areas of the unit including the antenatal clinic, maternity triage, the Barnsley birth centre, day assessment and mixed (antenatal and postnatal) ward. We reviewed the environment, maternity policies 7 maternity records and 9 prescription charts. 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. Following the inspection, we reviewed data we requested from the service to inform our judgements.

The trust provided maternity services at hospital and local community services and 2,972 babies were born at the trust during 2022.

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

Maternity

Requires Improvement

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

- Compliance to mandatory training, including safeguarding training was low, there was low compliance for midwifery appraisals, obstetric vacancies, pregnant women and people did not have access to their antenatal notes and separate postnatal notes were not always available for babies.

However:

- The service controlled infection risk well**,** the design, maintenance and use of facilities, premises and equipment kept people safe. 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.
- Staff felt respected, supported and valued and were clear about their roles and accountabilities. People could access the service when they needed it and did not have to wait too long for treatment.
- Following our inspection, we received 439 feedback forms from women and birthing people who had recently used maternity services at the hospital, the vast majority was positive and often outstanding feedback.
- Leaders were visible and approachable in the service, they had effective governance processes, identified, escalated, and managed risk effectively. The service worked in partnership with their local Maternity Voice Partnership, engaged well with women and birthing people to make meaningful improvements.

Is the service safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff, but not all staff were up-to-date, although leaders managed this proactively.

The mandatory training was comprehensive and met the needs of women, birthing people, and staff. Mandatory training included but was not limited to; fire safety, equality and diversity, information governance, infant feeding, and human factors. The training requirement for midwives had increased with the development of the core competency framework which followed from the Ockenden report (2022). This meant every midwife was on mandatory training for a full week every year. The requirement was the same whether a midwife was full or part-time.

Mandatory training was a training requirement determined by women's services through policy. It was compulsory for staff to attend all training relevant to their role. The compliance target was 90% or 95%, dependant on the topic.

The practice facilitators had developed a fetal monitoring training day which commenced roll-out in September 2022. It was mandatory for all obstetricians and midwives to complete the training day annually. Training included a simple communication tool developed by the Royal College of Obstetrics and Gynaecology, to improve escalation of a pathological CTG.

Maternity

Leaders monitored compliance monthly, and maternity services were on target to meet 100% compliance trajectory by the end of 2023. As of March 2023, CTG training compliance was 42% for midwives, 50% for obstetric consultants, and 40% for all other obstetric doctors. However, this training day was in addition to the session covered in mandatory training and contained a competency-based assessment. Ninety eight percent of all midwives and 100% of obstetric staff had passed the assessment.

The fetal monitoring (FM) lead and FM consultant or registrar also facilitated weekly CTG teaching updates. Cases were presented that raised the interest of staff. Learning points were shared on Wardbook, a closed social media group and emailed to staff to ensure learning was disseminated.

Training was multidisciplinary during Practical Obstetric Multi-Professional Training (PROMPT), emergency skills and drills. Compliance was 87.7% for midwives, 90% for anaesthetic doctors, 87.5% for obstetric consultants but 36% for all other obstetric doctors. PROMPT was mandatory training for all clinical staff working in maternity (excluding neonatal doctors), and live skills and drills were planned too as part of delivering best practice for training. There was an emphasis on multidisciplinary training leading to better outcomes for women, birthing people and babies.

Training was on a rolling programme and included 5 of the maternity emergency scenarios, set out in the core competency framework. Algorithm flow charts were on display in clinical areas. Staff received annual training in adult and neonatal life support. Training compliance was 82.7% for hospital midwives, 89.4% for community midwives, 96.1% for neonatal doctors and 70% for neonatal consultants.

Medicines management training included competency testing for midwives. Compliance was 88.4% for hospital midwives and 71% for community midwives. Practice facilitators delivered medicine management updates during tea trolley teaching too. This included topics such as midwives' exemptions, patient group directives and any updates related to medicines management. Medicines management was also included during midwives mandatory training week which was annual, and PROMPT training.

Medical staff received updates about specific emergency medications during obstetric skills and monthly postgraduate teaching. Some medication updates were also shared in the audit or perinatal meetings. For example, the value of corticosteroids in preterm labour.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

There was an information board dedicated to staff learning on the antenatal and postnatal ward. These included details of tea trolley training, a safety bulletin and clear and concise guidance on what to do when a fetal bradycardia occurred.

Safeguarding

Compliance to safeguarding training was low, although leaders had mitigated risks, staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so.

Not all staff had received training specific for their role on how to recognise and report abuse. Training records showed that only 66.6% of the maternity establishment had completed Level 3 safeguarding children training, and only 60.1%

had completed safeguarding Level 3 adults training. Only 29.1% of obstetric and gynaecological staff had completed level 3 safeguarding children training, and only 73% of obstetric and gynaecological staff had completed Level 3 safeguarding adults training. However, although compliance for safeguarding training was low, it was proactively managed, and leaders had mitigated risks.

Leaders acknowledged low compliance for safeguarding training posed a risk to safeguarding within maternity. Safeguarding was added to the maternity risk register, to monitor and review this risk. Compliance was low due to capacity of the safeguarding team. There was a Named Midwife and Safeguarding Maternity Advisor within the integrated safeguarding team, and more champions were to be trained to support with supervision.

