Buckinghamshire Healthcare NHS Trust

Stoke Mandeville Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Stoke Mandeville 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 Stoke Mandeville Hospital.

We inspected the maternity service at Stoke Mandeville 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 2014. As such the historical Maternity and Gynaecology rating is not comparable to the current maternity inspection and is therefore retired. This means that the resulting rating for Safe and Well-led from this inspection will be the first rating of maternity services for the location. We rated safe as requires improvement and well-led as good; this is a rating of requires improvement and the hospital remains as good. This does not affect the overall Trust level rating

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection. During our inspection of maternity services at Stoke Mandeville Hospital we spoke with staff including leaders, obstetricians, anaesthetists, midwives, theatre staff, maternity support workers, the Maternity Voice Partnership team, and women and birthing people.

We visited all areas of the unit including maternity triage, the birth centre, labour ward, day assessment and mixed (antenatal and postnatal) ward. We reviewed the environment, maternity policies, 5 maternity records and 6 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 4577 babies were born at the trust between April 2021 to March 2022.

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

Maternity

Requires Improvement

We rated it as requires improvement because:

- There was not always enough staff, although this was proactively managed by leaders.
- The lack of an embedded triage policy and triage risk assessment tool meant women and birthing people could be at risk of deterioration, due to delays in care.
- The environment was not suitable in all areas and staff could not maintain confidentiality of women and birthing people in triage.
- Staff did not always have enough suitable equipment.
- Staff did not always follow processes to safely prescribe medicines, prescription charts were not always completed in full, medicines were not always stored correctly, and medicine audits were not effective in identifying areas for improvement.

However:

- Most staff had training in key skills and recent appraisals. Staff understood how to protect women and birthing people from abuse.
- The service controlled infection risk well.
- Staff felt respected, supported, and valued.
- Leaders were visible and approachable in the service, they escalated, and managed risk.
- The service worked in partnership with their local Maternity Voice Partnership, engaged well with women and birthing people from vulnerable and diverse backgrounds to make meaningful improvements for all.
- A triage improvement plan had commenced in February 2023 to improve the environment, flow and oversight, and leaders had the ability to oversee it remotely.

Is the service safe?

Requires Improvement

We rated it as Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff and most staff had completed it.

Maternity

Mandatory training was a training requirement determined by women's services through policy. It was compulsory for staff to attend all relevant training and midwives annually. Training requirements for midwives had increased with the development of the core competency framework. This had followed on from the Ockenden report (2022) and included, but was not limited to fire safety, equality and diversity, information governance, infant feeding, and human factors.

Managers monitored compliance to mandatory training and alerted staff when they needed to update their training. Staff with temporary bank contracts were paid to attend study days and their compliance was monitored in the same way as substantive staff. Leaders told us staff were on target to meet the 100% compliance trajectory by the end of 2023.

Training was multidisciplinary during annual Practical Obstetric Multi-Professional Training (PROMPT) and was mandatory training for all clinical staff working in maternity. Midwives were rostered 12 months in advance for PROMPT training. In-situ simulations were provided to supplement the PROMPT training and assess systems factors in the live environment. PROMPT compliance was 92% for midwives, 97% for obstetric doctors, 88% for maternity support workers, but only 57% for anaesthetic consultants working in obstetrics.

Staff completed in-situ simulations to enable an immediate response to emergency situations. These were planned and included safety related subjects for maternity staff. Staff told us there was a designated room for practical training which was well-equipped.

All midwives and obstetric staff completed annual training in fetal wellbeing. This was followed by a mandatory competency assessment. Staff were required to repeat the training module if they failed the assessment on the third attempt. As of June 2023, fetal monitoring training compliance was 95% for midwives and 83% for all other obstetric doctors.

Safeguarding

Staff understood how to protect 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.

Midwifery, nursing, and obstetric staff received Level 3 safeguarding training specific for their role on how to recognise and report abuse. The compliance rate was 91%. The named lead for safeguarding was trained to Level 4. The safeguarding lead contributed to the training programme, although a named safeguarding midwife delivered the main programme.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff worked with other agencies to protect them. There was a detailed process for staff to follow, which enabled them to explore and capture information on vulnerabilities, safety concerns and possible risks for women and birthing people who used the service. Safety concerns were identifiable to midwifery teams, enabling the right level of support and monitoring.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff followed safe procedures for children visiting the ward, and there was secure access to clinical areas.

We were told the safeguarding lead attended monthly Multi-Agency Safeguarding Hub (MASH) team meetings where safeguarding risks were discussed, and decisions made to protect families. We were also told the safeguarding lead attended a weekly meeting with the neonatal team, and a regional meeting each quarter.

The internal IT system did not communicate with the system used by health visitors, so staff sent a referral at 16-weeks to notify health visitors of new pregnancies. Midwives held locality meetings with health visitors, where they discussed vulnerable individuals. A senior midwife was assigned to look after women and birthing people with high risks. Teenagers were looked after by a lead midwife and case managed according to need. Plans of care were uploaded to the shared drive to ensure all staff had access.

There was a maternal mental health board on the antenatal/postnatal ward. This included tips on how to promote good mental health, information to raise awareness about mental health, how to make a referral and support groups. The latter also included details of a support group dedicated for Dads. There was an information board dedicated to safe sleep for babies which included a QR code for families to access evidence-based information.

Cleanliness, infection control and hygiene

The service managed infection risks 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.

All staff groups completed mandatory training in infection control and hand hygiene annually. They also completed 2-yearly practical hand hygiene assessment in clinical areas.

Maternity services were visibly clean and had suitable furnishings which were clean and well-maintained. The flooring in the clinical areas and associated corridors allowed for effective cleaning.

