University Hospitals Birmingham NHS Foundation Trust

Birmingham Heartlands Hospital

Inspection report

Bordesley Green East
Bordesley Green
Birmingham
B9 5SS
Tel: 0121244200

Date of inspection visit: 8 February and 9 February 2023
Date of publication: 07/06/2023

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Birmingham Heartlands Hospital

Inspected but not rated

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 Birmingham Heartlands Hospital.

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

University Hospitals Birmingham NHS Foundation Trust provides maternity services across Birmingham, Sutton Coldfield and Solihull. The Maternity department at Heartlands Hospital comprises of delivery suite including triage, postnatal and antenatal wards, day assessment unit, midwife and consultant led clinics, scanning services, a bereavement suite, as well as a maternity led unit, although this was not always able to accept patients.

This hospital is not rated.

We also inspected 1 other maternity services run by University Hospitals Birmingham NHS Foundation Trust. Our reports are here:

https://www.cqc.org.uk/provider/RRK

How we carried out the inspection

We spoke to 25 staff including senior leaders, matrons, midwifes, obstetric staff, specialist midwives, clinical governance and the patient safety team to better understand what it was like working for the service. We interviewed leaders to gain insight into the trusts group leadership model and governance of the service. We reviewed 11 sets of maternity records and 20 prescription charts across the trust. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recently reported incidents and audit results.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received 7 feedback forms from women. We analysed the results to identify themes and trends.

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

Maternity

Inadequate 

Our rating of this service went down. We rated it as inadequate

- The environment was not well maintained and in parts, not fit for purpose due to the lack of sufficient and suitable space for women and birthing people to wait in comfort or to be seen and assessed.
- Women and birthing people were not always assessed and reviewed in a timely manner in the Pregnancy Assessment Emergency Room (PAER) putting the safety of women and birthing people and babies at risk.
- The service did not have enough staff to care for women and keep them safe. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- The service provided mandatory and maternity specific training in key skills to all staff but did not always ensure everyone had completed it.
- Systems to manage performance were not always used effectively. The trust identified and escalated relevant risks and issues and identified actions to reduce their impact. However, it was not always clear if action had been taken or followed up. Managers did not always investigate incidents thoroughly or in a timely way.

However:

- Leaders recognised that the instability of the senior leadership team had impacted on staff morale and the ability to implement and sustain improvements. A number of vacant posts had been recruited to, including the Director of Midwifery.
- The service engaged well with women and birthing people within the diverse community, particularly with regard to Female Genital Mutilation (FGM) as well as a specialist bereavement service.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. 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. We found that the service had deteriorated since the last inspection in November 2018.

Is the service safe?

Inadequate 

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

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff were up to date with all their mandatory training.

Staff did not always receive or kept up-to-date with their mandatory training. The trust target for mandatory training was 90%. Training records demonstrated that this target had not been achieved for practical manual handling training, level 2 infection control training or clinical life support (Level 2).

Maternity

The service had birthing rooms with pools within their maternity led units and delivery suite. In relation to pool evacuation, staff told us the use of nets was not suitable and therefore all staff were required to complete manual handling training to enable them to use a hoist if required. We reviewed the training data for manual handling and found these fell well below the trust's target of 90% compliance. Training data showed only 55% of staff were compliant with this training. However, 99% of staff had completed manual handling theory training. Therefore, we could not be assured that staff had the required skills in the event of sudden deterioration of women and the requirement for evacuation.

The trust provided level 1 and 2 Infection control training as part of mandatory training where 97% of staff had completed level 1 but only 61% had completed level 2. Therefore, we could not be assured staff followed best practice guidelines for infection control.

The service provided clinical life support (Level 2) (resuscitation) training. The rates at the service for both medical and nursing and midwifery staff compliance was 56%. This meant not all staff had the required training to provide lifesaving treatment to women and babies in their care.

Managers monitored mandatory training and rostered staff to attend when training days were organised. However, staff reported they were often pulled back on to the wards on these days due to staffing levels.

The service had a weekly programme of multi-professional simulated obstetric emergency training (PROMPT), in addition to the annual PROMPT training. Records showed staff completed skills and drills training on a weekly basis with scenarios such as baby abduction or use of equipment. Records for January 2023 demonstrated all staff had met the trust target of 90% with the exception of anaesthetic trainees (86%) and support workers (82%).

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

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that 95% of staff had completed Level 3 safeguarding adults and 92% safeguarding children training at the level for their role, as set out in the trust's policy and in the intercollegiate guidelines.

The trust had a well-established safeguarding team. The team consisted of band 7 and 6 specialist trained midwives who had close links with 3 local authorities. The specialist team worked across all trust sites supporting midwives with specialist supervision and training. The team covered specialisms including children, female genital mutilation, substance misuse, domestic abuse, mental health, homelessness, asylum seekers, migrant women, and teenage pregnancy. The team had dedicated administrative support. The midwives had established relevant links with charitable groups associated with developing links within the local diverse community. These connections ensured appropriate birthing plans and discharge plans to support the women and their babies. The safeguard lead was chairing a pilot project ICON (Babies Cry, You Can Cope). There were 5 pilots across the country, looking at how to reduce the risk of babies being shaken and harmed. The project had a range of steps to provide information to professionals and women at different stages of their pregnancy and following the birth.