Safeguarding training was facilitated by the safeguarding team. Compliance was low due to capacity of the safeguarding team. Additional staff were being employed via the NHS Professional Agency (NHSP) to mitigate capacity issues in the safeguarding team, and additional technical infrastructure had been procured to help the safeguarding team to work efficiently.

Managers reviewed safeguarding training and supervision compliance monthly to help improve compliance and submitted a report to the Safeguarding Steering Group with an updated action plan. We were told staff who were not up-to-date had been allocated training on the electronic roster, and safeguarding supervision was being allocated by the safeguarding champion. Training dates for the next 12 months and scoping for venue size was completed by November 2022. This provided capacity for the number of staff that were not compliant at that time.

As of January 2023, midwifery mandatory training had been incorporated into the mandatory full-week annual training. This now included 3.5 hours of safeguarding children's training, and 1 hour of safeguarding supervision. All maternity and obstetric staff also received an annual update on perinatal mental health during the annual PROMPT Day.

Staff knew how to identify adults and children at risk of, or suffering significant harm, and worked with other agencies to protect them. Staff routinely asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records. We reviewed 7 care records and saw all pregnant women and birthing people were routinely asked about domestic abuse and their mental health. We also saw referrals were made when additional support was needed.

Information regarding families who needed support and interventions related to safeguarding was shared with the corporate safeguarding team. The corporate team maintained a database and monitored all active cases to ensure the trust maintained full oversight of complex cases.

If an out-of-area pregnant woman or birthing person attended for care, staff contacted the unit where they had booked or their GP, to determine if there were any safeguarding concerns. They did not rely on professional curiosity.

If there was a safeguarding alert on the electronic record, the safeguarding plan and placed in a separate baby record, following the birth. Administrative staff made up the baby notes. However, we were told this could be missed, due to lack of admin support for the past 12 months. This meant safeguarding issues could be missed or actions could be delayed, and the service had not implemented any mitigations for this. However, during the factual accuracy process the service provided evidence which showed there had been no incidents reported in the previous 12 months where safeguarding information had not been recorded in a baby's record and during the factual accuracy process the trust advised that they had recruited administrative support.

Maternity

The safeguarding team visited clinical areas daily and offered staff support. They had introduced a '5 for 5'system where every month they asked staff 5 different questions based on recent themes and trends. The process raised awareness, encouraged engagement with frontline staff, and staff feedback contributed to the safety brief for the following week.

Staff read the safety brief out at every handover and discussed safeguarding concerns at handovers in all clinical areas. If a baby was to be placed into the care of the Local Authority, memory boxes were provided for birth parents and foster carers The boxes included early mementoes to start the "life story" work and promoted ongoing connection during safeguarding proceedings and supported the parent(s) through potential grief. No details of the foster carers were shared with the birth parents.

There were 2 perinatal health midwives who developed a package of services that included one-to-one support, group sessions, and unique antenatal educational classes for women and pregnant people who had anxieties about their pregnancy and birth. They also established a peer-to-peer support group for mothers and birthing people.

The duo had close working relationships with local mental health and social services. Women and birthing people who needed more specialist care and support had a seamless referral, and they published a quarterly newsletter for staff. This helped to share learning and highlight achievements. Shortly after our inspection the midwives won a national award from the Royal College of Midwives for improving support for women and birthing people with mental health issues in pregnancy and we received some exceptional feedback about the team

There was a maternal mental health board on the antenatal/postnatal ward which included tips on how to promote good mental health, information to raise awareness about mental health, how to make a referral and support groups. There was also an information board dedicated to safe sleep for babies which included a QR code for families to access evidence-based information. Dates for all training sessions, resources and the monthly safeguarding newsletter were updated monthly and on the intranet.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, 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. Staff cleaned equipment after contact with women and birthing people and labelled equipment to show when it was last cleaned. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service performed enhanced and more frequent cleaning of all areas to prevent the spread of COVID-19, in line with national guidance.

Staff followed infection control principles in the use of personal protective equipment (PPE). Staff used the right level of PPE, which was stored on wall mounted displays. We observed one doctor wearing a wristwatch but otherwise all staff were bare below the elbow. Hand sanitiser gels were available throughout the service, which we observed staff using as required. Laminated hand washing posters demonstrating best practice in techniques were on display above sinks.

Leaders completed regular infection prevention and control and hand hygiene audits. We reviewed the audits for the previous 3 months and noted results were consistently 100% in all areas.

The premises were all visibly clean and cleaning records and audits were up-to-date. Cleaning audits included testing staff knowledge of infection prevention and control. Results were consistently 100%. Clinical areas smelt fresh, and we saw domestic staff going about their duties throughout the day. Domestic staff knew what to do in the event of a blood spillage.

Environment and equipment

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

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. Staff followed safe procedures for children visiting the wards. All areas were accessed through a secure intercom system. Visitors were asked to identify themselves before they were allowed entry. Additional security measures included an electronic baby tagging system. However, the unit had not practised a baby abduction drill since February 2022, and we saw a visitor tailgating when a member of staff entered the Barnsley birth centre and did not check behind them.

The service completed ligature point risk assessments to ensure the environment did not present unnecessary ligature risk. The mixed antenatal/postnatal ward assessment was completed in August 2022, and the Barnsley birth centre assessment was completed in October 2022

There was a dedicated bereavement suite for families who had experienced a baby loss. However, this was on the Barnsley birth centre which meant bereaved women and birthing people might be able to hear babies cry and families celebrating.