The service performed enhanced and more frequent cleaning of all areas to prevent the spread of all infectious diseases, in line with national guidance. Staff cleaned equipment after contact with women and birthing people and labelled equipment to show when it was last cleaned.

Staff followed infection control principles and had access to personal protective equipment stored in wall mounted displays. Laminated hand washing posters demonstrating best practice in techniques were on display above sinks, and staff were observed cleaning hands before and after contacts. Most staff were bare-below-the-elbow, although we saw 1 doctor wearing a wristwatch and 1 maternity support worker wearing false nails.

The service performed well for cleanliness. We saw the results of cleaning audits for labour ward and Rothschild ward (mixed antenatal and postnatal ward), for March to May 2023 and an additional 1 for June 2023 for labour ward. These were completed by a third-party contractor and showed overall scores of 98% or above. Cleaning audits included testing staff knowledge of infection prevention and control, and 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 was not always suitable. The temperature within the antenatal/post-natal ward was excessive and confidentiality could not be maintained in triage. Staff did not always have enough equipment, but managed clinical waste well.

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.

Maternity

The service had completed recent ligature point risk assessments on the labour ward and mixed antenatal/postnatal ward, to ensure the environment did not present unnecessary ligature risk. We saw ligature risk assessments had been completed for Rothschild Ward (June 2023), the birth centre, day assessment unit and antenatal clinic (May 2023) and labour ward.

However, the layout and design of the environment was not always suitable for the services provided. There was a dedicated bereavement suite for families who had experienced a baby loss, but this was situated on the Labour Ward. This was not ideal, as bereaved families might have been able to hear babies cry and families celebrating.

Birthing rooms and other clinical areas were spacious, but triage was very small and congested. The space limitations created trip hazards because equipment wires fell on the floor between each bed space.

The environment in triage made it impossible to maintain confidentiality during telephone calls, face-to-face conversations, and assessments. Staff closed curtains across beds, but we overheard all conversations. We also heard all the information requested and shared during telephone calls. This included identifiable information such as the caller's name and date-of-birth, which we heard staff re-call. We overheard the advice staff provided too. It was also not possible for staff to discuss sensitive information such as safeguarding concerns in confidence. This meant safety could be compromised. However, leaders had recently introduced a designated waiting area for those needing initial assessment as part of the triage improvement plan.

Rothschild Ward was a mixed antenatal and postnatal ward (1 side was postnatal and the other antenatal). It had 46 beds and 6 were allocated to care for transitional care babies. Beds were separated into bays of 4, 5 and 6 beds. The bays were not spacious, and staff told us partners were unable to stay outside visiting hours unless women and birthing people had a mental health issue. However, as part of the factual accuracy process the trust provided their visiting policy which detailed various reasons for partners to stay beyond visiting hours.

Each bed had a privacy curtain which were dated when changed. Some curtains were not hung correctly and did not have sufficient hooks to secure in place. This meant privacy could be affected.

We were concerned about the high temperature on Rothschild Ward. When we visited the temperature was 28 degrees Celsius at 9am and 31 degrees Celsius by the afternoon. This was despite the use of 4 portable air-conditioning units. One woman told us they had moved from a very hot bay and were more comfortable since they had been provided with a portable fan.

The trust responded to our concerns about the excessive ward temperatures and confirmed what action staff would take if the temperature exceeded 25 degrees Celsius. As part of the factual accuracy process the trust told us this included raising the matter with estates or pharmacy, although staff did not tell us this when we visited.

A milk kitchen was located on the post-natal side of the ward but did not include any visual information about milk storage or breast or formula feeding. The milk fridge and freezer were secure and required staff to unlock them. However, we found numerous samples of undated breast milk and 1 was 3 months old (dated March 2023). We were concerned that breast milk was not being stored safely and safe storage was not monitored effectively. We escalated this to the matron who told us they would resolve the issue.

Formula milk was stored in the fridge due to the high temperature on the ward. Staff recorded the temperature of the fridge and freezer daily. We noted that the fridge temperature was frequently outside the accepted range, but staff re-set the temperature when this happened and monitored it.

Maternity

Staff told us they did not always have enough suitable equipment to help them safely care for women, birthing people, and babies. For example, sonicaids (used to listen to babies' heartbeat) and cardiotocography (CTG) machines (used to assess electronically fetal wellbeing electronically). Leaders were aware of the need for more fetal monitoring equipment due to feedback from staff and the fetal monitoring midwife. As part of the factual accuracy process leaders shared their business case to replace the fleet of 26 CTG machines as well as purchase an additional 4. Fifteen new machines had been implemented following our visit.

Trolleys which stored equipment for emergencies were locked and stored securely. Checks of the resuscitation trolley and other emergency items had improved since April 2023. However, the resuscitation guidelines attached to the resuscitation trolley on Rothschild Ward were dated 2015 and had not been updated to the most recent recommendations of 2021.

Midwives received mandatory training on how to use medical devices followed by 3 yearly updates. Electrical devices had been safety checked and stickers were attached to indicate when the next service was due. We saw information to confirm electrical safety checks had been carried out on 12,305 items. Safety signage related to piped oxygen were displayed close to the outlets by bedsides.

Staff disposed of clinical waste safely. Waste was handled appropriately with separate colour coded arrangements for general waste 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. The date opened was stated on the bins and within three months of expiry in all areas. Arrangements for control of substances hazardous to health were adhered to.

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. However, it could be difficult for staff to always identify and quickly act upon women and birthing people who attended triage and were at risk of deterioration as the triage tool and policy were not fully embedded.

Triage phone-line did not have a protected staff member to triage calls. This made it difficult for staff to ensure people attended the correct area, within a time frame specific to their risk and need.

