East Cheshire NHS Trust

Macclesfield District General Hospital

Inspection report

Macclesfield District Hospital
Victoria Road
Macclesfield
SK10 3BL
Tel: 01625661501
www.eastcheshire.nhs.uk

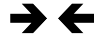
Date of inspection visit: 19 December 2023
Date of publication: 10/05/2024

Ratings

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

Our findings

Overall summary of services at Macclesfield District General Hospital

Requires Improvement 

Pages 1 to 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 Macclesfield District General Hospital.

We inspected the maternity service at Macclesfield District General 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.

The Macclesfield District General Hospital provides maternity services to the population of East Cheshire.

Maternity services include antenatal clinics, a triage area, a consultant-led delivery suite and a mixed antenatal and postnatal ward, and bereavement room.

Consultant-led intrapartum services had been non-operational during the COVID-19 pandemic and had recently reopened on 26th June 2023. As such, maternity services had been operational for a short time only, and this had implications for how aspects of the service were run and delivered. This limited the evidence the service could provide for our inspection. There were approximately 1000 births per year at the service.

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

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

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

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

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection. We visited the maternity triage, labour ward, and the antenatal and postnatal ward. We spoke with approximately 6 midwives, 1 support worker, 1 member of theatre staff and 3 women. We received 3 responses to our give feedback on care posters which were in place during the inspection. We reviewed 5 patient care records, 5 observation and escalation charts and 6 medicines records.

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

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

Maternity

Good

Maternity services had only been operational for 6 months prior to our inspection, our judgements have been made considering the limited data available to us.

- The service provided mandatory training in key skills to all staff. The staff were on trajectory for annual completion.
- Staff generally understood how to protect women and birthing people from abuse.
- The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste.
- The service generally had enough medical staff with the right qualifications, skills, training, and experience to keep women and birthing people and babies safe from avoidable harm, and to provide the right care and treatment.
- The service used systems and processes to prescribe, administer, record and store medicines.
- Staff kept records of women and birthing people's care and treatment and stored these securely.
- Staff mostly recognised and reported incidents. Managers investigated incidents and there was evidence of shared learning. Staff understood the duty of candour.
- Leaders had the skills and abilities to run the service. They were visible and approachable in the service for staff.
- Staff felt respected and supported. They were focused on the needs of women and birthing people receiving care. The service generally had an open culture where women and birthing people, their families, and staff could raise concerns without fear.
- Leaders and staff engaged with women and birthing people, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.
- Staff wanted to continually learn and improve services. They had an understanding of quality improvement processes.

However:

- The service did not always control infection risk. Staff did not always use equipment or control measures to protect women and birthing people, themselves, and others from infection. Equipment and the premises were not always assessed as clean.
- Staff did not always complete and update risk assessments or take action to remove or minimise risks. They did not always identify and quickly act upon women and birthing people at risk of deterioration.
- Staffing levels did not always match the recommended numbers, potentially putting the safety of women and birthing people and babies at risk.
- The service did not provide training or assess medicines management competency of midwifery staff.
- Records were not always clear and easily available to all staff providing care.
- The service wanted to provide a safe and high quality maternity service, but did not have a specific maternity vision for what it wanted to achieve or a specific maternity strategy to turn it into action.

Maternity

- Governance and data collection processes were in their infancy due to the short time the service was operational, and needed to be embedded.

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. The staff were on trajectory for annual completion.

The mandatory training target of 90% was to be achieved by 31 March 2024. Staff training compliance showed in November 2023, 85% of midwifery staff had completed the Practical Obstetric MultiProfessional Training (PROMPT) which was below the trust target of 90%. However, 100% of doctors had completed the training. We saw from the training trajectory provided the 90% target for midwifery staff should be achieved by January 2024.

The service provided fetal surveillance training in line with national recommendations, 95% of midwifery staff and 83% of doctors had attended against a trust target of 90%. The service had introduced a personalised care planning study day to meet requirements for safeguarding and the Saving Babies' Lives (SBL) care bundle versions 2 and 3. In November 2023, 77% of midwives, 54% of doctors and 74% of support staff had completed it, which was below the trust target of 90%. The service provided a training trajectory for all staff groups to be compliant by April 2024, and we saw that sessions had been planned and booked into 2024. The service planned to monitor which members of staff were compliant each year and whether this affected where on the unit they were able to work, for example, if they had not completed the required fetal monitoring training.

The service did not provide specific data on newborn life support training. However, other documentation submitted stated compliance was at 60% which was below the trust target of 90%.

Across the other 11 mandatory training modules such as manual handling, sepsis, and infection prevention and control, there were various levels of compliance across staff groups. Overall, midwives were 84%, doctors were 73% and support workers were 75% compliant, which was below the trust target of 90%. The service had begun training on learning disabilities and autism, but the breakdown of staff groups who had completed this training was not clear. The service stated 84% of antenatal clinic staff, 41% of teams and ward staff and 35% of doctors had completed this training. Post factual accuracy, the trust provided up-to-date figures for staff training as of December 2023, which showed 95% of antenatal clinic staff, 50% of teams and ward staff and 44% of doctors had completed this training.

There was a practice development team which monitored and organised mandatory training. They provided a quality report on training for December 2023 which documented challenges, concerns and improvements. The report stated staffing had been a barrier to providing training as well as room availability within the trust. The team had secured additional paid hours for midwives to attend the training, and secured rooms external to the trust for use. The small cohort of obstetric consultants in the service meant it was difficult for them to facilitate teaching sessions on PROMPT days alongside clinical responsibilities.

Maternity

The planned mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. Fetal surveillance training was scheduled monthly on the training plan. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. However, staff told us there was not organised, regular, case-based CTG teaching sessions for the multidisciplinary team, but there was ad hoc CTG teaching during clinical work.

Staff described ongoing 'skills and drills' training as sessions where staff would talk through scenarios, such as pool evacuation, which they had done in the last few weeks, rather than perform a clinical scenario. Skills and drills are intended to be a practical, simulated scenario with the multidisciplinary team in the environment they work in. Staff told us doctors were generally not involved much in the 'skills and drills' sessions. The practice development lead midwife acknowledged it was more difficult for medical staff to attend study days because their team was small and therefore training compliance was lower. However, practical, simulated scenarios were carried out in the PROMPT training.

The service had also developed and introduced a new suturing and intrapartum skills study day which it intended to roll out to preceptors and international recruits.

There was a comprehensive training needs analysis ratified for use through internal governance systems. This recognised that labour ward coordinators should be provided with accredited human factors training in line with national best practice recommendations. However, a national framework for labour ward coordinator education and development had only been published in November 2023 and an available provider had not yet been found. All staff were given a 1-hour training session on human factors which was provided in-house.

Safeguarding

Not all staff had received training on how to recognise and report abuse. However, staff generally understood how to protect women and birthing people from abuse.

Staff did not always receive training specific for their role on how to recognise and report abuse. Safeguarding training was combined into a study day with information for staff on the Saving Babies Lives care bundle. The impact of this was that if staff did not complete the training day, they were non-compliant in both areas, which posed a greater risk to keeping families safe from harm. As of November 2023, 54% of doctors had completed the training and compliance rates for midwifery and support staff were 77% and 74%, which was also below the trust target. The training target of 90% was to be achieved by 31 March 2024.