Managers ensured all specialist equipment was serviced and calibrated. They maintained oversight of equipment to ensure it was safe and ready for use. Records demonstrated staff carried out daily safety checks of specialist equipment.

There were resuscitation trollies in each clinical area, so staff from all areas had easy access. All clinical areas had an emergency trolley for obstetric emergencies. We checked the emergency trolley in triage and the postnatal ward. There was evidence that daily checks had been completed to ensure all items were present and in-date.

Staff were required to check emergency equipment and infant resucitaires daily and replace any missing, expired or damaged items immediately. There were 6 occasions were the neonatal resuscitaires were not checked in the previous 4 weeks on the Barnsley birth centre, but otherwise daily checks were completed and used items were replaced. Equipment was available and safe for use.

Staff disposed of clinical waste safely. Waste was handled appropriately with separate colour coded arrangements for general and clinical waste. Sharps such as needles were disposed of correctly, in line with national guidance. Sharps bins were no more than three-quarters full, and closed when not in use The date opened was recorded on the bins and were within three months of expiry in all areas. Arrangements for control of substances hazardous to health were adhered to.

Staff regularly checked birthing pool cleanliness and the service had a contract for testing for Legionnaires' disease.

The service had enough suitable equipment to help them to safely care for women and babies. For example, there were pool evacuation nets in the pool rooms on the Barnsley birth centre and on the day assessment unit there was a

portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. The Barnsley birth centre had a handheld scanner which was a new and upgraded piece of equipment which could not be utilised until key staff had completed training. During the factual accuracy process the trust provided evidence that key staff had completed the training by 19 May 2023.

Assessing and responding to patient risk

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

Staff completed risk assessments and care records for each woman and birthing person attending the service. We reviewed 7 maternity care records. The lead professional was confirmed in all cases and risk factors were highlighted. Women and birthing people were allocated to the correct pathway, to ensure the correct team were involved in leading and planning their care.

Carbon monoxide screening was performed in each set of notes we reviewed, in line with best practice guidance. Staff monitored the baby's growth, and accurately plotted this.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. They used national tools such as the Modified Early Obstetric Warning Score (MEOWS). We reviewed 3 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff.

Results highlighted that 92% (47/51) of women and birthing people had their observations performed in line with guidance. Twelve women and birthing people required escalation, but only 58% (7/12) were escalated in a timely manner. No adverse outcomes were identified in the audit, and no one deteriorated due to delayed observations. An action plan had been developed to address the areas that required improvement, and all actions had been implemented. The service had not audited compliance with Early Recognition of Deterioration in Maternity Patients' guideline since September 2021 because they were waiting to transfer to a numerical MEOWS. However, as part of the factual accuracy process, the trust submitted evidence that a new guideline had been approved to move to a numerical MEOWS.

Staff knew about and dealt with any specific risk issues. For example, staff used the 'fresh eyes' approach to safely and effectively carry out fetal monitoring, in line with national guidance. Leaders audited how effectively staff monitored women and birthing people who required continuous cardiotocograph (CTG) during labour. Audit of compliance to fresh eyes during the first stage of labour was consistently 90% and results had improved since October 2022. Of those that did not have fresh eyes, no babies required further observation, treatment, or admission to the neonatal unit.

However, audit of the 'fresh eyes' approach in the second stage of labour was 71-80% for January and February 2023. There was a fetal monitoring action plan to improve gaps in compliance. This included highlighting the time 'fresh eyes' reviews were due on the Barnsley birth centre board. Fetal monitoring leads engaged with local and national groups to implement ideas that had increased compliance.

Leaders also audited if women and birthing people were routinely given information about how to monitor their fetal movements, and if a CTG was completed for all women and birthing people who presented with reduced fetal movements. We saw that audit results for 2023 were 100% for both.

The service had access to specialist mental health support (if staff were concerned about a woman or birthing person's mental health) and the service provided transitional care for babies who required additional care.

The newborn and infant physical examination (NIPE) screen was offered within 72 hours of birth and the service audited compliance to this.

Staff booked interpreters for planned face-to-face appointments. They used a language interpreting telephone service which could be available 24 hours-a-day for unplanned contacts. There was also an information board dedicated to interpreting services.

Pregnant people who chose to give birth outside of guidelines were supported. They were offered an appointment with a consultant obstetrician. They discussed their decision and agreed a birth plan together. The aim was to support choice and to ensure the birth was as safe as possible. Midwives told us the teams worked together well to support informed choice.

Managers monitored waiting times and made sure women could access emergency care and treatment when needed and within agreed timeframes and national targets. All women who attended triage were RAG (red, amber or green) rated, dependant on their clinical need and urgency. Staff contacted the obstetric on-call team if a woman needed a review.

A snapshot audit of triage waiting times was last completed in August and September 2022 and identified that 90% or more women and birthing people were seen within 30 minutes. This was in-line with local guidance. However, we did not see a plan to re-audit this.

During the inspection we attended staff handovers and found all the key information needed to keep women, birthing people and babies safe was shared. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person. The service had introduced an SBAR sticker to support staff with the handover process and were monitoring compliance to this by monthly rolling snapshot audit. The results were not shared as they were due to be discussed at the women's governance meeting on 21 April 2023.