The Quality Improvement Team had spent time completing observations of flow and process in triage in April 2023. They noted that women and birthing people sometimes had to call back several times when the line was engaged, and sometimes had to attend triage unannounced as they could not get through. This created delays and could mean some people attended unnecessarily or attended the wrong area.

Staff were required to complete risk assessments for each woman and birthing person on arrival to triage. This included the completion of a standard clinical triage assessment. The assessment should be completed by a midwife, within 15 minutes of attendance, to help define clinical urgency, guide timing of subsequent assessment and immediate care.

When we visited, we found the process was for the midwifery support worker (MSW) to see women and pregnant people on arrival, take and record their observations and complete urinalysis, before the midwifery assessment. This was not in-line with the local triage policy, which triage staff were unfamiliar with.

The streaming process for women and birthing people to attend and be reviewed was not seamless. There was no process to prioritise call-backs taken by the MSW. This could affect timely reviews, management, and treatment.

Maternity

We did not see evidence of poor outcomes but did note delays had been recorded, which created risk. Staff were often unable to triage women and birthing people in line with local policy timeframes. This could be due to staffing shortages and high acuity. They often did not have timely medical reviews as they were reviewed by obstetric staff who also covered the labour ward. This meant waiting times were unpredictable because medical staff had other work commitments which took priority.

We saw the most recent audit results was for May and June 2022, which highlighted that 50% of delays were due to waiting for an obstetric review, or plan. Most of these delays were because the same obstetric team covered labour ward and triage and obstetric staff could be attending an emergency, in theatre or a ward round. Waiting times often exceeded expected timeframes within local policy.

We highlighted our concerns about triage immediately. This included unsafe staffing levels, lack of timely obstetric reviews, no dedicated staff member to manage the telephone-line and no process for calls to be diverted when there was no pick-up. We followed our concerns up the following day by issuing a Letter of Concern.

Leaders responded to our concerns and ceased the management of calls by MSWs. Call-backs ceased the week commencing 26 June 2023. Leaders told us that if the triage midwife was busy the MSW would answer the phone, take the caller's name, and take the phone to the labour ward coordinator to speak to the caller directly. Leaders also told us work was in progress to implement a Wi-Fi-based telephone system which had the capability to enable call-waiting functions and divert to the labour ward if calls were not answered promptly.

Leaders told us they were introducing a RAG (red, amber, green) assessment to outline the recommended timeframes for obstetric reviews and an escalation process if the timeframe was breached.

Staff completed risk assessments for women and birthing people on admission to other areas. They used a recognised tool, and reviewed this regularly, including after any incident. The risk assessment included consideration of safeguarding, social and mental health, previous medical and surgical history.

Staff knew about and dealt with any specific risk issues. Any risks related to these areas were recorded and there was evidence of actions, when required. For example, the use of medicine or stockings to reduce the risk of having a blood clot.

A nationally recognised tool to identify women and birthing people at risk of deterioration was used by staff. Where there were concerns from the assessment tool, they were escalated appropriately. Records showed evidence of the use of the Modified Early Obstetric Warning Score (MEOWS). This is designed to allow early recognition of physical deterioration in women and birthing people.

Staff used the 'fresh eyes' approach to carry out fetal monitoring safely and effectively, in line with national guidance. The fetal monitoring midwife audited compliance with the trust's Fetal Monitoring in Labour guideline, identified areas that required improvement and monitored to ensure changes were effective.

Leaders monitored and reported completion rates for key risk assessments, and we saw a 100% completion rate for risk assessments related to fetal growth restriction, preterm birth, preeclampsia, and haemorrhage in the previous quarter to our inspection.

Nurse / midwifery staffing

Maternity

The service did not always have enough staff, but this was proactively managed by leaders. Staff were appropriately trained, skilled and qualified to keep women, birthing people, and babies safe and provide the right care and treatment.

Staffing levels did not always match the planned numbers which could put the safety of women, birthing people, and babies at risk. However, on the day of our inspection there were 17 midwives plus 1 supernumerary coordinator supported by 2 registered nurses and 2 senior midwives on Rothschild Ward. This was in line with planned staffing levels and managers re-deployed staff to areas most-in-need, as required.

The service had high vacancy and sickness rates. Eleven midwives had left the service 6 months before the inspection. Staff told us low numbers of staff made them feel unsafe and sickness rates were increasing as staff became more stressed. Midwifery sickness rates ranged from 1.3% to 5.7% in May 2023.

The service used a nationally recognised tool to calculate midwifery staffing levels. We saw data for labour ward for the weeks commencing 27 March and 3, 10 and 17 April. Data showed staffing levels met acuity 61% of the time, with up to 2.5 midwives short 38% of the time and 2.5 or more midwives short 1% of the time and for Rothschild Ward (mixed antenatal and postnatal ward) data showed the ward was up to 2 staff short 19% of the time and over 4 short 9% of the time.

We were told there should be 2 midwives and 1 midwifery support worker (MSW) allocated to triage, but this rarely happened due to short staffing. When we visited triage there was only 1 midwife and 1 MSW. We were told this was common practice, despite high acuity in triage. We were also told there were occasions when there was just 1 member of staff covering triage, and this could be the MSW. The MSW generally managed the phone-line which was not in-line with local policy. One midwife sometimes had to work alone and manage the phone-line, as well as admit and triage women and birthing people.

Workload and flow were also impacted because staff often had to source suitable equipment from other areas, and they had no immediate access to medication. Staff did not report any of these issues as an incident because they had become normalised.

We were told that when triage was full women and birthing people were transferred to the birth centre and labour ward, who would then be responsible for monitoring and providing care. However, this added to labour ward acuity and the workload of the labour ward coordinator. We raised concerns about inadequate staffing on triage on the day of inspection and followed our concerns up in writing the following the day. The trust responded by provided an update of their triage improvement plan which included imminent actions to improve flow and efficiency in the area.