Staff generally knew how to identify adults and children at risk of, or suffering, significant harm, but the electronic system did not flag safeguarding concerns. There were no automatic safeguarding alerts, instead safeguarding forms ('orange forms') were stored on a shared computer drive, so staff needed to check this as a matter of routine. The triage paper assessment proforma included a prompt to check for orange forms. Staff told us the maternity support workers would also undertake safeguarding searches. We were told the safeguarding midwife audited documentation of safeguarding checks. However, staff did not always ask women and birthing people about domestic abuse, as only 1 out of the 5 records we looked at had evidence of this.

Maternity

There was a system where staff could access the national safeguarding database which showed social service records and closed cases. Staff could also access the general practice (GP) records system for information. There was an 'Acorn' team of specialised midwives who provided input for women and birthing people identified as having safeguarding, mental health, or vulnerability concerns.

There was a 'safeguarding newsletter' produced to inform staff of audit results and share key learning identified over a 3-month period. However, the newsletter was not concise and difficult to read, so there was a risk staff did not engage with the information and updates.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to give examples of safeguarding concerns and explained how they would make a referral to the Acorn team. Staff could contact the lead safeguarding midwife for advice in hours and the duty social worker at the local authority out of hours for emergency safeguarding concerns.

Cleanliness, infection control and hygiene

The service did not always control infection risk. Staff did not always use equipment and control measures to protect women and birthing people, themselves, and others from infection. Equipment and the premises were visibly clean at inspection, but this was not always the case.

The service did not always perform well for cleanliness. A cleaning audit was supplied dated 7 September 2023 which showed 12 out of 15 locations audited had failed cleanliness standards, including patient bedrooms, bathrooms and sitting areas, corridors, nurse stations, and a sluice. The audit data showed average compliance rates for each location, with none of the locations meeting the target compliance rate of 95%. An action list for remedial tasks completed was submitted by the trust.

Although overall compliance for a December 2023 cleaning audit was 97%, which met the trust target, clinical staff did not always meet compliance responsibilities in relation to keeping medical equipment and supplies clean when in open areas of the unit. For example, in corridors and nurse stations, where compliance in this area of the audit was 78%, which was not enough to assure service leaders that equipment was clean and ready for use. Action plans detailed how ward leaders planned to monitor and mitigate this risk, including standardising cleaning checklists, and staff double-checking these were filled in and tasks had been completed on a daily basis.

However, during the inspection, we saw that maternity service areas were clean and had suitable furnishings which were clean and maintained. The environment was visibly clean and clutter free. Disposable curtains were labelled with dates for changing.

There were processes for cleaning and recording that cleaning had been done. There was a checklist for cleaning all areas and rooms in the unit. There was a process for staff to clean rooms and floors after use. There were lists for documenting daily cleaning of equipment.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). We saw that staff were bare below the elbow, and there was alcohol gel and PPE available. Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in the antenatal areas, and PPE audits were completed on alternate months. The service provided audit results from September to November 2023 which showed an overall compliance rate of 99%.

Maternity

The service told us it had combined the hand hygiene, uniform compliance and PPE audits into an overarching staff infection prevention and control measures audit in December 2023, and 11 members of staff were audited that month. Results showed compliance rates of 100% in hand hygiene, uniform and completion of a PPE risk assessment. However, the audit showed a compliance rate of 20% in staff who removed their PPE correctly to minimise risk of infection spread. This made the overall audit compliance rate 84%, which was below the trust target of 90%. There was an action plan for the infection prevention team to provide daily spot checks on the ward, and for monthly bite-sized training to take place which showed a positive response to improving scores and mitigating risk.

We saw documentation of weekly flushing of little used water outlets.

Staff generally cleaned equipment after contact with women and birthing people. The equipment we saw at inspection was visibly clean and labelled to indicate it was clean and ready to use, but the December 2023 audit above showed this may not always be the case.

Environment and equipment

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

The design of the environment mostly followed national guidance. There was secure entry to the maternity unit, but people could exit the unit unchecked. However, there was an electronic baby tagging system which would alarm upon exit.

The majority of elements of the maternity service were all together at the same location within a large ward area, except for the antenatal day assessment unit (ANDAU) which was located elsewhere. The maternity unit was a 'horseshoe' arrangement with 5 labour rooms, an antenatal bay, postnatal bay, transitional care bay, side room and triage area. This meant there was visibility of almost the whole service at any given time and greater fluidity of staff movement around the different areas as needed. There was direct access to the Special Care Baby Unit (SCBU), and the main theatres complex was located across the corridor directly opposite the maternity unit, with the obstetric emergency theatre being the nearest theatre. This meant everything was easily and quickly accessible. There was no midwifery led unit for low-risk labour, but staff told us this was available as an option in the labour ward area.

The triage area had a separate assessment room and a 4-bed bay with the midwife's desk in the corner. However, there was not a dedicated space for telephone triage. The triage standard operating procedure (SOP) version 1, June 2023, stated 'all telephone calls must be performed in a confidential space', which was not the case as telephone assessments took place using the triage midwife's desk telephone, so was not confidential when triage beds were occupied.

The triage oversight board was combined in an overall board of maternity areas within the unit. This was mounted in the multi-disciplinary team (MDT) handover room in the middle of the unit, to keep patient details confidential. This meant the oversight board was not visible when working in triage to help maintain an overview of time frames, priority or which stage of the triage process a person was at. Staff told us that if there was a maternity support worker supporting triage, they would update the board so that the coordinator and obstetric team had oversight of triage.

There was a bereavement room which was clean and well maintained, and in which women and birthing people could give birth. There was a chaplaincy service, and memory boxes were available for families to make memories and take keepsakes.

Maternity

Staff mostly carried out daily safety checks of specialist equipment. We found that both the adult and neonatal resuscitation trolley on labour ward had all items present and in date with no gaps in the daily checks. The trolleys were locked with tamper proof tags. The emergency post-partum haemorrhage trolley, epidural and instrumental trolley were stored in a locked room on labour ward with no gaps in daily checks.

There were 5 labour rooms and 5 resuscitaires within the maternity unit, and 1 further resuscitaire in the emergency maternity theatre. One of the 5 maternity resuscitaires was moved to the elective theatre when the elective list was running, leaving only 4 resuscitaires for labour ward, postnatal ward, triage and transitional care. Although there were 5 labour rooms, leaders found 5 resuscitaires to be enough due to the small service size and the low number of births. We were told there had been no incidents reported concerning a lack of available resuscitaires. As the Special Care Baby Unit (SCBU) was co-located with direct access from maternity, leaders told us emergencies could be easily transferred to the SCBU.

The service had recently purchased new resuscitaires, and was in the process of installing wall air ports in rooms to connect these to an air supply, instead of needing to use portable air cylinders. This work was completed in early January 2024. Before this, there had been problems with gas leakage from the resuscitaire which had required a temporary fix to be created by the manufacturer. This was evident in some incidents reported.

The resuscitaires did not belong to a given room, but moved around rooms on labour ward as they were also taken to elective theatre when lists were running. Each had a daily checklist attached to show it had been checked and was ready to use, however there was a concern that as resuscitaires moved around, it may be difficult to maintain oversight of which had been checked and confirmed as being ready for use with no faults, and where the ready to use resuscitaires were in an emergency. At the World Health Organisation (WHO) check time out, which is a check point in the operating theatre after the initial WHO sign in, we noted that the theatre resuscitaire still had not been checked by this point in the process for the first emergency case of the day. We also noted 3 incidents reported since the service reopened where staff found resuscitaires they needed for a case were not ready to use. Following the inspection, the service completed a risk assessment for the number of resuscitaires and their rotation through different rooms and areas at our request, and planned to begin recording any checks completed in addition to the daily check on the daily checklist.