Midwifery Staffing

The service generally had enough staff and used bank to cover gaps.

The Head of Midwifery (HoM) had completed a midwifery workforce review as a priority in November 2022. This included a review of budgets, staffing lists, required and desirable roles, the leadership structure in the midwifery staffing group, and a review of the previous staffing report in 2020, using a using a nationally recognised acuity tool. There was also a staffing review in progress when we inspected, using the same nationally recognised acuity tool. The review was expected to be complete by May 2023.

The report produced by the HoM had recommended the Board approve the required adjustments to meet the staffing levels recommended to achieve 35 % for continuity of carer. This would include an additional 2.44 whole time equivalent (WTE) band 7 midwives and an additional 0.5 WTE band 5/6 midwife. The report highlighted that maternity services would require an uplift of 5.89 additional midwifery staff to achieve a 90:10 split of midwife/maternity support worker ratio to support their ambition to offer 35% of women and pregnant people continuity of care.

However, staff had raised concerns that the staffing levels were too low for the acuity of women and birthing people in the unit, so the leadership team were awaiting the recommendations of an external review. Leaders wanted to understand the ward acuity tool in greater depth and the required training of staff to input the right data into the tool is required. An updated staffing report was being presented to the Board, in April 2023 (shortly after our inspection).

Maternity services had a comprehensive escalation policy, with clear escalation pathways for hospital and community staff. Community midwives and continuity-of-care teams were part of the escalation process but were only on-call if they did not have a clinic the following day. This allowed for rest and recuperation. Managers and specialist midwives helped during times of high acuity during their work hours.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. There were 60 red flags recorded in the previous 6 months to our inspection. This included 7 occasions (over 6 months), where the Barnsley birth centre coordinator was not supernumerary, and 11 occasions where women and birthing people had incurred a delay of 3 hours or more, between admission for induction and beginning the process.

The red flags in maternity were shared monthly in the Provider Board Measures Paper and at Women's Business and Governance, where actions were discussed in more detail. The maternity governance team reviewed red flags and worked with staff to deepen understanding around time critical activities. Delayed activity generally related to midwifery staffing on the birthing centre. This was because it was considered safer to delay an induction or augmentation than to compromise 1-2-1 care in labour, or the supernumerary status of the co-ordinator.

Funding had been secured to support a midwife post to focus on developing student placements and host more midwifery students at the unit. Leaders saw this as crucial to help improve the national shortage of midwives.

Women who had experienced a baby loss were looked after by Barnsley birthing centre midwives, supported by the bereavement team. The bereavement lead midwife managed the service, led on bereavement training and supported Barnsley birthing centre staff to care for bereaved families.

Managers generally supported staff to develop through yearly, constructive appraisals of their work. Seventy percent of nursing and midwifery staff had a recent appraisal although it was not possible to know the exact number of midwives as the percentage was amalgamated with nursing staff for gynaecology. The professional midwifery advocates and practice development midwives helped midwives prepare for appraisals and revalidation.

Managers made sure staff received any specialist training for their role. For example, midwives were encouraged to complete the examination of newborn course to streamline care and the professional midwifery advocate course. Midwife sonographers completed a postgraduate diploma or degree in ultrasound scanning before being accredited as competent. Midwife sonographers reviewed and signed off normal scans and action plans. They also provided continuity to women and pregnant people who required serial scans.

Staff told us managers and the HoM were supportive of their development and managers identified developmental opportunities and encouraged staff to apply. For example, a midwifery support worker had secured a place on the midwifery apprenticeship course which commenced in March 2023, and another had been seconded as a band 4 to support band 2s and 3s to upskill.

However, there had been no administrative staff on the mixed antenatal and postnatal ward since May 2022. This meant notes were not always immediately available when babies were admitted to the neonatal unit from the community. As part of the factual accuracy process, the trust also advised that the administrative post had been recruited to.

Medical staffing

The service did not have always have enough medical staff but were actively recruiting, used long-term locums to fill gaps and gave locum staff a full induction. Managers supported medical staff to develop through regular, constructive clinical supervision of their work and all medical staff had a recent appraisal.

There was a shortage of medical staff at all grades, but the service proactively managed gaps by using long-term locums and leaders had created 2 additional obstetric consultant posts to increase the establishment. One consultant vacancy had been filled and this position was expected to commence in October 2023. Despite an active and ongoing recruitment campaign, 1 post was still vacant. This put a strain on obstetric consultants who had to provide additional on-call cover to fill gaps including covering gynaecology when on-call, and the additional requirements of leading on multidisciplinary training and attending key meetings. We noted that 4 (weekly) incident panel meetings had to be cancelled in 2022 due to lack of consultant availability, the consultant was called away to an obstetric emergency during 1 meeting, meaning there was only partial attendance, and the perinatal mortality meeting was cancelled in January 2023 due to lack of obstetric availability.

There was a risk that there may not be capacity to provide the required consultant on-call support to specialist trainees in obstetrics, in line with the Royal College of Obstetrics and Gynaecology 2019 curriculum Entrustability Matrix. However, there had been no incidents due to inadequate obstetric cover as this was proactively managed. In addition, the trust shared their recent results for the General Medical Council survey for their obstetric trainees and we saw that 92.3% of trainees reported satisfaction with the clinical supervision provided out-of-hours. Consultants provided additional on-call cover and there were very high levels of satisfaction in relation to clinical support in and out-of-hours, which mitigated the risk in relation to training.