Maternity

The service employed a midwife who specialised in female genital mutilation (FGM). Their role was to educate, raise awareness and support women affected by FGM. They shared their skills and knowledge through annual training sessions for trust staff as well as delivering training at Birmingham University. They had worked with interpreting services face to face due to the delicate and sensitive nature of the topic, as well as providing information in several different languages. The trust fairness task force team (who focus on equality and diversity) were very proud of how the midwife had engaged with the local community, not only supporting pregnant women, but also others affected by FGM.

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

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. Patient records detailed where safeguarding concerns had been escalated in line with local procedures. Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. The safeguarding team had worked on a new version of the abduction policy. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

When women had their babies taken into care at birth or shortly afterwards by social services the midwives ensured they received ‘Hope’ boxes which contained early memories of the baby and pregnancy journey. Early intervention was also being developed with social work teams to provide a support network through the birthing journey for the women.

The safeguard lead had been developing connections with CPIS (Child Protection - Information Sharing Service). This service provided a network across the country of women or their babies who could be at risk. The team were adding additional data for women 28 weeks plus to the register to provider a broader range of details.

The bereavement team was well versed in the diverse nature of the community and religious and cultural observances. The team worked closely with community groups to connect with women and their families. The team linked with the foetal medicine department and were aware in advance of those women and families who may need their support.

Cleanliness, infection control and hygiene

The service did not manage infection risk well. Areas of the building had not been well maintained making effective cleaning difficult. Cleaning records were not always kept up to date and the environment was not always visibly clean.

The environment and equipment were not always visibly clean. We found chairs in clinical birthing areas that were damaged and flooring in waiting rooms that needed replacing, posing a safety and infection prevention control risk.

Cleaning documents were not always completed. For example, the cleaning record for the pool room had not been completed for a month, and another record for a bathroom had not been completed since August 2021. The records in the cleaning schedules folder were not up to date. Therefore we could not be assured that adequate cleaning of the environment was taking place to manage the spread of infection.

The service audited cleaning checks every month. We looked at audits for the last 5 months and found the audits were not consistently completed for each ward on each month. The audits completed showed results over 90% compliance and reflected where areas needed additional cleaning or action. However, they did not identify who was responsible to complete these tasks or by a required date. Therefore we could not be assured action was taken when improvements were required to ensure the safety of women and birthing people.

The trust had not shared with us any audits or records in relation to the pool cleaning schedules. We found in the delivery suite, the last recorded date for the cleaning date for the pool was 24 January 2023, however, staff told us it had been used for induction of labour recently. This meant we could not be assured the trust had an adequate procedure to ensure the pool was cleaned following usage.

We observed staff cleaning equipment. However, after cleaning, the equipment was not labelled to show it had been cleaned. When we later spoke to the staff member, they said that they would use green I'm clean stickers. We found stickers were not consistently used within the service. Therefore staff could not be assured that equipment was clean and ready for use.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Leaders completed infection prevention and control (IPC) and hand hygiene audits. Data showed hand hygiene audits were completed every month in most maternity areas. For the delivery suite, we only received a hand hygiene audit for December 2022 which showed 100% compliance with hand washing. Other wards had completed hand hygiene audits in November 2022, December 2022 and January 2023. Compliance for the wards was between 88% and 100%.

Data showed environmental IPC audits had been completed in November and December 2022 and January 2023 for delivery suite. However, for the majority of other wards only one audit had been completed for each area between September 2022 and January 2023, with the exception of Eden Suite, where 2 audits had been completed. Compliance was between 92% and 98%. However, comments regarding the issues identified, reflected that cleaning was not adequate to meet standards and equipment needed replacing. For example: high level cleaning to remove dust, light fittings dirty, damaged chairs, flooring and sealant around hand wash basins. However, on analysing the audit, it was difficult to see how the auditor had achieved such a high compliance score.

Environment and equipment

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

Leaders at the trust had recognised as early as June 2016 the pregnancy assessment emergency room (PAER) was not fit for purpose due to increased capacity and lack of bed space. The need for building work to improve the lay out of the maternity service was on the trust risk register. In March 2020, a building improvement project working group started considering what changes to the layout might be required. Although we asked for planned estates strategy for maternity department, with any short, medium and long term plans to improve the environment, we only received the floor plans

for the proposed new build. Due to the proposed reconfiguration of the building, it appeared that routine maintenance had not been carried out. We saw that there was long term damage to floor coverings, patient chairs were in poor condition and the environment was in general disrepair. This placed women and birthing people at risk of potential infection control risks and not been seen in a timely manner due to a lack of facilities.

The service did not have suitable facilities to meet the needs of women and birthing people's families. The waiting area for PAER was shared with the day assessment unit, scanning department as well as people waiting for routine appointments such as blood tests. This waiting area was uninviting and only provided people hard plastic chairs to sit on. People were regularly waiting over 4 hours to be reviewed.

The layout of the waiting room had the potential to conflict with people's cultural needs as well as women's privacy and dignity. The population of women and birthing people attending the unit was culturally diverse with a third of women from an Asian or Asian British background, and just under a tenth of women from a Black and Black British background. There was a risk of a woman or birthing person being in early labour and sitting with other women and their partners. Additionally, we found an example of a delay in accessing care, as a woman had chosen to sit in the antenatal clinic waiting area due to how busy the PAER waiting area was.

In addition, the space available in PAER was insufficient to meet demand. We were notified via an incident report from December 2022 around the delays that 13 women had experienced waiting for cardiotocographs (CTG, continuous recording of the foetal heart rate obtained via an ultrasound transducer placed on the mother's abdomen) to be completed due to the shortage of available beds.