The service mostly had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. There was also a family room with a kitchen for parents with a baby staying on the SCBU. Feedback from women, birthing people and partners we spoke with during the inspection was generally positive.

The service mostly had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in addition to the resuscitaires discussed above, in the 2 pool rooms on labour ward there were pool evacuation nets. The service conducted portable appliance testing on all relevant equipment and records showed testing was up to date.

During the inspection, the theatres blood fridge was not functional. Staff were expecting a new blood fridge soon, and in the event of a haemorrhage requiring blood transfusion, the major obstetric haemorrhage protocol would be activated so blood would be delivered to theatre as an emergency. Following the inspection, the service completed a risk assessment for the absence of a dedicated theatres blood fridge at our request. Since the inspection, the service had received the new blood fridge and were expecting it to be ready for use after January 2024. Post factual accuracy the trust informed us the new blood fridge would be functional from 15 March 2024. However, new training and processes needed to be implemented before the ‘go live’ date was planned for 8 April 2024.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste into the relevant bin.

Assessing and responding to risk

Staff did not always complete and update risk assessments or take action to remove or minimise risks. They did not always identify and quickly act upon women and birthing people at risk of deterioration.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration but did not always complete or follow recommendations. Staff used a national tool known as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 5 MEOWS records and found staff correctly completed 4 out of 5 them and had escalated concerns to senior staff where applicable, except for 1 occasion where a measurement was outside the normal range, but normal for that individual. Staff completed a monthly audit of 10 MEOWS records to check they were fully completed and escalated appropriately. We asked for the most recent 3 months of audit results, however only results dated December 2023 were provided. The audit measured against criteria around the frequency of observation, but did not detail whether the MEOWS chart had been completed in full. Audit results showed observations were not done as per MEOWS recommendations following caesarean section 33% of the time, which may not be enough to ensure women and birthing people at risk of deterioration are identified and escalated in a timely way. The audit stated some of the MEOWS recommendations for frequency of observation were not part of the local guideline. This posed a risk of confusion for staff and may lead to mistakes.

The standard operating procedure (SOP) for triage stated that the MEOWS was recorded on the triage proforma to facilitate escalation if observations were outside normal ranges. There was space for the MEOWS on the triage paper assessment proforma, but this did not include the reference ranges and scoring system for the MEOWS, so it was not possible to tell from the paper proforma how the total MEOWS had been calculated, and which parameters were outside the normal range, and by how much. The proforma also did not include the additional non-physiological parameters of the MEOWS.

Staff completed newborn risk assessments when babies were born, and used recognised tools to identify when babies were deteriorating, for example the Newborn Early Warning Track and Trigger (NEWTT) tool. Staff audited the use of the NEWTT tool monthly, however the service provided results for December 2023 only. Results showed out of 10 records which met the criteria for NEWTT, 9 had charts commenced appropriately. In 3 out of 9 cases, the observations were charted late, which caused a delay in potential identification of deterioration. However, the audit showed 100% of babies that required it were escalated appropriately to medical staff.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, but there was no evidence that all staff adhered to a standardised prioritisation process or that people were assessed and treated within the timeframes required according to their priority. There was a triage service to assess and treat women and birthing people experiencing urgent care needs. Staff used an evidence-based risk assessment tool for maternity triage. The service audited the reason for attendance and the initial triage by midwife time. Data collected between September and November 2023 showed 95% of women and birthing people were seen by a midwife within 30 minutes of arrival, which is in line with national guidance. However, the service did not collect and audit data on effective risk assessment and prioritisation of women and birthing people, or whether they were reviewed by appropriate medical staff in a safe timeframe. This meant the service was not assured that their triage system was safe.

The triage SOP included prioritisation processes, but we were not confident staff were formally prioritising (red, amber, green, or RAG rating) all people assessed in triage in a standardised way. Instead, it seemed they relied more upon

clinical experience and judgement. When we inspected the service there were only 2 postnatal records where people had attended triage, neither of which had the RAG rating section completed (but 1 case was inappropriate for triage therefore not applicable). Staff told us that because activity within triage was so low, in reality, people did not wait for assessment or care. Leaders told us they were working on triage to ensure a standardised process and reliable, consistent RAG rating. This included a triage update within maternity mandatory training. Following the inspection, they planned to audit compliance with prioritisation category time frames, and leaders produced a quality improvement plan for triage to address areas for improvement.

The telephone triage process used paper proformas for first, second and third calls to triage, including prompts to advise the person to attend triage at the second or third call. Proformas were kept on a clipboard, intended as a way to have oversight of telephone activity and repeat callers. However, there was a mixture of different days on the clipboard, and it was not clear that this was effective if the repeat caller was not on the same day but later in the week. The proforma was filed in the patient's handheld notes which go home with them if they attended, or in their hospital record if for telephone advice only. Staff needed to transfer the paper notes onto the electronic record, which was duplication of work. The electronic record did not have purpose made triage proformas, so staff would have to add this as an episode of care amongst other episodes.

For callers who could not get through to telephone triage there was a message system to guide them, for example calling 999 in an emergency, attending triage, or calling back if they had any of the listed symptoms, and the triage telephone also rang on labour ward. However, there was no way to monitor or find abandoned calls. The triage SOP stated that if a person had not attended as expected within 4 hours, the midwife should try to make contact with the person. The only way to monitor patients who did not attend was by the telephone proformas on the clipboard.

Following the inspection, the service planned to audit weekly calls data on a monthly basis and ask patients about problems getting through, which would be incident reported. They also planned to standardise the telephone triage conversation and process to ensure standardised prioritisation and advice.

Staff did not always know about and deal with any specific risk issues. For October and November 2023, an audit designed to assess compliance with the Saving Babies Lives (SBL) care bundle versions 2 and 3 using 10 sets of records per month, showed there was 70% compliance with hourly risk assessment of fetal and maternal wellbeing and fresh eyes at 60 minutes, and 65% compliance with having a second reviewer assess the cardiotocography (CTG). CTG is a continuous reading of the fetal heart rate which is obtained through an ultrasound probe placed on the abdomen of the woman or birthing person, and fresh eyes is an hourly peer review of the CTG interpretation. The audit showed 30% had evidence of a structured review in cases needing escalation, and 80% had a holistic review at the start of monitoring or labour. We also noted evidence of CTGs not being done in incidents reported. This level of compliance may not be enough to assure the service that fetal monitoring in labour is safe, and the service did not increase the audit to see if the results were consistent over higher numbers of records. However, the service identified training needs and areas for improvement and used these to form an action plan with appropriate time frames for completion.

Leaders also told us that within an hour of admission to the labour ward, the Band 7 midwife would do a joint review of the care plan including CTG monitoring, and setting the clock for when the fresh eyes review was due. This was intended to ensure staff were clear on how often the CTGs were required and on who they should escalate concerns to. We were told the fetal monitoring lead midwife was planning to use CTGs for training in clinical areas, and the central monitoring of CTGs started since reopening could be used for training. The fetal monitoring midwife also audited 10 sets of notes monthly to monitor compliance with Saving Babies Lives Care Bundle version 3. Cardiotocography (CTG) was performed in 1 out of the 5 records we reviewed, and fresh eyes had been completed (CTG was not applicable in the other cases).