Managers used long-term locums to fill gaps in the rota. Locums received a comprehensive induction. The service did not use locums who were unfamiliar with the service. The trust was about to launch a new online training platform for all locum medical staff that attended the Trust. This would give them access to systems training and policies.

The service always had a consultant on-call during evenings and weekends. Consultants led 2 multidisciplinary rounds on the Barnsley birth centre throughout the day, where they reviewed and planned care of women and birthing people, and shared learning with the rest of the team.

The escalation policy included guidance for staff about medical staffing levels and when staff must contact the consultant and ask them to attend. Staff told us this worked well, and they were familiar with it.

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

All planned caesarean sections took place in main theatre with a dedicated team and were separate to Barnsley birth centre acuity. Third and 4th degree perineal repairs and manual removal of placenta(s) took place in the theatre on the birthing suite.

Maternity

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date and stored securely. However, postnatal notes were not always easily available.

Records were a mixture of electronic and paper. Women and birthing people's antenatal and birth notes were electronic, and handheld following the birth. Gaps between different electronic and paper documentation impacted the ability to have complete oversight of women and birthing people and could create risk. Equally, women and birthing people did not have access to their records until after they had given birth, although staff told us they could print off their care-plan during pregnancy.

Postnatal notes were not always readily available for term babies that required transfer from the postnatal ward to the neonatal unit. This was because there had been no administrative staff since May 2022, and it was their role to photocopy notes prior to discharge. In addition, notes were not always immediately available when babies were admitted to the neonatal unit from the community. This was because the care the baby received from birth until discharge was documented in the maternal records which may be in the community. This created a potential risk.

This risk was reflected on the maternity risk register and had been reviewed and updated on 23 February 2023 when the service implemented a change in practice by ensuring postnatal booklets for out-of-area women and birthing people remained on the ward and their discharge summary was sent electronically. As part of the factual accuracy process, the trust also advised that the administrative post had been recruited to.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Medicines management was fully integrated with the trust electronic patient record and enabled the entire drug chart to be viewed on a single screen, with medicines schedules.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 9 medicine charts, and all were fully completed, accurate, and up-to-date. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit. Midwives had to complete a mandatory training module to be able to give a patient group directive.

Staff stored and managed all medicines and prescribing documents safely. The clinical rooms where medicines were stored were locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff monitored and recorded fridge temperatures and knew to act if there was variation. However, there was no regular pharmacy technician attending the antenatal and postnatal ward which could have a direct impact on medicine management processes.

Staff checked controlled drug stocks daily. Records for checking controlled drugs demonstrated that the medicine policy was followed. Records showed two staff checked the stock in line with the policy. The process for maintaining safe controlled drug checks was effective.

Medical gases were checked and stored safely. They were stored securely to prevent them from falling. This was in well-ventilated areas, away from heat and light sources, in an area that was not used to store any other flammable materials.

Maternity

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. Governance leads were visible and completed daily walk arounds, so staff had the opportunity to ask questions and raise concerns. Training in incident management was provided at induction and during regular trust training sessions. It was a clear process which staff understood and followed.

We reviewed incidents reported in the 3 months before inspection and found them to be reported correctly. There had been no incidents that met the referral criteria for investigation by the Healthcare Safety Information Branch (HSIB) in the previous 6 months to the inspection, and there were no reports in progress.

Managers reviewed incidents on a regular basis so that they could identify any immediate actions required. However, the inability to obtain postnatal notes in a timely way to complete investigations sometimes impacted on the timeliness of investigations. There were 11 outstanding electronic incidents at the time of our inspection. This was due to a delay in accessing postnatal notes to complete the reviews (6 were postnatal readmissions and 2 were term admission to the neonatal unit).

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations. Families were de -briefed and findings were shared in advance of receiving the report. A member of the governance team completed a 30-day check-in of the progress of all serious incident reports, maintained contact with the investigator and kept the family updated of progress.

Managers debriefed and supported staff after any serious incident. We were given several examples of how staff had been supported. Staff had access to a variety of chosen support which included a professional midwifery advocate, manager, pastoral midwife or clinical counsellor. Psychological support and safety were routinely considered as part of investigations into clinical incidents.

Staff received feedback following incident investigations and themes from incidents were shared. Safety messages were updated weekly and shared during a safety briefing during clinical handovers, the handover book, by email and a closed Facebook Group. This was disseminated weekly in response to staff feedback.

Staff understood the duty of candour (DoC). Managers assessed the application of the DoC against all incidents and maintained and monitored compliance through their maternity dashboard.

Is the service well-led?

Good

Leadership

Maternity

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 staff. They mostly supported staff to develop their skills and take on more senior roles.

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

The clinical director was an anaesthetist and met with the obstetric lead monthly. The obstetric lead met with the consultants every 6 weeks. The head of midwifery (HoM) was supported by a deputy HoM, 2 matrons, the governance team, specialist and band 7 midwives. The HoM managed the matrons and the professional midwifery advocate (PMA) team. The deputy HoM managed the maternity safety, quality and governance manager and specialist midwives. The matrons managed the lead midwives/team leaders.