We observed unsafe storage of equipment within the unit, in particular, outside the induction bay and emergency theatre 1, which posed a risk to women and birthing people in an emergency. We saw 2 wheelchairs and a computer on wheels partially obstructing the door to the induction bay and a small equipment trolley in front of one of the doors to emergency theatre 1. Urgent assurance was sought from the trust during the inspection regarding these concerns. The written response did not provide full assurance that the issues had been addressed.

Following the inspection we raised concerns regarding the environment of the second emergency theatre within the maternity unit, due to the lack of space for recovery following procedures, as well as processes and procedures for the use of theatres in emergencies. We were assured that the trust was aware of the challenges with the emergency theatres, it was highlighted on the risk register and where possible, action had been taken to mitigate risks. Data we requested showed there had been a minimal number of delays to emergency sections within the 12 month period audited.

The maternity unit was fully secure with a monitored entry and exit system.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment outside maternity theatres was checked daily.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, hoists were used to evacuate women from birthing pools, and the service has access to a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Maternity

Assessing and responding to patient risk

Women and birthing people were at risk of harm. Staff completed and updated risk assessments for each woman but did not always take action to remove or minimise risks. Staff did not identify or act quickly when women and birthing people were at risk of deterioration.

Staff completed risk assessments for each woman on arrival, using a proforma specific to the service. This involved RAG rating women. However, systems were not used effectively. We did not see any audits of maternity triage waiting times.

There was no clear system to prioritise women according to clinical need. During the inspection we saw midwifery staff RAG rated women accordingly during their initial assessment. However, once women were seen and RAG rated, midwifery staff did not prioritise women in the list they generated for the obstetric staff. Midwifery staff added the names of women to the bottom of the

list of women to been seen by medical staff. The white board in PAER did not reflect the RAG priority or identify in what order women should be seen. This meant women or birthing people were at risk of not having their needs reviewed in a timely manner and this could place them and their unborn babies at risk of harm.

Staff did not always act in a timely manner when risk identified the need for a CTG. Cardiotocography (CTG) was used during pregnancy to monitor foetal heart rate and uterine contractions. For example, a serious incident demonstrated the staff did not identify that a CTG should have been commenced sooner following a spontaneous rupture of membranes. This could have improved the outcome for the mother and baby.

There was missed opportunities to have ‘fresh eyes’ on women and birthing people’s clinical observations. Best practice is to have a "fresh eyes" or buddy approach for regular review of CTGs during labour. We looked at the CTG and fresh eyes datix audit which covered August 2022 to January 2023. These showed that women's birthing journey had been reviewed and any required action to improve areas had been identified. It showed missed opportunities for fresh eyes as well as discrepancies between interpretation of partograms (*record of key data (maternal and fetal) during labour entered against time on a single sheet of paper)* which led to delays in identifying increased risk.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists and outcomes of the audits were shared through the Theatre Standards Group and Clinical Quality Monitoring Group (CQMG). The audits identified the sign out procedures were disorganised with lots of activity continuing, final counts were performed too early and not all staff engaged in the WHO process. Information from the audits was displayed on posters and shared in learning sets through the use of power point presentation of the audit details, including recommendations. There were also plans to increase the number of audits completed across all theatres.

The service used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) in identify women and birthing people at risk of deterioration. The MEOWS chart was used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating. It was recognised that early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remain the key factors in providing high quality care to sick pregnant and postpartum women (MBRRACE 2016).

Maternity

Leaders were not able to assure themselves that MEOWS were being completed in line with best practice or identify any learning or areas for improvement, as records were not audited. Leaders told us audits were not completed on the use of MEOWS and all records were directly inputted into the electronic record system.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

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

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

We observed variations in the way handovers were conducted, which meant that all necessary key information to keep women and birthing people and babies safe may not be shared. Midwifery led handovers utilised computerised handover sheets and were clear and concise. They demonstrated good planning for the care and treatment for women and birthing people and babies. The handover used a format which described the situation, background, assessment, recommendation (SBAR) for each patient to share information. However, we observed that the medical handovers did not use the SBAR format to its full capacity. Staff had 2 safety huddles each shift to ensure all staff were up to date with key information, in addition to the midday multiagency safety huddle, attended by representatives from other NHS trusts within the locality.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. The newborn and infant physical examination (NIPE) screens babies for specific conditions, ideally within 72 hours of birth. The service audited completion of NIPE examinations, the audit we reviewed showed 98% compliance of the required timeframe. This meant they monitored that screening was completed in a timely way. The service also provided transitional care for babies who required additional care.

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

Midwifery Staffing

There was inadequate midwifery staff across the service. The service had issues with recruitment, retention and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Staff spoken with reported they were often short staff and frequently asked to move to other areas to provide support. This impacted on their ability to care for women and birthing people, as well as their wellbeing, as they were often unable to have their break. On the day of the inspection, one of the postnatal wards was short staffed. 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 red flag event is a warning sign that something may be wrong with midwifery staffing. We reviewed data showing the red flags reported by the trust between September and December 2022, 57 in total. The most reported were 'delayed or cancelled time critical activity' and 'delay between admission for Induction and beginning of process'. The main reason noted for these red flags was staffing and bed

availability on Delivery Suite. This puts women and birthing people at risk of not delivering their baby on the delivery suite due to a lack of bed space. The action from these was to continue to review all planned admissions to consider forward planning. The introduction of the midday huddle provided transparent conversations about activities within all units and to consider the workload.