Leaders 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. We saw that red flag events were reported in the midwifery staffing six monthly oversight reports for monitoring and oversight. The most frequently recorded red flag event was delayed induction of labour. There have been 66 delayed inductions over 6 months (between 10 and 17 a month) reported in the Maternity Oversight Report October 1st- March 31st, 2023. Delayed inductions were reviewed at the daily safety huddle and at medical handovers as a minimum. A daily local maternity and neonatal system safety huddle had also been implemented and mutual aid was sought to support delayed inductions when possible.

Maternity

A practice development team of 4 staff supported midwives. Managers supported staff to develop through yearly, constructive appraisals of their work and we saw 98% of staff within the women, children and sexual health directorate had a recent appraisal.

Managers made sure staff received any specialist training for their role. For example, some midwives had received funding for specialist training including master's level courses in advanced midwifery practice and the professional midwifery advocate course.

A preceptorship programme was used to assist newly qualified midwives to consolidate their skills. This was said to be an enjoyable experience, with flexibility to complete as appropriate. We saw a board dedicated to students in clinical areas, which included information on how to access additional support and details of a monthly student listening event where students could make suggestions for discussions and share ideas for improvement. We also read several pieces of positive student feedback regarding the support they received when working on labour ward.

Medical staffing

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

The service was budgeted for 20 whole time equivalent consultants. One consultant was not covering on-calls and there was 1 vacant post. Consultant presence on the labour ward was organised as ‘consultant weeks’ as suggested in Safer Childbirth (2007). Some weeks were split between 2 consultants, or some days could be covered by a different consultant, but there was always a dedicated labour ward consultant on site Monday to Friday from 8am to 8:30pm. Consultant cover was guaranteed as leave for holidays and study were arranged outside of the allocated week and during this time all other routine clinical commitments were cancelled. This system improved continuity-of-care.

The weekly rota for consultant presence and on-call cover was available in all the clinical areas. The service always had a consultant on-call during evenings and weekends. Consultants led a formal round/handover on labour ward in the morning, at 5pm and the evening. They also completed a walk-around at 1pm to ensure they had oversight and could support the teams.

Leaders monitored the number of weekly hours of senior obstetric cover on labour ward. This was 74.5 hours per week for the 3 months in the most recent report (April 2023) and showed staff reported a red flag if the hours were below this. The service was not adhering to recommendations outlined in Safer Childbirth (2021), and Standards in Maternity Care (2016), by providing 98 hours of consultant presence by 2010 in-line with 4,000-5,000 births per year.

Leaders told us there was a clear standard operating procedure, which included what situations a consultant must be called for. This was on display in the handover room. Coordinators recorded if a consultant had been called in their handover documentation. The labour ward lead consultant audited notes if there was a scenario where a consultant should have been called but were not. Results were shared at safety champions meetings.

Theatre pathways were effective. There was always 1 theatre emergency team specifically for obstetrics. There was also an elective obstetric team that operated Monday to Friday mornings for planned caesarean sections (c/s). A further

general surgical team could be available to assist with simultaneous obstetric emergencies although this depended on theatre activity within the general hospital. Elective and emergency c/s did not impact on labour ward acuity, and we were told there were regular review multidisciplinary reviews of inductions of labour and plans of care for high-risk women and birthing people to ensure minimal delays and potential transfers to theatre.

We were told there had been some recent challenges with obstetric cover, due to maternity leave. This had been mitigated by consultants performing roles normally completed by more junior staff, when needed. We were told his was temporary (until August 2023), and the risk was not high enough to be on the risk register.

There was 24-hour access to a duty consultant anaesthetist for obstetric cover and there was anaesthetic consultant cover between the hours of 8am and 6pm, Monday to Friday. Trust guidelines indicated there was 24-hour resident duty cover on the labour ward from a combination of trainee anaesthetists, and doctors competent in obstetric anaesthesia. Guidelines were available to demonstrate what action medical staff should take when there was an anticipated delay in having an epidural placed and when 2 obstetric theatres were in use for emergencies at the same time.

Mitigations for reduced anaesthetic medical staffing on the labour ward were managed in accordance with the trust's procedures. We were informed an intensive care unit doctor of level ST2 or above who had had their initial obstetric competencies signed off would support in such situations The staffing of obstetric anaesthetics was subject to an external annual review and the most recent inspection had been completed in May 2023. We noted it was reported that women, children, and sexual health division had a high locum spend at middle grade level. This was building a cost concern but not a safety concern as it is covered by familiar staff on their Bank.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work and 96% of medical staff had a recent appraisal. Medical staff told us they felt supported to do their job through clinical supervision and were given the opportunities to develop. Every consultant had a mentor, particularly for their first 5 years. There was a supportive framework for trainees and registrars, offered through educational supervisors.

Records

Staff kept detailed records of care and treatment. Records were stored securely and easily available to staff providing care, but not always fully completed.

Records were a mixture of electronic and paper. Gaps between different electronic and paper documentation may impact the ability to have complete oversight of women and birthing people and could create risk.

There were lots of different systems for staff to navigate. For example, for requesting scans, checking bloods results, and recording care. Leaders were aware this was problematic and having their own maternity digital system was part of the maternity strategy.

Leaders had engaged with staff, their Maternity Voice Partnership and service users to determine what would be the most suitable digital system and several suppliers had presented their packages during open forums. This helped to ensure staff were part of the decision-making. They had engaged with their Local Maternity and Neonatal System to choose a package that would support them to work across departments and organisations, so they could provide seamless care for service-users.

Records were stored securely and could only be accessed by clinical staff. When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Maternity

We reviewed 5 records which included care from booking to discharge. Records were not always easy to follow. Most information was readable, although it was not always clear if entries were made by a doctor or midwife, and signatures were not always added to the Situation, Background, Assessment, Recommendation' (SBAR) assessment. This is a written communication tool which helps provide essential, concise information, usually during crucial situations.