Maternity

The service had introduced a review tool for electronic fetal monitoring in the antenatal period to assist clinicians in safe interpretation and escalation of CTGs. Audits on its use showed it was being used consistently but was not always completed in full, including appropriate classification of the CTG and a review by a second clinician (fresh eyes), which is best practice. Data showed fresh eyes compliance for July to October was 80, 70, 90 and 60% respectively, which showed this area of practice was not embedded. There was an action plan following the audit, however it did not specifically address this finding.

Incident data from the service showed there were 41 incidents of post-partum haemorrhage (PPH) since the unit reopened, however we could see only 26 of these recorded as incidents on the National Reporting and Learning System (NRLS). The service dashboard showed a large number of PPHs for a small service. For 500-1000ml there were 109 PPHs, for 1000-1500ml there were 43 PPHs, and for 1500-2500ml there were 12 PPHs since opening in June 2023. Leaders and safety champions were aware of these figures. The difference between PPH figures in the incident data and those on the dashboard raised concerns that staff did not always report PPHs in line with local policy or national guidance. When speaking with staff during the inspection we noted a lack of awareness around factors such as weighing swabs to measure blood loss.

The service started a monthly audit for PPHs and provided the December 2023 results. This audit of 23 cases included looking at the causes, type of cases, sizes of PPH and management of the PPH. Findings included the labour ward coordinator being present for 57% of cases, weighing of swabs to ensure accurate measurement of blood loss only occurred in 13% of cases, and a proforma was only used for record keeping in 9% of cases. Blood loss was above 1500mls in 8 cases, and in no cases was the massive haemorrhage protocol instigated. Conclusions included that use of the PPH proforma, the measurement of blood loss by weighing and the massive haemorrhage protocol were not embedded in theatre or maternity teams. Actions identified the need to embed these processes and to re-audit compliance monthly.

All planned inductions of labour (IOL) went through a coordinator. Staff told us they would have 2 IOLs per day at most, there were no outpatient IOLs, and the service would sometimes care for women transferred from other hospitals for IOL. Staff said IOLs would be prioritised based on risk, and that IOLs may be delayed by 1 to 2 hours, and that the maximum wait for artificial rupture of membranes (ARM) would be about 4 hours.

There were 2 pool rooms on the labour ward. These could also be used by high-risk women and birthing people because there was wireless monitoring. However, staff told us there was no formal pool exclusion criteria, only a general high-risk assessment, but gave examples of instances in which use of the pool would not be suitable. Post factual accuracy the trust shared a copy of the waterbirth policy dated April 2023, which included inclusion and exclusion criteria. However, discussions with staff indicated not all staff were aware of this policy.

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. The specialist team of midwives called the Acorn team provided support for persons with safeguarding or mental health concerns. Staff could make referrals to the Acorn team for both safeguarding and mental health concerns using a specific referral form called the orange form. The service could access the mental health crisis team 24/7.

There was a policy and guideline for staff on ligature risk, and a ligature audit had been completed on the unit in 2022 which showed the environment had been assessed for risk. However, the unit had been closed until June 2023, and not all staff were aware of specific ligature risks. Post factual accuracy the trust informed us the ligature risk assessment had been completed in 2023 not 2022 as stated on the assessment form and shared the amended risk assessment.

Maternity

At the inspection handovers included the necessary information to keep women and birthing people and babies safe, but the service did not audit this to make sure all handovers were consistent. We attended the multidisciplinary morning handover, which included a safety huddle and 'hot topics' (current issues, staff information). This meeting was attended by the expected outgoing obstetric and midwifery night staff, incoming day staff and anaesthetic and theatre staff. The medical handover with discussion of all patients followed this, using a paper handover sheet and board with patient details.

The handover tool included a recommended format of situation, background, actions and recommendations (SBAR). The service did not complete any audits on the effective and appropriate use of the handover tool, which meant it could not be assured that staff consistently provided handovers containing the necessary information to keep people safe. Leaders told us audits would be commenced as part of a new audit tool on fetal surveillance, which included an intrapartum and postnatal SBAR, but did not plan to look at SBARs completed at shift changeovers, which posed a risk that information was missed.

We observed staff use the World Health Organisation (WHO) safety check and time out in emergency obstetric theatres for an emergency case. This involved the expected staff and included the expected checks and information. A large paper proforma was used to prompt and record the checks. The service monitored the use of surgical safety checklists, and between September and November 2023, the audit showed 98% compliance.

The service provided transitional care for babies who required additional care. There was a separate transitional care bay within the unit. This was run by neonatal staff, with neonatal nurses caring for the babies and midwives for the mothers. All newborn and infant physical examination screening assessments were done by paediatric doctors.

Midwifery Staffing

Staffing levels did not always match the recommended numbers, potentially putting the safety of women and birthing people and babies at risk; however, managers could generally adjust staffing to mitigate this.

Staffing levels did not always match the planned numbers, potentially putting the safety of women and birthing people and babies at risk. The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Data showed that during October 2023, there were 27 red flag incidents recorded. Leaders monitored red flag data for themes, however themes for October showed that staff reporting events did not have enough training on recognising and reporting them correctly. For example, there were 2 occasions when the unit coordinator was not supernumerary, but these had been graded as a delayed time-critical activity, which did not show leaders the correct nature of the staffing problem. Out of 27 total incidents, 44% of these were delays to the induction of labour process. Data in November showed there were 6 red flag events, 2 of which were delayed induction of labour.

There was a supernumerary shift coordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Staff told us that the postnatal ward lead was allocated patients to care for as well as run the ward on occasions. There was no clear process for monitoring antenatal women and birthing people, whereas those on postnatal ward had a named midwife. Antenatal women and birthing people were allocated last and in busy periods, allocated to the postnatal ward lead midwife.

Leaders did not use a specific maternity acuity tool designed to ensure leaders could monitor the staffing levels relative to the needs of the service 4 hourly. Instead, the service used a generic tool which was completed twice a day (morning

and evening). The tool used care hours per day as a measure, which is not suitable for the nature of maternity, which has fluctuating acuity. We were told the service had met with the tool supplier with plans to make the tool more suitable. In the interim they used red flags, but there was no monitoring of capacity and staffing, and no staffing safety huddle. Staff relied more upon clinical judgement and discretion to adjust staffing. However, this was made more feasible and viable by the layout of the service, which facilitated overall visibility and fluidity of work in the majority of areas of the maternity service.

The number of midwives and maternity support workers (MSWs) did not always match the planned numbers. Staffing on the unit was planned as 6 midwives during the day and 5 overnight, and the unit was fully staffed with midwives at the time of the inspection. However, there were not always enough support staff, and staff told us this impacted upon, for example, vital observations (MEOWS) not always being done on the postnatal ward, and may result in retrospective entries by midwives in the postnatal notes. Staff also said they may work extra hours in the evenings, for example to complete notes and referrals. Not having enough MSWs was on the risk register and there was a plan to recruit MSWs.

Triage minimum staffing level for the birth rate of approximately 1000 per year is 1 Band 6 midwife and 1 MSW 24/7 in line with national recommendations on safe staffing of triage. However, at the time of inspection, triage was staffed by 1 midwife and sometimes 1 MSW or healthcare assistant (HCA) from the unit, but the MSW/HCA was not allocated specifically to triage. The triage midwife covered both the telephone and the in-person assessments. The service was auditing monthly activity in triage to inform triage staffing levels going forward. The service planned to increase annual births from about 1000 to 1500 and recognised staffing would need to increase to allow this.