Birth Rate Plus' is an evidence-based methodology based on national standards for workforce planning. The service last completed a staffing and acuity review in June 2021. The staffing reflected in this acuity review included the services at Solihull and Willow the maternity led unit, which at the time of the inspection were closed. Therefore this was not an accurate reflection of staffing requirements. The trust recognised in 2022 that they needed to complete a full staffing review. However, despite 'red flag' events continuing to warn of staffing issues, the decision had been made to delay the staffing review ('Birth Rate Plus') until the appointment of a permanent Director of Midwifery. This post had been recruited to and it was anticipated the assessment would be completed once this member of staff was in post.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Reports seen confirmed supernumerary status for all shifts except one between September and December 2022. They were supported in this role by the safety co-ordinator between the hours of 9am and 5pm.

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

The service had high vacancy rates, sickness rates and high use of bank nurses. We saw that the service had a vacancy rate for midwives of approximately 31 whole time equivalents (WTE) for inpatient areas. The trust had a range of actions and controls to mitigate the risk. These included asking staff in specialist roles and managers at Band 7 and above to work clinically. The relocation of staff to ensure one to one care in labour and dedicated labour ward co-ordinator roles were maintained and managed to move capacity as required across sites. However, midwifery staffing fill rates across the trust for December 2022 was 69% of day shift and 75% for night shifts.

Sickness levels across the trust for nursing and midwifery registered staff for December 2022 were 7%. Bank and agency usage varied from week to week. Information provided by the trust demonstrated that on specific weeks between June 2022 and January 2023, for inpatient areas, bank fill rates ranged between 6% to 29%. For the trust as whole during this period bank fill rates ranged between 16% and 23%.

The service was unable to demonstrate that staff were fully competent for their roles. Not all staff had completed an annual appraisal or were fully up to date with their mandatory training.

The trust could not be assured staff had received the required support for their roles. Although there were systems and processes for managers to support staff to develop through yearly, constructive appraisals of their work, noted less than 60% of midwifery staff had received their annual appraisal. An audit undertaken in December 2022 identified that only 59% of nursing and midwifery registered staff within maternity services had a completed annual appraisal. Not all staff spoken with were up to date with their appraisal or had found it a useful exercise.

A practice development team supported midwives. The team included 2 practice development lead midwives, a clinical midwife trainer, 4 clinical preceptorship support midwifes, 3 professional midwifery advocates, a foetal surveillance midwife, 2 digital midwifes and an international recruitment midwife. Staff were positive about the support provided by the practice development lead midwives.

Managers made sure staff received any specialist training for their role. For example, 7 midwives had received funding for specialist training including a masters level course, leadership courses and 3rd trimester scanning training.

Medical staffing

The service did not have enough medical staff with the right qualifications, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Women and birthing people were not seen and reviewed in a timely manner by medical staff in the Pregnancy Assessment Emergency Room (PAER).

The service did not have enough medical staff to keep women and birthing people and babies safe.

The trust reported there were 4.25 whole time equivalents (WTE) consultant vacancies across all maternity services. A number of these posts had been recruited to, with staff due to commence employment in January and February 2023. However, in January 2023 4.25 WTE consultant vacancies remained unfilled.

Medical staffing rotas for 2022 indicated gaps in medical cover across the service. We saw gaps in medical cover for PAER occurred every month during 2022, with the greatest number of shortfalls (16) occurring in July 2022, and the least number (1) occurring in August and September 2022. This meant there was no rostered medical cover to see women and birthing people who attended PAER. During the week commencing 4 July 2022, of the 5 working days there was only medical cover in PAER for one afternoon. There were occasions where there was no medical cover for 2 or 3 consecutive days. For example week commencing 20 June 2022 and 11 July 2022. There were examples of multiple single days without medical cover, for example the week commencing 14 November 2022 and the week commencing 12 December 2022. We could not be assured that women and birthing people were seen and reviewed in a timely manner.

We did not see any on call arrangements for the Pregnancy Assessment Emergency Room (PAER) for evening and weekends. Staff told us during these times medical staff covering labour ward would also be designated to cover PAER. Multiple staff told us that there were delays in women being seen for medical review due to a lack of medical staff availability. This was in part due to gaps in rotas as well as medical staff attending ward rounds or carrying out other procedures. We observed this during the inspection as one woman who should have been reviewed within 15 minutes waited 50 minutes to be reviewed.

The trust had already identified a serious patient safety issue due to the time taken to review women in PAER. The audit of the records of 100 randomly selected women and birthing people who attended between June and October 2022, identified that women, regardless of their RAG rating were not seen within the required timeframes, placing them and their unborn babies at risk of harm. Out of the 7 women who were RAG rated Red, only 57% (4) had been reviewed within the required timeframe of 15 minutes; 75% of women RAG rated Green and 61% of women RAG rated Amber were reviewed within the respective timeframes of 4 hours and within 60 minutes.

A review of the incidents reported by the trust identified reports of delays in women being medically reviewed in PAER, delays in commencement of emergency caesarean sections, and medical staff attending when requested by ward staff. For example, incidents relating to PAER reported delays in clinical review for 5 women in July 2022, multiple women waiting over 4 hours for a doctor review in November 2022 and women been discharged home without medical review, scan review or safe care planning in January 2023. The impact of the lack of medical cover was demonstrated in an incident reported in December 2022 where multiple patients in PAER had breeched the 30-minute triage time and 4 hours wait for reviews and CTG's. In addition 13 women were waiting at the time for CTG's, as no beds were available, one midwife had been moved to delivery suite due to staff shortages and the ward manager was working in PAER.