The leadership and specialist midwives' structure had evolved, and most specialist roles were fully established and were seen as essential to meet service specifications and national recommendations. The service pro-actively bid for funding opportunities to support these roles. Funding had also been secured to support a midwife post to focus on developing student placements and host more midwifery students at the unit. This was also to help address the national shortage of midwives.

In line with 'Spotlight for Maternity' (2016), maternity services were invited to report directly to the board. Monthly maternity performance indicators formed part of the trusts integrated performance report which was reviewed by the board. The HoM attended board meetings and presented any midwifery papers/reports. Parents stories were also presented to the board to help understand their lived experience. This raised the profile of maternity services and supported the board in understanding issues such as staff vacancies. The board were described as engaging, supportive and proactive about driving improvements in maternity services.

Leaders were visible and approachable in the service for women, birthing people and staff. Leaders were well respected and described as approachable, and supportive. 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 6 maternity safety champions and a non-executive director who completed regular walk-arounds monthly. Front-line safety champions maintained a log of what they had observed including staff feedback, which was anonymised. This included an account of actions that had been completed in response to concerns or feedback. For example, procuring additional equipment.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress.

The HoM had completed a midwifery workforce review as a priority on commencement in role. This included reviewing budgets, staffing lists, required and desirable roles, the leadership structure in the midwifery staffing group and a review of the Birthrate plus report received in 2020.

The director of nursing and quality and mental health midwife were having reverse mentoring. The reverse mentoring paired senior white leaders (mentees), with black and minority ethnic staff (mentors). This was to help them explore their mentees' practices in relation to equality, diversity and inclusion.

Maternity

Vision and Strategy

The service had a vision for what it wanted to achieve, and leaders and staff understood it.

Maternity services shared a vision document for 2021/2022. We saw that some of the vision had not been implemented at the time of our visit. For example, women and birthing people did not have access to their digital records, and a midwifery led unit was not an option for place of birth. However, most of the vision had been achieved, although the service did not provide their strategy regarding progress.

Culture

Staff felt respected, supported, and valued. They were generally focused on the needs of women 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, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued. They were positive about the leadership team and felt able to speak to leaders about difficult issues, and when things went wrong. All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. They were proud to work for the trust and felt valued and respected by management. Staff described healthy working relationships where they felt respected and able to raise concerns without fear. The culture was one of learning and focused on improvement, not blame.

There were historic tensions between hospital staff and the 3 continuity of care (CoC) teams. Leaders were aware of this and felt this was largely due to not fully understanding each other's work, and workload. A planned listening event took place the day following our inspection, to explore options to help staff better understand each other's role. For example, staff rotation and a 'a day in the life of' to encourage team cohesion with an appreciation station and post box to nominate colleagues and show appreciation.

Leaders understood how health inequalities affected treatment and outcomes for women and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. For example, they monitored the number of women and birthing people cared for by the continuity of care (CoC) teams. Their local target was for 25%-35% of pregnant women and birthing people to be cared for a CoC team. They also monitored the number of women and birthing people from ethnic minority groups and those <10th centile according to the deprivation index cared for by a CoC team. This was reported to the local maternity dashboard.

However, there was some inequality in the type of care women and birthing people booked with CoC teams received. For example, they received face to face antenatal preparation classes and all other women and birthing people could only access classes online.

Leaders developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. The trust had an equality, diversity and inclusion policy and process. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment. However, leaders did not they review incidents and complaints to see if there were any themes concerning women and birthing people from disadvantaged backgrounds, or ethnic minority groups.

Maternity

The service had an open culture where women, their families and staff could raise concerns without fear. Women, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were managed fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and visitor areas. Staff understood the policy on complaints and knew how to manage them.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes. Complaints were fed back to individuals to help them understand the parent's perception of their care. They were presented at maternity study days to share learning. Themes were shared at handovers, huddles, on staff notice boards, their governance newsletter, and by email. Complaints were presented to monthly specialty and CBU governance and directorate risk meetings, and could be used to inform training and skills and drills.

The trust employed Freedom to Speak up Guardians (FTSuG), and Freedom to Speak up Ambassadors to support staff who wished to speak up about a concern or issue. They were not employed directly by the maternity service, but we saw information on display about how to contact them and raise a concern in confidence.

The maternity website was comprehensive and easy to use. There was an array of information and videos to ensure women and families were well informed and improve information and support informed consent.

The pastoral midwives and preceptorship midwife supported newly qualified midwives. They developed welcome packs for students, new starter packs and booklets for career progression from band 2 to 5. The pastoral midwives organised a recent 'time out' day to help identify where and how they could most support staff. Managers completed exit-interviews when staff left their employment in maternity services, to help identify any areas for improvement and a counsellor was readily available in the unit, to provide emotional support.

There were 10 professional midwifery advocates (PMA), who met monthly to look at themes and trends to support staff more effectively. The team had a rota to ensure a PMA always completed a daily walkabout to check-in with staff and see how they could provide any necessary support. Three of the teams were allocated to support community staff and continuity of care teams. They organised health and wellbeing events for staff, and resources such as menopausal support. The PMA team focused on specific projects such as supporting kindness. They offered support following incidents which could include emotional support as well as practical support with preparing and writing statements.