The ward manager generally had the resources to adjust staffing levels daily according to the needs of women and birthing people, and this was made easier by the service layout. Managers moved staff according to the number of women and birthing people in clinical areas. Community midwives rotated through the maternity unit, spending 4 weeks out in the community and 4 weeks in the maternity unit. When short of staff on the unit, staff told us they could draw upon community staff to come in to cover gaps, as they were familiar with the unit. There were also 2 clinical retention midwives who could step into clinical work wherever needed, and worked most of their time clinically. The trust told us there were clear escalation processes relating to staffing via three times a day escalation meetings in hours, with site managers, senior managers on call and executive on call out of hours.

The November 2023 public trust board meeting papers showed that the vacancy rate for registered midwives for teams and wards was 11.2% as of September 2023, with 6.5 whole time equivalents (WTE) vacant and 1 WTE maternity leave. For antenatal clinic the vacancy rate was 9.5%, with 0.59 WTE vacancies and 0.8 WTE long term sickness absence. There were no maternity support worker vacancies. Overall, the staffing gap was 8.8 WTE (14.03%). Information provided stated there was ongoing recruitment to midwifery posts, with 6.71 WTE in the recruitment pipeline.

Managers requested bank staff familiar with the service. Staff told us they did not use agency staff, only bank staff.

Managers calculated and reviewed the number and grade of midwives and maternity support workers (MSWs) needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in October 2021. This review recommended 69.55 WTE maternity staff Band 3 to 8, compared to the actual funded staffing of 67.41 WTE at that time. Since the review the trust provided information that additional funding had been allocated by the Integrated Care Board (ICB), and at March 2023, their recruitment plans for obstetric consultants, midwifery staff, anaesthetic consultants, anaesthetic doctors and operating department practitioners (ODPs) were rated as either criteria met or on track to be met, except for anaesthetic consultant staffing which was at the stage of no solution yet confirmed. They had also received external funding for recruitment to 3 specialist midwife roles.

Maternity

The board received a bi-annual staffing report that reflected maternity staffing in isolation, which gave the board an accurate overview of staffing risks in maternity services. The report dated October 2023 reported a staffing risk in relation to MSWs, and otherwise stated a shortfall of less than 7 WTE maternity staff against the benchmarking staffing template conducted in 2021.This represented approximately 10% of the total workforce. Leaders felt assured that the safe staffing criteria for reopening met the decreased level of activity following the 3 year suspension of the service. The service planned to do a repeat staffing template exercise in 2024.

The service had measures in place to try to make sure staff were competent for their roles, but did not always ensure training was completed. There was a 4 week supernumerary period for new starters at the service. Staff told us this was not just for Band 5 preceptor midwives, but also for staff who had not worked at the service before. The 2 clinical retention midwives provided clinical support to both new starters and any other staff needing support.

Staff told us there was no specific training for working on triage, but they would not have Band 5 midwives working in triage without support, and there were the clinical retention midwives to provide clinical support.

The labour ward coordinator had a Band 7 ‘buddy’ and manager for support, but had not received any leadership training.

Staff told us they could do electronic learning when not busy, and that if they had to do this in their own time, they would be paid bank rates.

We were told there had been difficulty getting staff training records from the other trusts where staff had worked while this service was suspended. There had been a programme of 6 study days including PROMPT training as part of the reinstatement of the service.

Overall compliance for appraisals was 86% across the maternity unit, however at the time of inspection was only 56% for labour ward staff. The trust told us the appraisal period ran from April to March and the 90% target was required to be achieved by 31 March 2024.

There were 13 specialist midwifery roles to support the service and manage risk, including fetal monitoring, IT, practice development and recruitment and retention.

The service did not provide more specialised or complex care generally, and did not routinely provide an enhanced maternal care service, only 1 to 1 midwife care during labour in line with national guidance, and increased frequency of standard monitoring where needed. However, critical care outreach support was available for people requiring enhanced maternal care on an individual case by case basis. People needing a higher level of care than this would be transferred to the main high dependency unit or intensive care unit. Reinstatement training had included the recognition and escalation of the deteriorating patient with 92% compliance, and sepsis training with 87% compliance. However, an absence of enhanced maternal care training involving elements of high dependency care still raised concerns, particularly considering the high numbers of PPH that staff may be caring for on the maternity unit.

Recovery care was provided by main theatres recovery, therefore by trained recovery nurses. Overnight there was 1 recovery nurse resident and 1 on call.

Medical staffing

Maternity

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

Based on inspection findings the service generally had enough medical staff to keep women and birthing people and babies safe. We requested, but did not receive, data on vacancies, sickness absence and turnover for medical staff.

There were 2 ward rounds on the labour ward each day, which was in line with national recommendations. Postnatal patients were only seen by the consultant if necessary.

The on call team completed a ward round of reviews of antenatal and postnatal patients as well as those in the labour ward area of the unit. During the inspection, we observed a ward round which was carried out by the obstetric consultant, anaesthetic registrar, labour ward coordinator, 2 junior doctors and the midwife looking after the person. However, staff told us anaesthetic staff did not always attend the ward round, but that anaesthetic attendance was improving.

We were told all new locum doctors supplied by agencies were given an induction pack, including identification and IT access. They would be placed on the lowest on call tier and supervised by the on call middle grade doctor. We were also told agency doctor curriculum vitaes and references would be scrutinised by the clinical lead for obstetrics or 'hot week' (on call) consultant before work would be allocated. However, the service had low rates of locum doctors. Staff told us that rota gaps were usually covered by bank doctors who had already worked at the service, and that locum use was rare. We were also told that they had not used locums for middle grade cover for a number of years as these gaps were usually covered by existing middle grades, nor did they use external locum consultants.

The service generally had a good skill mix and availability of medical staff on each shift for the volume of activity. Staff told us triage was covered by the on call registrar, and that women and birthing people attending triage with more serious symptoms would be reviewed by a registrar or consultant level doctor. They said if the on call registrar was busy, they would request a registrar or consultant from the antenatal clinic. Triage staff told us they did not have any problems getting timely doctor reviews.

There was a separate elective caesarean section list on 3 afternoons of the week with dedicated theatre and staffing. This meant there was separation of emergency and elective case work, so electives would not impact on emergencies and vice versa.

There was 24/7 obstetric theatre staffing. We were told that if there was a second obstetric emergency, main theatres were used if free and if it was before midnight, after which time main theatres staff were on call from home. There was an operating department practitioner (ODP) resident on site all night for maternity, but if they were busy, a second ODP could be called in from home, and it was procedure that cases could not go to theatre until the second ODP arrived.

However, category 1 caesarean sections would need to be done before a second team could arrive at the hospital from home. In very urgent cases where it was not possible to use the main theatres team, staff told us they would risk assess the case and split the obstetric theatre team if necessary. They said this was a viable option because obstetric theatre was staffed according to the Association for Perioperative Practice (AFPP) recommendations 2009. This arrangement meant the recovery nurse would need to cover the ODP role, however not all recovery nurses are trained in the ODP role. Staff told us there was a theatres establishment review asking for a second resident ODP overnight.