Maternity

The trust had high usage of locum staff. We saw that between April 2022 and January 2023, locum consultant and junior doctor cover had been used every month, ranging from 11 consultant shifts in July 2022 through to 81 shifts in November 2022 and 99 junior doctors shifts in June 2022 to 1 junior doctor shift in January 2023. Additional junior doctors had been recruited, which had reduced the reliance on locum staff. There was a written welcome pack for locum and agency clinical staff.

Junior medical staff told us that support from senior staff had improved although they felt this could be improved further.

The service always had a consultant on call during evenings and weekends. The consultant attended twice daily ward rounds to review the care and treatment of women and birthing people and their babies. Junior medical staff told us they were rostered to work across all three maternity units within the trust. They said they would prefer to work blocks of shifts in one location as travel between the sites could be problematic.

Records

Staff kept records of women and birthing people's care and treatment. However, records were not always detailed, stored securely or audited.

Women and birthing people's care records seen during the inspection were comprehensive and all staff could access them easily. The trust used a combination of paper and electronic records. The majority of information was recorded electronically although paper records were used for medicine charts. We reviewed 8 records and found records were clear and complete.

When reviewing serious incidents, the trust had found that the level of recording could be improved. It was highlighted during an audit of patient records in PAER that documentation could be improved. In 44 out of 100 records the triage sheets had missing information. There was a lack of contemporaneous documentation in the majority of cases.

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

Records were not always stored securely. We observed confidential information had been left unattended on the security desk on the ground floor of Princess of Wales Unit. We also saw a clinic list with patient details in an unlocked room in the maternity unit.

The trust told us they did not routinely audit records, unless it was part of an investigation or to review complaints. They told us if any errors were identified during this process, these would be addressed with the midwife and support provided by the Professional Midwifery Advocates. A lack of audits meant the trust were not consistently reviewing the completion of records to ensure they were in line with guidance or the trust policy. Therefore, the trust could not be assured all records were correctly completed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines although they were not always used effectively.

Maternity

The service did not have systems in place to check staff competency when using medicines was in line with trust policy and national guidelines. The trust told us competency tests were currently completed on the wards. A new package of training was being developed, however this was not in place at this inspection. This meant the trust could not always be assured of the training competencies of staff in relation to medicines.

Staff did not always store and manage all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation. However, we found that fridge temperatures had not always been recorded on a daily basis. We found gaps in records on the labour ward and Maple ward. We also found medicines in an unlocked box in the pool room and a box of intravenous fluids stored on the floor in labour ward.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 20 prescription charts and found staff had correctly completed them. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit. Staff reviewed each woman's medicines regularly and provided advice to woman, birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines were recorded on paper systems and the 10 sets of records we looked at were fully completed, accurate and up-to-date.

Incidents

The service managed safety incidents although there were delays in reviewing incidents. Staff recognised but did always reported incidents and near misses due to time constraints. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support.

The service were not aware of, investigating or learning from all incidents and near misses as staff did not always report them. Staff knew what incidents to report and how to report them in line with trust policy. However, staff told us they did not always report incidents and near misses due to time constraints. Senior midwifery staff also told us staff did not always report delays in care. Staff could describe what incidents were reportable and how to use the electronic reporting system. Leaders could not be assured they had full oversight of all risks within the service due to inconsistent reporting.

There were no 'never' events reported for this location. However, a 'never' event had occurred at a different location and had been identified by staff postnatally. We saw that this event had been investigated and the findings shared at board level. However, we did not see any learning from the event shared with staff.

There appeared to be a disconnect between how staff and senior management described how incidents were managed and responded to. Some staff told us they felt there was little point reporting incidents as it took too long to get a response and no action was taken as a consequence. They said senior management did not share what action they were taking, or take on board what staff were saying, which had an emotional impact on staff.

We spoke with members of the Clinical Governance and Patient Safety team. Weekly risk meetings reviewed incidents from across the maternity service to identify any themes or trends. Incidents were reviewed using the Perinatal Mortality

Review Tool (PRMT) and any learning shared, through presentations which took place four times a year. There was a dedicated email which staff could use to raise issues with the safety board anonymously. Support for midwives was available through the PMAs, or through the Preceptee Clinical Support Midwife team for band 5 and 6 staff. The Clinical Governance and Patient Safety team were aware of the criteria for reporting incidents to the Healthcare Safety Investigation Branch (HSIB) for investigation and that any still births or neonatal deaths required a 72 hour review.

Incidents were not investigated and responded to in a timely way. There were 59 incidents open over 60 days. This was against national guidance put in place to support learning and prevent events reoccurring.

Actions were not always addressed and monitored as a result of recommendations from HSIB. In the last 6 months 11 incidents had been referred to the Healthcare Safety Investigation Branch (HSIB) for investigation, however 3 of these were rejected. We reviewed 3 reports and actions plans and saw actions were not in place to address all recommendations and had not been monitored regularly. For example, recommendations included providing clear guidance on who to contact when faced with concerns, orientate staff when they are transferred to different area and ensure the initial full assessment in triage is completed in line with local guidance. We found during this inspection maternity support workers were undertaking initial observations on mothers who attended PAER. This led to delays in the mother being assessed by a qualified member of staff leading to potential missed diagnosis

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

Is the service well-led?

Inadequate  

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

Leadership

Due to a period of instability there had been a lack of consistent leadership within the service and a number of senior posts remained vacant, leading to delays in improvements being implemented. New and interim leaders had started to support staff to develop their skills and take on more senior roles. However, they were not always visible and approachable in the service for woman, birthing people and staff. Executive leaders did understand the priorities and issues the service faced, although these were not always managed effectively.