A post-natal check list had not been completed in 1 of the records we reviewed, and 1 continuous electronic trace had missing information. We checked 5 medicine charts and noted they did not all have signatures and name details in the contact section. The date and time was also missing from 1 record.

Medicines

Staff did not always follow processes to safely prescribe medicines, prescription charts were not always completed in full, medicines were not always stored correctly, and audits were not always effective.

We saw several medicines which were not stored correctly on the labour ward and mixed antenatal and postnatal ward. Most medicines contained instructions about the temperature they should be stored at. This included not being stored above 25 degrees Celsius. The temperature on the mixed antenatal and postnatal ward was 30 degrees Celsius on the day of our visit. Annex 24 of the medicines policy states temperature monitoring where medicines were stored must be measured and recorded daily. The ward temperature was being recorded but not directly in the area where medicines were stored. As the medicines cupboards were not in a separate temperature-controlled room, they were subjected to the temperature changes on the main ward.

There was an annex in the medicines management policy related to the safety of medicines requiring cold storage. This included checking fridge temperatures. Records showed these checks were mostly completed.

Several medicines were being stored unsafely which meant they may not have been suitable for use. Medicines held in the post-partum haemorrhage emergency trolley were also stored in temperature conditions beyond those recommended. This included medication to control blood pressure, contractions and to treat severe bleeding following childbirth.

Some medicines in this trolley were not kept in the original box and did not have the accompanying user guidance. Magnesium sulphate for intravenous use was stored in a plastic bag on this trolley and the guidance for it was stored electronically which could create a delay. Oxytocin was outside its original package and did not have a date noted as to when it came into use. This product can be stored at 25 degrees Celsius for 6-months, then should be discarded. (Oxytocin is a hormone that's produced in the hypothalamus and released into the bloodstream by the pituitary gland. Its main function is to facilitate childbirth.) We escalated this immediately to managers who told us they would discard the medicines. We followed our concerns up the following day in a Letter of Concern. The trust was responsive and informed us medicines were removed from emergency trolleys and were now kept in the fridges.

Staff stored medicines in locked cupboards, identified alphabetically. These cupboards were located behind the nurse station and not within a separate temperature-controlled environment. Keys were kept by the person in charge, although it was not always easy to find who had them. As there was only 1 set of keys, this could cause delay in accessing keys.

There was no medicine cupboard in triage which meant midwives had to constantly visit the other side of labour ward to access required medicines and the QI project highlighted that drugs were stored unsafely in an unlocked cupboard as a short cut. However, a triage improvement plan was in progress and leaders were trying to source a suitable cupboard and venue to store it, as part of the plan.

Staff did not always follow systems and processes to prescribe and administer medicines. Medicine records showed some improvement was needed for recording dates and indicating if a doctor or midwife had added their signature and date. Midwives may administer or supply medicines under midwife exemptions, without the need for a prescription. Staff were aware of their ability to prescribe drugs on a midwives' exemption. There was no list on the ward to confirm which medicines were included under exemptions. However, a list of drugs approved for administration by registered midwives under midwives' exemptions were available on the trust internet.

Controlled drugs (CD) were stored in a secure cupboard in clinical areas. CD checks were up-to-date. We noted oral morphine should be stored below 25 degrees Celsius and the ward was at 31 degrees, when we did the checks. In addition to this there was no start date recorded on the bottle of morphine which is a requirement as it should be discarded 90 days after opening

We observed two clinical staff preparing to give a CD. They were stopped and asked by the matron to put on a do-not-disturb red tabard. This took some time to comply with and it was clear this was not usual practice.

A book for recording checks of the emergency trolley was kept near to some of the medicines. This was not clear and added to the confusion around safety checks, as a separate check list was kept by the trolley.

All midwifery staff completed a basic drug calculations test at interview or on commencement of post. They also completed a medicines management e-learning module and competency assessment during their induction and an e-learning package and drugs calculation test annually although staff could not give examples of learning from medicine safety alerts or incidents to improve medicine related practice. However, it was difficult to understand how effective this training was, given the issues we identified.

Medicines management audits were completed in clinical areas. Audit results for April, May and June 2023 were 100%. However, they had not identified the concerns we found. For example, lack of room temperature monitoring in areas where medicines were stored and temperatures could be excessive, and oversight of maternity specific emergency trolleys. This was despite the issues with temperature control of the estate which was on the corporate risk register as an ongoing matter.

Incidents

Staff recognised incidents and generally reported them. 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.

The volume of incidents we were made aware of was not excessive. For the period 1 December 2022 to 21 June 2023, there had been 80 incidents.

Maternity

Staff knew what incidents to report and how to report them. There was a clear process for staff to follow. The trust used an electronic reporting system which all grades of staff had access to. Training in incident management was provided at induction and during regular trust training sessions. Despite this, they did not always report when there was insufficient staff or a lack of equipment. Lack of reporting reduced the ability of the provider to understand the extent of the problem/s and look for resolution.

Themes from reported incidents were identified and used to make improvements. For example, a project was initiated in response to transitional care and re-admission of babies with jaundice. The project was aimed at reducing the number of avoidable re-admissions and included babies at risk of jaundice, breastfeeding support, and previous familial history of jaundice.

The safeguarding lead told us about learning which had come out of a safeguarding matter. They had identified that professional curiosity was not always happening, as questions were not always as probing as they should be. Had they been at the time of the incident, enhanced follow up would have been arranged. One staff member described how they were involved in a learning exercise following an investigation. They indicated how this had helped them but were not aware of any shared learning to the wider team from the reflections.