There was a Maternity Staffing and Escalation standard operating procedure (SOP) (version1, 2023), but this did not explain staffing arrangements in the event of a second obstetric emergency, so there was no SOP covering opening of a second theatre. Leaders told us they felt current processes for opening a second theatre, which relied upon good staff communication and anticipation, were appropriate for the level of theatre activity at the moment, but acknowledged that if this increased the second theatre process would need to be formally standardised. We were told there had been no incidents where a second theatre had been required since the service was reinstated.

There was a dedicated middle grade anaesthetist allocated to maternity services 24/7 who was supported by an on call anaesthetic consultant. However, the consultant also covered main theatres and supported the main theatres junior anaesthetist. The service always had a consultant obstetrician on call during evenings and weekends.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they felt supported to do their job through clinical supervision and were given opportunities to develop.

Records

Staff kept records of women and birthing people's care and treatment and stored these securely. However, they were not always clear and easily available to all staff providing care.

Women and birthing people's notes were not always comprehensive, and not all staff could access them easily. We reviewed 5 paper records and found they were mostly complete. However, they were not straightforward to navigate and easily find information.

Records were a mixture of paper and electronic records, so there was no single point of visibility for everything. The electronic record used was basic and there were concerns as to whether it was fit for purpose for maternity. There were no plans to change to a different system currently or in the near future, but ultimately the service was planning to have a mobile computer system and no paper records. Staff were required to duplicate documentation in triage, and staff said it was difficult to always transfer paper notes on to the electronic record. This also meant there may not be clear oversight of women and pregnant people who had called triage before. There was inconsistency of filing of telephone triage paper proformas (in the handheld notes if the person had attended triage, or in the hospital notes if it was a telephone consultation only). Staff said they were frustrated at using several systems to document information; they were concerned this may result in inconsistency and said it took too long to complete.

The use and completeness of the electronic records had been audited. Results from September 2023 showed records were completed appropriately. There was a national patient safety alert regarding the electronic records system used by the maternity service, and staff were aware of this. The safety alert related to over-writing of records, and we saw evidence that the trust had considered the risks and put in place mitigations and workarounds.

The service completed audits of record keeping to provide assurance of quality. The maternity notes audited by the service scored 88% compliance against the audit tool used, which met local and national targets of 75%. The service had also audited records against Ockenden (2020, 2022) recommendations in September 2023; these were largely 100% compliant, with the exception of personalised care plans being present in the notes, and mental health screening. The service had developed an action plan in response to these findings.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

Maternity

The service used systems and processes to prescribe, administer, record and store medicines. However, the service did not provide training for, or assess medicines management competency, of midwifery staff.

Staff had correctly completed the medicines charts we saw, but the service could not be assured staff always followed systems and processes to prescribe and administer medicines safely. We reviewed 6 prescription charts and found staff had correctly completed them. However, the service did not provide training in, or assess medicines management competency for, maternity staff, including those who were newly qualified. It had identified this as a risk and said it was working with pharmacy to ensure there was a policy and framework in place for newly qualified staff by April 2024. The impact of this was that the service could not be assured that staff were safely administering medicines before April 2024, and nor could the service maintain any ongoing assurance that qualified staff had retained their competency.

Staff stored and managed all medicines and prescribing documents safely. We checked a random sample of medicines in the medicines cupboards and fridge, and found these were in date. Medicines were stored in locked cupboards, and the medicines room was locked. We checked 2 controlled drug storage areas and found the records of stock balance were correct, and there was evidence of twice daily checks.

Medicines and milk fridges had daily temperature checks completed with no gaps. The milk fridge temperature records showed the temperature was outside of range for the current month. We asked staff to check this. All milk stored in the milk fridge was labelled and in date, and the fridge was locked and kept in a locked room.

Emergency medicines for the management of post-partum haemorrhage (PPH) were kept in an easy to access 'grab box' on a specific PPH trolley.

Incidents

Staff mostly recognised and reported incidents. Managers investigated incidents and there was evidence of shared learning. Staff understood the duty of candour. Managers were aware of current relevant safety alerts.

Staff were able to give examples of incidents that should be reported and knew how to report these using the electronic system. However, we noted PPH numbers were lower in the incident data than in the dashboard data, and service leaders had noted that not all incidents of post-partum haemorrhage (PPH) were being reported accurately.

There was a process to review incidents on a regular basis so that managers could identify potential immediate actions. The risk and governance midwife completed initial 72-hour reviews of maternity incidents, together with the clinical governance lead obstetrician, depending on what the incident related to. The initial reviews with a medium or above harm grading automatically went to the executive-led check and review panel, chaired by the director of corporate affairs and governance, with membership including the director of nursing and quality (board midwifery lead), the medical director and the chief operating officer, who decided on the next steps. We were told incidents with lower harm gradings may also go through the corporate governance panel if maternity governance felt they needed a discussion at that level, or if they were unsure, they would bring these to the panel anyway.

However, incidents were not always graded correctly in line with regulations and national guidance. We noted a number of PPHs of 1500mls or more which had been graded as low or no harm. A greater number of incidents being classified as no or low harm meant there was a risk that duty of candour was not carried out on all eligible incidents, and such incidents would not be reported to the board. The service was conducting monthly audits of PPH incidents to monitor themes and had carried out a thematic review.

Maternity

Managers investigated incidents. Maternity incidents reported through the electronic system were allocated to the risk and governance midwife, who then allocated these to the most appropriate investigator within maternity. However, the risk and governance midwife was the only member of maternity staff who had completed an external investigation course. The service had adopted the new approach to responding to patient safety incidents, known as the Patient Safety Incident Response Framework (PSIRF), in September 2023. Staff told us they were still finding their way with this new framework, and would carry out incident reviews regardless of the PSIRF framework, if they felt a review was needed.

There was 1 incident remaining open over 60 days that was under investigation, this was in relation to microbiology results delays. These were performed at a neighbouring service and were not always reported and available to clinicians in a timely manner. There were 4 overdue incidents according to the maternity quality and safety report for December 2023.

Incidents were reviewed by the maternity clinical governance group, which reported to the planned care directorate safety quality and standards sub-committee. The top 3 individual significant incidents were detailed during the meeting. The sub-committee monitored overdue incidents and themes for learning. Leaders were also aware of a recent safety alert for the electronic patient record and had taken steps to address the associated risks.

Managers had not evidenced that they reviewed incidents potentially related to health inequalities, although the trust told us ethnicity, first language and deprivation index data was shared with the Local Maternity and Neonatal System (LMNS) . However we saw that going forward, with the new PSIRF incident system, the trust planned to incorporate this. The trust also told us they were actively engaged in the Greater Manchester Integrated Care Partnership's new equity and equality implementation group.

Staff received feedback from investigation of incidents. There was evidence of shared learning with staff about incidents. We saw examples of learning from incidents, which were displayed in the multi-disciplinary (MDT) handover room. Staff told us that learning from significant incidents would also be discussed at handovers. There was also a safety huddle slide show running continuously on the screen in the MDT handover room throughout the day. Leaders told us about a very recent presentation by theatre staff at the morning MDT handover, which discussed learning around management of PPHs since the elevated level of PPHs had been recognised. The trust told us learning from incidents was shared via newsletters, team meetings, safety huddles, handover and emails with presentations.

Staff understood the duty of candour and there was evidence this was completed. The maternity quality and safety report stated that duty of candour had been completed in 100% of cases. However, the way harm level was graded meant that not all events were eligible for detailed investigation or duty of candour, which meant opportunities for learning and improvement may be missed.