There had been a period of instability within the leadership structure across the trust. A number of senior posts were either filled with interim staff or vacant. The Director of Midwifery (DoM) post had been recruited to, with a planned start date of June 2023. This post was currently filled with an experienced interim DoM. There were two Head of Midwifery (HoM) posts. An existing member of staff had been recruited to the HoM for Birmingham Heartlands Hospital.

Maternity services were part of Division 6 within the trust. The designated board member for maternity was the Chief Nurse, who was also the safety champion. There was a clear organisation structure for the division and below that, the

senior midwifery team. The DoM was supported by the HoMs, in addition to matrons for inpatient care, intrapartum care, community, maternity governance and screening (including foetal medicine and antenatal clinic), as well the named midwife for safeguarding and lead midwives for bereavement and service and practice development. There was a clear line of reporting into the executive directors and board.

Following the inspection the Trust provided an updated structure for Division 6. This indicated separate General Manager and Operational Manager roles had been created for Maternity and Gynaecology. The Operational Manager roles had been recruited to, and the General Manager for Obstetrics was due to commence in post during May 2023. The General Manager for Gynaecology was already in post and covering for Maternity in the interim.

Leaders understood the priorities and issues the service faced. However, due to a period of instability there had been a lack of consistent leadership within the service and a number of senior posts remained vacant, leading to delays in improvements being implemented.

Although matrons and ward managers were visible and supported staff, not all staff felt that more senior leaders were visible in the service for women and birthing people and staff. They felt that the executive team did not visit the service on a regular basis.

The service was supported by maternity safety champions and non-executive directors, although some safety champions were new to the post.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action, however leaders had plans to develop one.

There were an overarching vision and values for the trust, in addition to the implementation plan. There was an expectation that each division would develop their own service strategy. We were told there were plans to redevelop the maternity and neonatal strategy. Staff engagement was due to take place in March 2023, ensuring staff had input into the new vision and strategy. The engagement team were supporting the process, with plans for an away day in April 2023 to deliver the final vision and strategy.

Staff told us that the trust vision and strategy used to be displayed on the home screen of all computers, but this was no longer the case, meaning staff no longer knew where the trust was with their vision and strategy.

Culture

Staff did not always feel respected, supported, and valued due to workload and staffing levels. Staff tried to focus on the needs of women and birthing people receiving care. The service did not always promote equality and diversity in daily work.

Staff did not feel respected, supported, and valued**.** Staff we spoke with said they could speak up about concerns but they did not always feel they were listened to, or action taken.

Trainees in an approved training post in the UK completed the General Medical Council National Trainee Survey (GMC NTS) regarding the quality of training received, support and wellbeing. In the 2022 survey, scores at the Heartlands Hospital were significantly below (i.e. worse) than the national average for six indicators. These indicators were overall

satisfaction, reporting systems, teamwork, supportive environment, adequate experience, and facilities. The 2022 results saw an improvement from the 2021 results where 15 indicators had scored significantly below the national average. The trust had been working with Health Education England, who had imposed conditions on the trust in response to the survey results.

Health Education England (HEE) undertook a further visit on 30 March 2023 and shared their findings with us. HEE had requested an urgent response from the Trust in relation to the findings.

Staff engagement and morale had declined in the NHS Staff Survey 2021 when compared to the 2020 scores.

The trust shared with us their staff survey from 2021. All the questions had been RAG rated using a traffic light system and any red items had an action plan with related timescales. While we saw evidence of completed actions relating to the 2021 survey, the trust did not share the most recent survey results from 2022 and we were therefore unable to assess whether these actions had an impact on the responses from staff. Therefore, we cannot be assured that action had been taken in response to the staff survey.

Women, birthing people, relatives and carers knew how to complain or raise concerns. The service received 8 complaints in the 3 months before the inspection. Themes identified included delays in care and treatment and attitude of staff. Complaints were reported to the board on monthly basis.

We looked at the results of the Maternity Survey 2022. To summarise, many women praised the general quality of care at the trust. However, many of them felt they had mixed experiences. At some stage they had negative interactions with individual members of staff (mainly midwives and MSW) who did not treat them with dignity and respect. Examples included women's concerns about birth choices, pain, and labour progress were not respected, such as "Not listened to" and "didn't believe me" were repeatedly mentioned, as well as staff perceived as being rude and unhelpful.

The Maternity Voices Partnership (MVP) told us they had been asked to raise concerns with the trust about the care provided to women. This included delays in care, lack of consideration of medical conditions unrelated to pregnancy and inappropriate comments about women who did not have English as their first language. The MVP told us the trust had responded positively to concerns raised on behalf of a person who had used the service.

The trust delivered maternity services at three sites, two of which we visited as part of this focused inspection. The diversity of the local populations of the two sites visited was very different. Birmingham Heartlands Hospital was close to Birmingham City Centre and served a more diverse population with 80% identifying as from an ethnic background. There was also higher levels of deprivation within the community. Good Hope Hospital was located within a suburb of the city in a more affluent area with 60% of the population identifying as white British. We saw the standard of maintenance and upkeep at Good Hope Hospital was superior to that at Birmingham Heartlands Hospital. There was an acceptance amongst the staff group that the standard of the facilities and estate was acceptable at Birmingham Heartlands Hospital, whereas at Good Hope Hospital, staff had accessed charitable monies to improve the environment. Leaders told us there were plans for an upgrade to certain areas of the current maternity unit at Birmingham Heartlands Hospital although a definite timescale had not been agreed.