Leaders facilitated a ‘hot debrief’ immediately after any serious incident. Hot debriefing is a form of debriefing which takes place 'there and then' following a clinical event and has the advantage of earlier intervention, improved participation, and improved recall of events. We were given several examples of how staff would be supported. Midwifery and medical staff had access to psychological support through occupational health. Midwifery staff would be supported by a professional midwifery advocate or chosen manager, and educational supervisors and consultants supported medical staff.

Managers considered the need for an evidence-based approach using a trauma risk management (TRiM) methodology. This helped to identify risks for people who may suffer poor mental health following a traumatic experience.

Staff received feedback following incident investigations and themes from incidents were shared. Learning from incidents was shared at handovers and huddles in all clinical areas. Safety messages were updated weekly and shared with all staff by email, a closed Facebook group, verbal handover, and the handover board. Themes from incidents were discussed between the governance and practice development team and incorporated into training sessions to disseminate learning and help prevent reoccurrence.

There were polices and procedural guidance to assist staff in identifying and responding to risk. For example, policies for electronic fetal monitoring, capacity, and escalation in the maternity service. These were in date and appropriate for use.

Maternity services had an up to date Being Open and Duty of Candour Policy which staff understood. Managers assessed the application of the duty of candour (DoC) against all incidents and compliance was monitored as part of an annual audit of moderate, severe and death incidents by the head of patient safety and litigation.

Is the service well-led?

Good

We rated it as good.

Maternity

Leadership

Leaders within maternity 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, birthing people and staff. They 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 understood the challenges to quality and sustainability within the service and plans to manage them, which were shared with staff.

The leadership structure was well-defined and was made up of an interim divisional director for obstetrics, gynaecology, children, young people, and sexual health. There were obstetric leads for governance, labour ward, the mixed antenatal and postnatal ward, fetal medicine, diabetes, and perinatal mental health. There was a director of midwifery (DoM) supported by a head of midwifery (HoM) and gynaecology, matrons, lead midwives, specialists, and band 7 midwives.

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.

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 DoM attended board meetings and presented any midwifery papers/reports. There was a group approach to presenting to the board If matters needed to be reported or escalated by exception.

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 and supportive, and proactive about driving improvements in maternity services.

Leaders were well respected and described as approachable, and supportive. The service was supported by 4 maternity safety champions which included a non-executive director who completed regular walk-arounds. They gathered feedback from walk-abouts and triangulated this with feedback from the Maternity Voice Partnership to make improvements. For example, they recruited infant feeding support workers for day and night shifts to improve breastfeeding support.

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.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. This was developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services, improvement, addressing health inequalities and were aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Maternity services had a vision to provide outstanding care, healthy communities and be a great place to work with a strategy for how to implement that between 2022-2025. There were 5 objectives which included maternity and neonatal safety, demand for the services, achieving digital maturity, financial stability and their people plan.

Primary and secondary drivers were outlined to help achieve their aims with detailed lists of ideas for interventions to help meet the aims and objectives within the strategy. Driver diagrams showed implementation plans to deliver strategic aims and priorities. Leaders told us they wanted it to be easy to understand and continual, although it was not clear from staff we spoke with, how or if, they had contributed to these.

Culture

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

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.

Senior staff commented on the pressures on staff and their hard work and commitment despite challenging circumstances. Leaders and staff recognised the commitment and willingness to work as a team, supporting one another, and of having good support from midwifery leaders.

Leaders understood how health inequalities affected treatment and outcomes for women, birthing people 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.

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. Leaders told us they reviewed incidents and complaints to see if there were any themes concerning women and birthing people from disadvantaged backgrounds, or ethnic minority groups.

Feedback from issues raised was presented on notice boards. This included staff reporting IT equipment and lack of other equipment being an issue. The response was that IT had been upgraded and additional items of equipment had been bought.

It was recorded in the Midwifery Staffing Six Monthly Oversight Report for 1st October 2022 to 31st March 2023, that the staff survey results demonstrated several key improvements. Also reflected was a team who needed increased support and active steps to feel valued and engaged.

Women and birthing people we spoke with were positive about their experience, and 2 said communication, support and general attitude had improved since their previous experiences. We heard staff dealing with discharge processes and a parental concern about their baby in a compassionate manner.

Following our inspection, we received 24 feedback forms from women and birthing people who had used maternity services at the hospital. There was a negative theme from some related to poor experience of care in labour and following birth, staffing levels, and not feeling listened to. Five out of the 24 pieces of feedback were positive about care, although 2 out of those 5 also commented that there was insufficient staff.

Maternity

The service had an open culture where women, birthing people, their families and staff could raise concerns without fear. The service clearly displayed information about how to raise a concern in clinical and visitor areas. Staff understood the policy on complaints and knew how to manage them.

All complaints and concerns were managed fairly, and the service used the most informal approach applicable to deal with complaints. We saw 100% of formal complaints for the previous 12 months, had been responded to with 28 days.

Complaints were fed back to individuals to help them understand the parent's perception of their care. Themes were shared at handovers, huddles, on staff notice boards, their governance newsletter, and by email. Complaints and compliments were considered as a means of checking if the culture was reflected as they would expect.

We noted themes, actions and learning from complaints were triangulated with feedback from the Friends and Family Test results and the Maternity Voice Partnership following their regular walkarounds and listening events. This was included in the quarterly Perinatal Quality Surveillance Model Report for review and oversight.

The trust employed 5 Freedom to Speak up Guardians (FTSuG), to support staff who wished to speak up about a concern or issue. They employed an outreach model to ensure a FTSuG was visible and accessible to all areas, including community services. There was information on display about how they could support staff and to contact them and raise a concern in confidence.