Managers debriefed and supported staff after any serious incident. Staff told us they generally felt supported. We were told the service was trying to embed a 'hot debrief' process, but staff had not received any formal training on this. The trust shared examples of completed 'hot debrief' forms, which demonstrated support was provided for staff. The trust also told us that following the implementation of the PSIRF process, a revised 'hot debrief' template had been introduced trust wide and a copy shared with us.

Is the service well-led?

Maternity

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

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for staff.

The service had a quadrumvirate leadership structure which consisted of a head of midwifery, obstetric clinical lead, neonatal clinical lead and deputy director of operations for planned care. They were supported by a midwifery risk and governance lead, an obstetric governance lead and a corporate clinical risk manager and head of clinical governance.

Leaders submitted careful planning documents to show how they had reimplemented the service in a safe way, with support from NHS England and regional teams. This included, but was not limited to, consideration of policies and guidelines, recruitment, national drivers and data collection. Communication with staff members was continued throughout the closure of the unit to maintain visibility and transparency of the work. Communications and reimplementation strategies and plans demonstrated a focus from leaders on staff wellbeing and showing them personal appreciation.

It should be recognised that leaders had managed the process of suspension of the service and the recent reinstatement, which had not been an easy task, and had required them to manage multiple different elements and considerations.

The trust chief executive officer released monthly podcasts to staff which shared news and updates on trust business.

Leaders were visible and approachable in the service for staff. Staff we spoke with during the inspection all agreed that leaders were visible, approachable and supportive.

The service was supported by maternity safety champions and non-executive directors. There were 2 board-level safety champions for the service, an executive (the chief nursing officer) and a non-executive director (NED). The NED met with maternity service leaders monthly and was able to articulate information about the service's demographics and challenges, for example safeguarding provision, maternity incentive scheme assurances, staffing, and clinical issues such as the high numbers of PPHs and the electronic record system. Areas of good practice recognised by the safety champions included communication between the service and executive-level leaders, learning from incidents and identifying areas for improvement.

The board-level safety champions completed walkabouts on the wards to collect staff views and scrutinise the service. We saw minutes from a walkabout completed in October 2023, which identified some concerns around safe staffing, and some minor estates issues. Minutes contained the management response to issues identified, which showed positive engagement and an appetite to improve, although it was not clear how long it took to implement changes following the walkabout, as the minutes were not documented with a date of completion.

Vision and Strategy

The service did not have its own vision and strategy since reopening 6 months prior to inspection. However, leaders had planned engagement sessions to develop a maternity specific vision and strategy.

Maternity

The service had reinstated births in June 2023 after a three year closure, and at the time of inspection, had not yet developed a maternity specific vision and strategy. However, the trust aim was to ensure a high quality and safe maternity service supported by the trust wide vision ‘to deliver outstanding care and improve the health of all the people we service’, which also applied to maternity.

Leaders said they had planned engagement sessions to think more clearly about service development and a vision and strategy. Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services, and planned to use these to underpin the strategy when it was developed. The service had an ambition to grow in terms of births, however it was recognised that this would be over time. Leaders acknowledged that in response to increasing demand, working practices, systems and processes would require strengthening and would need to be more formalised to cope with greater activity.

There was a trust wide strategy in place encompassing quality and safety, people, clinical work, estates, 'green' policies, and digital systems, which set out measurable outcomes for progress.

Culture

Staff felt respected and supported. They were focused on the needs of women and birthing people receiving care. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff felt respected and supported. Staff we spoke with during the inspection felt the culture was good within the service and they felt supported.

The 2022 NHS staff survey response showed that 66% of questions showed no significant difference to national average scores. The service scored better than average for 29% of the questions, especially in areas related to positive workplace relationships and inclusivity, and staff feeling trusted to do their job. There were 5% of questions where the service scored worse than average, and the service’s worst performing questions were related to workload and staffing pressures. However, this survey dates from the time when the service was suspended, during which time 22% of staff had been redeployed to host sites for extended periods at the time of the survey. Therefore, some of the survey responses may be based on feedback about the host sites, rather than East Cheshire maternity services.

Maternity services were part of a trust wide ‘people plan’, which was a strategy developed to look at staff recruitment, retention, and trust values. There were several workstreams included in this, however this was an overarching trust wide plan, and therefore did not respond to service specific challenges.

Staff were focused on the needs of women and birthing people receiving care. Women we spoke with during the inspection told us they were very happy with the care they received, and found staff welcoming and willing to explain things and answer their questions.

Leaders understood that health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. Leaders could articulate the demographics of the population the service cared for, and were aware of the importance of tailoring the service to meet the specific needs of different elements of the population. We noted that the cardiotocography (CTG) audit tool was being expanded, so that from December 2023, it would also consider ethnicity, deprivation index and whether CTGs had been classified.

The service acknowledged the importance of an open culture where women and birthing people, their families and staff could raise concerns without fear. Policy documents we saw clearly emphasised the need for, and advantages of, an open culture that focused on patient experience, improvement and collaboration through learning. Staff we spoke with told us they would feel comfortable raising concerns. The trust told us there was a Freedom to Speak Up Ambassador within the service, who also liaised with the Freedom to Speak Up Guardian if required.

Staff knew how to acknowledge complaints, but women and birthing people did not receive feedback from managers after the investigation into their complaint in a timely way. Data showed the service had received 3 complaints from September to November 2023. Complaints were monitored by leaders, however none of the complaints were responded to in a timely way according to the trust policy. Responses were made 2-4 weeks later than planned, which could cause delay in identifying any learning and improvement, and may lead to missed opportunities to provide the best care. The responses we reviewed contained comprehensive, detailed information which showed careful consideration of the complaints. The trust shared their customer care recovery action plan, which included actions to improve the timeliness of responses to complaints.

Managers investigated complaints, identified themes and shared feedback with staff. Learning from complaints in order to improve the service was a fixed agenda item on each regular team meeting. However, it was not clear how effectively feedback reached staff on the ground. The trust told us learning from complaints was shared via newsletters, team meetings, safety huddles, handover and emails with presentations.

Governance

Governance processes were in their infancy and were yet to be embedded but we found staff were generally clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service. However, this did not always translate into timely improvements.

We noted some gaps in governance systems and processes. However, there was a clear governance route to the trust board. The maternity clinical governance group fed up to the directorate safety, quality and standards sub-committee, which in turn informed the board safety, quality and standards (SQS) committee. This formal committee has a direct line of sight with the trust board, and leaders said the head of midwifery presented regularly at the trust board, in line with current national recommendations.

Leaders did not always monitor key safety and performance metrics, and were therefore unable to always address those where performance was lacking in as proactive a way as may be expected. Performance dashboard data appeared in the directorate performance review meeting. However, in October 2023, the only performance data being monitored was caesarean section and breastfeeding rates, and the caesarean section rows were empty of data. Data forms were not always clearly labelled with the month the data referred to. However, the trust told us that the maternity senior leadership team received performance reports including staffing, training, quality, activity, escalations, actions and service challenges. Comprehensive service dashboard data was submitted to the regional local maternity and neonatal system (LMNS), and the service provided evidence of this for July to November 2023.

Patient experience was not always recorded clearly to assure the service that the patient voice was collected and used to inform practice. However, following factual accuracy process, the service provided a copy of the equality delivery system (EDS) for 2022/23 reporting template, a national pilot, which had been completed in February 2023. Within this the antenatal screening service was considered. The EDS is a tool that supports NHS organisations to make

improvements to their approach to addressing health inequalities. The trust overall rating for this exercise was 'achieving'. We saw from the minutes of the April 2023 safety, quality and standards (SQS) committee meeting that it was noted that positive third party assurance that the trust was achieving across each domain assessed in the EDS was provided.