The fairness taskforce team, who lead on equality and diversity across the trust, told us leaders had made an active decision to keep hospital signage in English only, despite the wide range of languages spoken and understood by women and birthing people accessing the service.

Governance

Maternity

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

Leaders did not operate effective governance processes, throughout the service and with partner organisations. The service did not have a strong governance structure that supported the flow of information from frontline staff to senior managers. Although there was a comprehensive series of well-structured governance meetings, leaders did not always monitor key safety and performance metrics due to the lack of audits. For example, use of SBAR for handovers, audit of care records and the decision to delay the review of 'Birth Rate Plus'.

We found several safety concerns on the management of equipment, records, cleanliness and infection prevention and control (IPC). There was a lack of oversight of these issues and some cases, there had been no recent audits carried out to monitor compliance or improvements.

Maternity services sought assurance through various governance meetings in the service divisional meetings and trust board meetings. We saw the reports submitted for discussion were detailed and comprehensive. We reviewed the minutes of various meetings and saw that issues were escalated from the ward to board. Actions were clearly documented but not reviewed at the next meeting to evidence that they had been implemented. Therefore, we were not assured action had taken place. Additionally, we did not see evidence of how discussions and learning was fed back to the staff team. For example, we didn't see any newsletters or information boards providing feedback or learning to staff. Therefore, the trust could not be assured that their governance processes were effective. Oversight of safety in maternity services was reported to the board monthly. We reviewed the last 2 reports and found appropriate risks and issues and key challenges were escalated, and they were reflected in other reports we reviewed.

Managers did not always investigate and close incidents in a timely manner. NHS Patient Safety Incident Response Framework 2022 was put in place to ensure effective investigation of incidents and for continuous learning and improvement. The framework outlines proportionate response timeframes for trusts to follow. The trust had a backlog of 59 incidents that had been open over 60 days. As of February 2023 due to staff capacity it was not clear what the service was doing to close the open incidents or how long the incidents had been open. This may result in incidents being repeated due to the delay in identifying learning and implementing any required changes.

We were not assured that all 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. We saw and were told not all staff had received an annual appraisal, feedback from incidents either wasn't given or took a long time to be received and not all staff had completed mandatory training.

The triumvirate met monthly. We looked at meeting minutes for the last 3 months. The agenda had a clear process to cover operational issues, financial, procurement, matrons, guidelines and consultants. These areas identified any issues and the actions required for them to be addressed. However, the action plan list at the end of each meeting was not always completed and not reviewed at the following meeting to see if the issue or action had been addressed. This meant we could not be assured that issues that had been identified were consistently being addressed to an agreed outcome. The safety champion visited the maternity service at least once a month to speak with staff and observe the environment and feed safety concerns up to the board. We reviewed records of these meetings. The safety champion had introduced a 'you said we did' section, and we saw evidence of this displayed in some areas. For January 2023 the record included 'Methods for weighing swabs – New scales have been ordered'.

Maternity

Not all policies we reviewed were up to date. We reviewed 13 policies and found that 4 had not been reviewed in line with the review date. The out of date policies ranged from one month to 30 months. Leaders told us they experienced delays in approval of new or revised policies by the Clinical Guidelines Group. Therefore the trust could not be assured that they were always following the mot up to date or national guidance.

Management of risk, issues and performance

Systems to manage performance were not always used effectively. Where identified, leaders escalated relevant risks and issues and identified actions to reduce their impact. However, it was not always clear if action had been taken or followed up.

Maternity performance measures were reported using the maternity dashboard.

The service did not have effective systems and processes in place to identify risk in the first instance. The maternity service had a risk register and included risks such as mandatory training, non-compliance with Ockenden, delays in caesarean sections due to theatre capacity and the lack of an allocated senior obstetrician in the Maternity Assessment Centre. We found all risks on the risk register did not have a risk owner for reviewing and monitoring them. There was mitigation, action and due date, although there were still actions on the risk register where the due date had passed and no further update on progress or current status. In addition, staff did not always report incidents so leaders could not be assured they had full oversight of all risks within the service due to inconsistent reporting.

We saw that risks were discussed at trust wide meetings, including via the monthly Maternity Safety report. The purpose of the report was to provide an update on key maternity safety initiatives which would support the trust achieve the national ambition. It also provided evidence for NHS Resolutions Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. The information in the report was detailed and provided sufficient detail for board members to understand the identified risks and any mitigating actions.

The service participated in relevant national clinical audits such as National Neonatal Audit Programme, National Maternity Dashboard audit and MBBRACE. Outcomes for women were a combination of positive, negative and partially met on some national standards.

The hospital participated in the MBBRACE 2020 audit. The result showed the stabilised and adjusted perinatal mortality rate at the trust was more than 5% higher than the comparator group average for all births and for births excluding congenital anomalies.

Clinical Quality Improvement Metrics (CQIMS) are a set of 12 metrics derived from the Maternity Services Dataset for the purpose of identifying areas that may require local clinical quality improvement. The November 2022 result showed that the rate of Babies who were born preterm at the trust was in the middle 50% of all trusts nationally.

The service had a comprehensive programme of audits to check improvement over time, however, the implementation of the programme was inconsistent. Although they audited performance and identified where improvements were needed, it was not always clear what action had been taken to bring about these improvements, or repeat audits completed. Managers did not always share and make sure staff understood information from the audits. We saw little evidence of feedback from managers to staff. As a consequence, this risked events reoccurring, staff not being up to date with best practice and poor staff morale.