There were 9 professional midwifery advocates who provided any necessary support. They offered support following incidents which included emotional support as well as practical support with preparing and writing statements. They supported midwives with their revalidation and development and collected feedback and ideas to help improve their maternity service.

Governance

Leaders operated effective governance processes, throughout the service. However, staff were unfamiliar with local guidance for working in triage and leaders did not always have oversight of audits.

The trust moved to a centralised governance structure in 2022, although maternity and neonatal services reported to the chief nurse through the director of midwifery (DoM). There was a lead midwife for governance who managed a small governance team. This included the quality and risk management midwife, the paediatric governance lead, and 2 governance support workers. There was a consultant obstetrician for governance who was also the obstetric lead for fetal monitoring.

Leaders had not addressed where staff were working outside of local guidance and policy for triage. They had identified a lack of timeliness of obstetric reviews from audit results in June 2022. However, risks were not immediately mitigated to monitor drop-off calls, people who did not attend or attended without their handheld records.

A quality improvement (QI) project for triage had commenced in February 2023 (8 months following audit results). The QI project was aimed to monitor flow and ensure more timely and efficient risk assessments. Leaders had recently introduced a designated waiting area as part of the triage improvement plan for those needing initial assessment and to aid the flow. Leaders also confirmed their monitoring of triage performance over the last 12 months where 1 incident (which was assessed as unavoidable) occurred. They were confident the system and triage were safe, and told us about their ability to oversee it remotely.

Maternity

Leaders did not have oversight of medicine management when we visited and although they responded to our concerns immediately, it was difficult to understand how these issues had not be identified internally, as part of audit and governance process.

We saw agreed actions from incidents were not always timely. For example, we noted an action which was due to be implemented on 31 March 2023 (following a serious incident), was still outstanding. The number of overdue actions from incidents were 5, but the service was working towards reducing this number which had been 17 in April 2023.

There was a detailed programme of audit to drive improvements in maternity services and there was a tracker to help maintain oversight of the programme. Despite this, we saw most audits had not commenced on planned dates and did not include the expected compliance target or previous results.

The trust had not met 3 out of 10 safety actions (results published May 2023) for year 4 of the Maternity Incentive Scheme (MIS). The MIS rewards trusts meeting the 10 safety actions designed to support the delivery of best practice in maternity and neonatal services through an incentive element to trust contributions to the CNST (Clinical Negligence Scheme for Trusts). The un-met safety actions included: avoiding unnecessary term admissions of babies, compliance with all 5 elements of the Saving Babies' Lives care bundle (SBLCBv2) and demonstrating that at least 90% of all maternity staff had attended multi-professional emergency training for maternity, within the last training year.

However, the service did have oversight of term admissions to the neonatal unit by maintaining an overview of all Datix. The service maintained oversight of non-compliance with SBLCBv2 through their overview and monitoring of the maternity risk register and they maintained oversight of the anaesthetic attendance at PROMPT through the perinatal quality surveillance reports.

There was evidence that some audits were completed in-line with the tracker timeframes. For example, risk assessments for the appropriateness of continuous electronic fetal monitoring. This audit showed escalation was appropriate in 85% of cases. However, only 42% of Fresh Eyes reviews were completed within 30-minutes (as recommended in local and national guidance), and a Fresh Eyes sticker was only completed when there was a decision to expedite birth in 25% of cases. Suggested solutions had been introduced and included highlighting that obstetricians and the fetal monitoring lead midwife could be asked to perform Fresh Eyes reviews. There was a re-audit in May 2023 (1 month later) to determine if the solutions were effective.

Matrons fed information related to complaints, staff feedback, incidents, and areas in need of development upwards. Matrons provided audit information using an electronic system. This was a quality inspection App and platform for health and care settings. Areas for improvement were identified, such as additional breastfeeding support and more timely call-bell responses. Both were included in the audit programme, although we saw they had not yet started.

The trust Safeguarding Committee met bi-monthly. A quarterly report was produced, and an annual report fed up to the Board. Leaders monitored key performance indicators which were reported as part of the trust’s quarterly Perinatal Quality Surveillance Model Report and the trust Safeguarding Committee met bi-monthly.

Midwives and nurses of all grades received annual training on clinical governance as part of mandatory training. This was a 1.5-hour slot where a case study was presented to encourage staff to consider risk and ensure they know how to complete incident reports. This was in addition to a generic e-learning module of 1 hour. The governance lead met the practice development team monthly to review training needs, and ensure any themes form incidents and complaint's themes were weaved into training.

Maternity

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

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.

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 assurance measures. An assessment of the likelihood of the risk materialising, possible impact, and the review date were also included.

Leaders and staff told us the vacancy rate was 17% and their highest risk, although 1 leader told us their highest risk was lack of electronic cardiotocograph monitoring machines (CTG). Leaders proactively managed the vacancy factor. Active recruitment and retention were in progress and the trajectory was for an increase of at least 19 wholetime equivalent midwives by October 2023.

Leaders provided the trust board with a 6-monthly report on midwifery staffing. They completed a review every 6-months, in line with maternity incentive scheme recommendations. Maternity governance processes were followed to ensure the vacancy levels were risk assessed, escalated, and mitigated as far as possible. There was recognition that more needed to be done to reduce agency costs and a recruitment midwife was in post to look at what could be done to improve the situation.

Leaders had met with NHS England to discuss a support package and possible solutions for their vacancy rate, although they advised they could not offer any additional recommendations to what they had already tried and implemented. Leaders had introduced some ‘quick wins’ which were having a positive impact. For example, they had implemented flexible workings and over 60 members of staff had made use of this. They had looked at succession planning and supporting recruitment with international midwives. Six midwives were completing a master's degree and there was a plan to offer another 9 funding in September 2023.