In addition, following our inspection we received 439 feedback forms from women and birthing people who had recently used maternity services at the hospital. Forty-five (10.2%) out of 439 reported a negative experience which was mainly related to postnatal care and short staffing numbers. Fifty- two (11.8%) women and birthing people reported a mixed experience and 342 (80%) reported a positive experience. There were themes related to the positive feedback, much of which was outstanding and included midwifery staff who were generally described as caring, professional, helpful, and supportive. Medical staff, administrative staff and theatre staff were also described as caring, and women and birthing people reported feeling safe, respected, listened to, and well informed. There was also a theme around women and birthing people choosing to have subsequent care and birth(s) at Barnsley hospital and recommending the service. We also spoke with 4 women and birthing people during our inspection who shared exceptional feedback about the maternity staff and the care they had received.

Governance

Maternity

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.

Leaders operated effective governance processes, throughout the service and with partner organisations. 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.

There was a maternity safety, quality and governance manager who managed the governance team. There was a lead obstetrician for governance, and governance minutes reflected that meetings were multidisciplinary and included the bereavement midwife to include the family's perspective of care. The maternity governance team also attended a weekly safety huddle with the trust clinical governance team.

The Quality and Governance Committee reviewed the maternity minimum data set monthly to maintain oversight of Barnsley maternity services. The report provided monthly oversight of perinatal clinical quality as per the minimum required dataset, ensuring a transparent and proactive approach to maternity safety across the service. The report was intended to provide assurance surrounding any identified issues, themes, and trends, to demonstrate an embedded culture of continuous improvement.

All potential serious incidents were discussed at the weekly Patient Safety Panel which was chaired by either the director of nursing and quality, or the medical director. The panel reviewed the incident to confirm whether it was a serious incident. The panel acknowledged that some incidents caused harm whilst not meeting the full criteria for a serious incident investigation. These incidents were classified as high-level reviews (HLR) and were still investigated using a concise system-based approach investigation, and learning was shared through the trust's governance structures.

Thematic issues were identified from all levels of incidents. For example, themes for the 6 months prior to our inspection highlighted that family members who lived with women and pregnant people and smoked were not offered referral to smoking cessation services. Another theme identified high-risk women and pregnant people did not always have an obstetric review following booking with a clear plan of care documented. All themes were added to mandatory training and action plans were completed to drive improvement and learn lessons.

All term admissions to the neonatal unit (NNU) were graded moderate harm as per the Local Maternity and Neonatal Service (LMNS) criteria. This was regardless of whether they were avoidable or not. All admissions to the neonatal unit (NNU), were reviewed at the multidisciplinary weekly ATAIN meeting. Themes were identified. For example, during quarter three, the top themes for moderate harms were term admissions to the NNU and postnatal readmission of the mother/birthing person to the unit.

Actions were completed to reduce reoccurrence. For example, the hypertension guideline had been updated to ensure the mother/birthing person's blood pressure was stable before discharge, to help prevent avoidable readmission.

As of the 28 February 2023 there were 98 trust approved documents and 29 were out-of-date. Following a meeting with the executive team, maternity was conducting weekly extraordinary guideline meetings to review and approve guidelines outside the Women's Business and Governance meeting. . The aim was for all the out-of-date guidelines to be approved by the 31 March 2023. At the time of our inspection, we were told 4 guidelines were out-of-date.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Managers wrote action plans when they identified gaps in compliance. For example, the audit results for compliance to the world health organisation checklist was 100% for sign-in for the previous 3 months and 98.8% for sign-out. They had written an action plan to address the non-compliance which included spot-check audits.

There were various reports that were shared with staff to raise awareness about progress and improvements. For example, the fetal monitoring midwife produced a fetal monitoring monthly highlight report. This included recent training and audit results, dates for case presentations and updates on related initiatives such as procurement for additional CTG monitors and progress toward implementing centralised CTG monitoring. New CTG stickers were implemented in March 2023. Date of birth replaced NHS numbers to make it quicker for staff to complete them.

There was a clinical governance information board on the mixed antenatal and postnatal ward. These included themes identified from incidents, leaning from incidents and associated actions to prevent re-occurrence, areas for improvement, things that had gone well and positive feedback/updates.

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.

A risk register was used to identify and manage risks to the service. The risk register included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, it's possible impact and the review date were also included.

The highest risk for maternity services was the lack of a maternity electronic records that had the capacity to interface with other systems to enable sharing of data with other professionals, organisations and women in line with Better Birth (2016) recommendations.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed and discussed during clinical governance meetings.

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes. As part of the factual accuracy process the trust also confirmed that the Trust Board had recently reviewed their stillbirth and neonatal death rates which showed the trust was below the national average for both rates since MBRRACE reporting started in 2013.

Mandatory training was concerned with minimising risk, promoting quality and ensuring the trust met external frameworks; for example, the Maternity Incentive Scheme, Ockenden (2022) Immediate and Essential Safety Actions and professional registration for midwives to ensure they complied with statutory requirements. Although training

compliance was not yet at the trust target, maternity services had met the training standards required to achieve the Maternity Incentive Scheme year 4 and were on target to achieve full compliance for year 5, by the end of 2023. In addition, we did not find any evidence that the training compliance created additional risk of harm to women and birthing people. For example, there had been no HSIB referrals for over 12 months.

The trust monitored the number of incidents and serious incidents that staff reported monthly. Governance and risk leads joined up with leads across the local maternity and neonatal system to identify learning from incidents across the system.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

Information Management

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

The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical KPIs. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts.