Where identified, leaders escalated relevant risks and issues and identified actions to reduce their impact. When reported, risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. However, it was not always clear what action the leadership team had taken to make changes where risks were identified.

Information Management

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

The service collected data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers.

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

The information systems were integrated and secure**.** Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff recognised the need for improvement in engaging with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They had started to collaborate with partner organisations to help improve services for women and birthing people.

During the inspection we spoke with the Maternity Voices Partnership (MVP) chair for the Local Maternity and Neonatal System (LMNS) and a representative for the host organisation. The MVP was being redesigned and there had been a period of 6 to 12 months without an MVP link person for the services. Each hospital within the LMNS (5 in total) will have a designated chair. These posts have been recruited to and will be attending for their induction in the near future. The MVP told us that the trust had not worked well or engaged with them in the past, but the relationship had improved following the appointment of the interim DoM. The MVP shared an example where the trust had responded positively to concerns raised on behalf of a person who had used the service.

The service made available interpreting services for women and birthing people and pregnant people. However, there were inconsistencies across clinical areas in the use of interpreting services and availability of information in different languages. Ward staff regularly used telephone translation services, however face to face translation services tended to be used more by the specialist midwifes. We noted that face to face translation services could be used more proactively in areas such as clinics.

Leaders and staff were aware of the needs of the local population. Despite the multicultural population, the trust did not have a lead person for equality and diversity within maternity services. Specialist midwives worked in innovative ways to engage with the diverse population. However, we saw a lack of signage / information in different languages within the trust buildings or clear directions to the maternity units.

Learning, continuous improvement and innovation

Maternity

Staff wanted to be committed to continually learning and improving services. However, factors such as staffing levels and vacancies within the leadership team had impacted on the effectiveness of learning and improvement at the service. Quality improvements were in place but completion timescales had been delayed by factors outside the control of the service. There was some evidence to innovation and participation in research.

Staff wanted to be committed to continually learning and improving services. However, the instability within the senior leadership team had impacted on the ability to implement and sustain any required improvements. The trust had a quality improvement programme that was reviewed at least quarterly. However, we saw that the planned timescales for completion had not always been maintained.

The service aimed to improve services by learning when things went well or not so well and promoted training and innovation. We saw the process for staff identifying and reporting concerns, although this was not always used effectively. Some training packages identified learning from incidents. However, we did not see the feedback and learning from incidents was shared across the wider staff team.

We saw some evidence of innovation and participation in research. The service collaborated with regional universities and charities to support research studies. The safeguard lead was chairing a pilot project ICON (Babies Cry, You Can Cope). There were 5 pilots across the country, looking at how to reduce the risk of babies being shaken and harmed. The project had a range of steps to provide information to professionals and women at different stages of their pregnancy and following the birth.

Outstanding practice

We found the following outstanding practice:

- The trust had a well established safeguarding team. The midwives had established relevant links with charitable groups associated which developing links within the local diverse community. These connections ensured appropriate birthing plans and discharge plans to support the women and their babies. The safeguard lead was chairing a pilot project ICON (Babies Cry, You Can Cope). There were 5 pilots across the country, looking at how to reduce the risk of babies being shaken and harmed. The project had a range of steps to provide information to professionals and women at different stages of their pregnancy and following the birth.
- The bereavement team was well versed in the diverse nature of the community and religious and cultural observances. The team worked closely with community groups to connect with women and their families. The team linked with the foetal medicine department and were aware in advance of those women and families who may need their support.

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

Maternity

- The trust must ensure staff are up to date with mandatory training modules. Regulation 12(1)(2) (c)
- The trust must ensure staffing for maternity is sufficient to deliver the service in line with national guidance. Regulation 18 (1))
- The trust must ensure staff act to remove or minimise risks following risk assessment for each woman. (Regulation 12(1)(2))
- The trust must ensure incidents are investigated without delay in line with trust policy. (Regulation 17(1)(2))
- The trust must ensure effective risk and governance systems are implemented which supports safe, quality care. (Regulation 17(1)(2))
- The trust must ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform in line with the Trust's own target. (Regulation 18(1)(2))
- The trust must ensure all equipment is clean, fit for purpose, regularly maintained, replaced and checked in line with Trust policy and documented clearly. (Regulation 15 (1)(2))
- The trust must ensure that accurate and contemporaneous records are maintained securely. Regulation 17(1)(2)
- The trust must ensure that policies are up to date and reviewed in accordance with the review date. Regulation 17(1)(2)

Action the trust SHOULD take to improve:

Birmingham Heartlands Hospital

- The trust should ensure staff adhere to assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. (Regulation 12(1)(2))
- The trust should ensure staff check thoroughly when completing daily checks of emergency equipment. (Regulation 17(1)(2))
- The trust should ensure all medicines are stored correctly and securely, including those requiring cold storage. (Regulation 12(1)(2))
- The trust should consider using the situation, background, assessment and recommendation (SBAR) for all handovers between clinical staff.
- The trust should continue to act on staff surveys, investigate concerns regarding bullying and racism and ensure equal opportunities for all staff.
- The trust should consider ways in which to strengthen and support the senior leadership team.
- The trust should ensure the vision and strategy is shared with all staff once developed. Regulation 17(1)(2)
- The trust should ensure all learning from incidents is shared across the wider staff team. Regulation 17(1)(2)

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 7 other CQC inspectors, and one CQC inspection manager. There were 3 specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.