We were told the CTG machines were being upgraded the week following our visit and there would be a second update following a successful trial. The procurement process for new CTGs had been completed to also ensure staff had access to the same model. This process was expected to be completed by the end of June 2023.

There were polices and procedural guidance to assist staff in identifying and responding to risk. For example, policies for electronic fetal monitoring, capacity, and escalation in the maternity service. These were in date and appropriate for use although staff were unfamiliar with the policy for working in triage and staff on the ward the mixed antenatal and postnatal ward were unfamiliar with visiting policy.

We were told there was a business continuity plan to manage temperature control of the estate, which included plans for a heatwave. Temperature control was a long-standing issue and although mitigations were implemented when we visited, they were not very effective.

Maternity

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

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 care and support for women and birthing people.

Maternity services had a smartboard situated in the staff handover room. The 'at-a-glance' screen provided an immediate and live overview of all activity within maternity services. For example, the number of women and birthing people in triage, the number waiting to be discharged, having their labour induced and planned caesarean sections.

Engagement

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

The service had a well-established and valued Maternity Voices Partnership (MVP). The MVP was multidisciplinary and helped to ensure the voices of women, birthing people and families were heard by the trust, and used to make meaningful improvements.

Maternity services and the MVP were focused on equality and inclusion. The trust had provided the MVP with additional funding to enable them to recruit engagement leads who spoke the most common local languages. They had developed posters translated into the10 most used languages. Leaders were also looking at 'interpreter-on-wheels' which used an iPad to enable face-to-face contact with an interpreter, and additional resources to support communication for people with additional needs.

The MVP worked hard to listen to communities who had previously been less heard. They attended community open days, health and wellbeing events and held multiple listening clinics to listen to local people and advocate for them. They set up a Mamas and Babas group aimed at the South Asian community and developed a voice video to develop a wider understanding around some of the cultural issues faced locally.

The MVP completed regular walk-arounds and their feedback was used to make improvements. They delivered training, were involved with recruitment, co-produced user information leaflets, videos, information packs, the maternity website, and guidelines.

They worked in partnership with external partners to improve maternity services. For example, the Family Nurse Partnership, family centres within the county, the council, and Buckinghamshire New University programme for

midwifery students. They attended local, regional, and national forums to represent the voice of maternity services. Additionally, they maintained a significant social media presence across multiple channels, engaging with local users of the maternity service, sharing information, and providing a forum for 'Question and Answer' sessions with clinical staff and more.

We saw the minutes of the last 3 meetings between the maternity service and the MVP. Meetings were multidisciplinary and demonstrated engagement which included ethnic minority groups and showed an appreciation of the need to design maternity services in response to local feedback. Survey results were discussed. There was recognition of lower response numbers from the more deprived southern part of the county, acknowledgment that this needed to be improved, and how this could be achieved.

Maternity services provided updates to the MVP which included staffing status, recruitment, and the new building. There was some evidence of their commitment to continually address health inequality, whatever their focus was.

The maternity website was detailed and easy to use. There was a range of information and videos to ensure women, birthing people and families were well informed to support informed consent. The maternity landing page included a tool which supported translation, speech and read-aloud support. This gave assurance that the online experiences of services users were accessible.

There was a trust wide telephone outage during our visit, but the trust was very responsive and communicated effectively to the public through the trust website and social media.

The service made it clear and easy for women, birthing people, and families to give feedback and they monitored this and reported the Friends and Family Test results quarterly. The response rate was 10% - 65%% for the 3 months prior to our inspection and positive feedback was 85%-90%.

There were systems to engage with staff and the governance team had introduced a QR code to make it easier for staff to share ideas for improvement and any concerns. 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 Guardians and where staff could get support.

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.

The Director of Midwifery and the Turning the Tide oversight group won the Health Service Journal award in the NHS Race Equality category in 2022. Their report outlined the experiences of maternity staff, women, and birthing people of Black, Asian, and ethnic minority heritage during the COVID-19 pandemic. It made several recommendations for improvement, 1 of which was to achieve equity in career development, opportunity, and wellbeing for non-white staff and to address current barriers.

The Turning the Tide team developed a national mentoring scheme for Black, Asian, and ethnic minority midwives and maternity support workers in collaboration with the Royal College of Midwives.

Maternity

There was a variety of Apps to support-parents-to be. They included a Mum and Baby App with information to support plans and decisions about maternity care. There was an App to support Dads which aimed to help individuals cope with the physical and emotional strains fatherhood could place on individuals and relationships.

An ibook postnatal guide for parents was introduced at the trust. This was developed by another trust and shared across the local maternity and neonatal system The book had chapters on care of the newborn, including extensive research-based information on safe sleeping, infant feeding, and bonding. A registered midwife also presented short videos to support practical information.

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 services were working toward Baby Friendly accreditation. They had achieved stage 1 and were preparing for stage 2.

Outstanding practice

We found the following outstanding practice:

- 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.
- The Director of Midwifery and the Turning the Tide oversight group for their report made recommendations for improvement, 1 of which was to achieve equity in career development, opportunity, and wellbeing for non-white staff and to address current barriers.

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 anaesthetic staff are up-to-date with maternity mandatory training modules. Regulation 12(1)(2)(c).
- The service must ensure they have a suitable environment to triage pregnant women and birthing people which includes sufficient suitable equipment. Regulation15(c)
- The service must monitor the triage improvement plan to ensure women and birthing people are triaged and reviewed according to their clinical need and urgency. Regulation 17(1)(2)(a)(b)(c)
- The service must improve the governance of medicine management. Regulation 12(1)(2)(g)

Maternity

SHOULDS

Maternity

- The service should consider how they can improve confidentiality of women and birthing people attending triage.

Our inspection team

The team that inspected the service included a CQC lead inspector, 1 CQC specialist advisor, 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
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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

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