Staff collected data to support higher risk women and birthing people at all booking appointments. This included their ethnicity, postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced age and co-morbidities. This data was used in planning women and birthing people's care and support.

Engagement

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

The service had a highly evolved, embedded and valued Maternity Voices Partnership (MVP) that helped to ensure the voices of women, birthing people and families were heard by the trust, and used to make meaningful improvements. For example, they completed a monthly walk-around and their feedback fed into the monthly Maternity Patient Experience Action Plan, which was launched in January 2023. They contributed to the design of user information leaflets, videos, information packs, the maternity website, and guidelines. They had been involved with the research into the needs of women and birthing people from ethnic minorities (2021), and subsequent changes to make services more responsive and appropriate to women and birthing people from ethnic minorities.

The MVP worked with maternity services to encourage and support diverse membership and hosted a quarterly engagement event with significant others which included representation from maternity services.

They met with maternity managers monthly, attended governance meetings, the transformation group meetings and had recently been on the interview panel for the appointment of a matron. The MVP described feeling like equal partners.

The maternity website was comprehensive and easy to use. There was an array of information and videos to ensure women and families were well informed to support informed consent. The maternity landing page was accessible in multiple languages. There was a read-aloud service and easy read capability via the software application 'Recite ME'. This gave assurance that the online experiences of services users were accessible.

There were systems in place to engage with staff. There were staff information boards in all clinical areas. These included details of how to contact the maternity safety champions, the Freedom to Speak up Guardian and where staff could get support. The governance team had introduced a QR code to make it easier for staff to share ideas for improvement and any concerns.

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. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation.

- Barnsley maternity service had commissioned research in 2021 into the needs of women and birthing people from ethnic minorities who accessed their maternity services, to make services more responsive and appropriate to their needs. The research was completed in partnership with their local Maternity Voices Partnership, NHS South Yorkshire Integrated Care Board and Barnsley Community Voluntary Service.
- The recommendations following the research were made in-line with their local Equality and Equity guidance (2020), and the Ockendon Report (2022). Findings could not be generalised to the general population of community from ethnic minorities in Barnsley due to low number of participants. However, some immediate actions were implemented. This included updating the maternity website to ensure it was available in multiple languages, ensuring electronic GP referrals were available in multiple languages and updating leaflets and posters in multiple languages. Additional recommendations were made, and managers were presenting the research and findings to the All-Party Parliamentary Group on Maternity shortly after our inspection.
- NHS England funded an evaluation of the implementation of Midwifery Continuity of Carer, and Barnsley was chosen as one of three sites to participate in the evaluation. The head of midwifery was due to attend an evaluation workshop shortly after our inspection, to hear the findings of the full evaluation.
- There were 'Whose Shoes' visualisation boards in different areas. The boards reflected engagement events that helped participants explore key local issues and identify opportunities for development and change.
- There were comprehensive governance boards in all clinical areas. They were updated weekly, and information was included that was relevant to each clinical area and maternity services in general. were clear, comprehensive, informative for families and staff and very well maintained.

Maternity

- The service planned to launch an APP for dads-to-be called DADPad shortly after our inspection. The APP provided Dads with guidance on how to support and seek help (when needed), for their partners and themselves, as they adjusted to their new roles. It aimed to help individuals cope with the physical and emotional strains fatherhood could place on individuals and relationships.
- Maternity services were accredited with the United Nations Childrens' Fund (UNICEF) UK Baby Friendly accreditation. They were committed to ensuring all mothers and birthing people were supported to make informed decisions about how to feed and respond to their baby.
- The infant feeding lead had presented at the UNICEF Baby Friendly Initiative conference in November 2022 about the breastfeeding climate change work the trust was undertaking.

Outstanding practice

We found the following outstanding practice:

- The safeguarding team provided 'HOPE' Boxes for birth parents who were separated from their babies due to safeguarding concerns and included early mementoes to start the ' life story' work. The boxes were also provided for foster carers, but their details were not shared with the birth parent(s).
- The perinatal midwives who won the Royal College of Midwifery award for outstanding project support for mental health in pregnancy. The pair had been nominated for the award at the time of our inspection and won the final which took place in May 2023.
- Barnsley maternity service had commissioned research in 2021 into the needs of women and birthing people from ethnic minorities, who accessed their maternity services. Maternity services had implemented some immediate changes in response to the research to make services more responsive and appropriate to women and birthing people from ethnic minorities.
- The service had a highly evolved, embedded and valued Maternity Voices Partnership that worked in partnership with maternity services to ensure the voices of women, birthing people and families were heard by the trust, and used to make meaningful improvements.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure staff are up to date with maternity mandatory training modules including safeguarding level 3 adults and children training. Regulation 12(1)(2) (c).
- The service should ensure midwifery staff have an annual appraisal to support their learning and development. Regulation 12(1)(2)(c)

Maternity

Action the trust SHOULD take to improve:

- The service should ensure staff check neonatal resuscitaires daily and replace any used or out-of-date stock or equipment immediately.

- The service should ensure they re-audit following completed action plans to address compliance gaps to policy.

Our inspection team

The team that inspected the service included a CQC lead inspector, 2 other CQC inspectors, 2 midwifery specialist advisors and 1 obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation

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