Leaders were aware of issues with performance in the management of postpartum haemorrhage (PPH) and review of cardiotocography (CTGs), and discussed their approach to improving this. Leaders conducted a detailed thematic review of PPH management and produced an action plan to address the findings, with allocated responsibilities and time frames. The thematic review responded to an upward trend for PPH over 1500 mls in September and October 2023, and the findings of monthly PPH audits. The thematic review and action plan was being finalised at the time of the inspection and was supplied following the site visit. The service had also shared the PPH incident theme from September 2023 with the Local Maternity and Neonatal System (LMNS). They continued to audit SBL3 Element 4, effective fetal monitoring during labour. We saw the January 2024 audit for this, which included recommendations and an action plan with allocated responsibilities and time frames.

At the time of the inspection, the triage prioritisation system and compliance with meeting prioritisation assessment times had not been audited. As triage proformas were filed in the patient's handheld notes that went home with them, there was no mechanism to audit this retrospectively. This meant that the service could not assure itself that people were seen within safe time frames according to urgency.

In triage, the service only audited compliance with the initial assessment in 30 minutes for September, October and November, not compliance with prioritisation (red, amber and green (RAG) time frames / doctor reviews within the RAG time frame). The November audit included doctor review times, but these were not related to RAG rating time frames, which was not included on the daily log sheet. The maternity triage standard operating procedure (December 2023, version 2) stated the number of women and birthing people seen within the time frame for red/orange/yellow/green required monitoring, but also stated the frequency of monitoring as yearly. Since the inspection, leaders planned to monitor RAG rating time frame compliance as well.

There was not a standard operating procedure for the opening of a second theatre for times when 2 obstetric emergencies occurred at the same time, to standardise this process. We noted that systems and processes were not always standardised and formalised, which meant safety and effectiveness were not assured.

Leaders understood the need to improve governance systems and processes, both now and when the birth rate and activity increased, for the service to run safely and smoothly.

The service used the Perinatal Mortality Review Tool (PMRT) framework to investigate fetal and neonatal deaths. From March 2023 until December 2023, there were 4 cases involving the service, 2 of which were joint cases involving other neighbouring trusts. Evidence showed the service was not always able to manage and review cases in a timely way. The recommended time frame in which to complete PMRTs is within 4-8 weeks, however, at the time of the inspection, none of the cases had been reviewed in this time frame, and 1 had taken over 8 months to complete. The service told us this was due to waiting for reports from other agencies, or internal processes within the trust.

Cases that met the criteria were reported to the Maternity and Newborn Safety Investigations programme (MNSI, previously Healthcare Safety Investigations Branch, or HSIB), and there was 1 case that was referred in the 6 months

prior to the inspection. Of the 2 cases investigated by the MNSI in the 12 months prior to the inspection, the main recommendations were about appropriate service guidance, information sharing and clinical oversight. The service developed a short action plan in response to MNSI recommendations, with appropriate time frames for completion, which was ongoing at the time of the inspection.

Maternity services were discussed at the trust board meeting on 5 occasions between September 2022 and September 2023. Minutes showed discussions were detailed regarding risks and developing proper governance arrangements during the reimplementation phase of the service. We also saw evidence that maternity performance was reported at other elements of the governance structure, for example, the safety, quality and standards (SQS) sub-committee of the board. The maternity quality and safety report to the December 2023 SQS committee included information on activity, PMRT cases, HSIB (now MNSI) cases, incidents, incident themes and overdue incidents, duty of candour, guidelines, staffing, training and updates on compliance with Ockenden, the maternity incentive scheme (MIS) and Saving Babies Lives (SBL) 3. We also saw that a maternity data pack for September 2023 had been produced for the SQS committee and other meetings. This also provided information on incidents, duty of candour, complaints, risks, and policies and guidelines overdue for renewal. A maternity summary report to the November 2023 senior management team meeting provided information on activity, staffing, training, challenges and key actions.

Clinical governance meetings were held monthly and were attended by service leaders. The meetings had standing agenda items which included, but were not limited to, the risk register, the maternity performance dashboard, recent clinical audits, infection prevention and control measures, safeguarding, complaints, and clinical guidelines. However, it was not clear whether all staff had the opportunity to attend.

Safety and quality meetings were held monthly. We requested the minutes for the last 3 meetings, but the service only shared meeting minutes dated July 2023. The minutes showed discussions around policy, serious incidents, feedback in both directions from ‘ward to board’ and vice versa, and other items.

Quarterly quality and safety reports were produced for the safety and quality standards (SQS) committee, and these documented the number of births and antenatal bookings, and outlined cases for HSIB (MNSI) and Perinatal Mortality Review Tool (PMRT) analysis. The report gave leaders a clear view of progress against these cases and nationally recommended time frames. For example, 1 case had been delayed due to the complex nature of investigation across 3 different NHS providers. Staff told us that as the service was small, there were not many incidents for PMRT analysis. The trust provided evidence that clinical staff attended PMRT reviews. The risk and governance midwife attended the LMNS safety learning monthly.

There was a policy in place for safe working hours for medical staff, and this was supported by the junior doctors’ forum and exception reporting to the board.

The bi-annual staffing report to the board dated October 2023 was comprehensive and detailed some maternity service issues. However, it documented staffing ‘red flags’ trust wide and did not drill down into maternity specific red flags, which meant trust leaders were not sighted on potential risks.

Public board papers for July 2023 showed that an update on progress against the recommendations made by the Ockenden reports (2020, 2022) was provided by the head of midwifery for the May 2023 safety, quality and standards committee (SQS) meeting, but there was no evidence that further assurance around the service as a whole was sought. Public board papers for November 2023 showed that a maternity safety and quality issues report was presented by the head of midwifery at the September 2023 safety, quality and standards (SQS) committee, which provided information

about the service following the return of intrapartum care in June 2023. Minutes showed there had been discussions around triage and postpartum haemorrhage. The board acknowledged the need for a comprehensive, detailed maternity services dashboard so that leaders could easily review necessary information. The minutes did not state an estimated timeline for the new dashboard to be implemented or reported to the board.

Staff did not always follow up-to-date policies to plan and deliver care according to evidence-based practice and national guidance. The September maternity quality and safety report stated 3 guidelines were out of date, but these were reviewed and ratified prior to the inspection in October and November 2023. The triage service was not compliant with the latest national guidance on staffing and prioritisation, and there was a cardiotocography (CTG) toolkit on the electronic staff record (ESR) which was out of date with current guidelines (paper copies of the current guidance were being used until the ESR issue was resolved).

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. They generally identified and escalated relevant risks and issues, but did not always implement actions that resulted in a timely, reliable and effective reduction in impact.

Leaders generally identified and escalated relevant risks and issues, but did not always implement actions that resulted in a timely, reliable and effective reduction in impact. The service used a risk register to manage new and ongoing risks. The trust had a corporate risk register that allowed leaders to identify, monitor and manage risks. There were 3 items on the corporate risk register related to maternity care. The risk register showed comprehensive consideration of risk tracked over time. The 3 risks on the corporate risk register related to resuscitaires, mandatory training, and proper competencies and skill mix available. These had been reviewed and mitigating actions had been identified.

The risks identified on the risk register were not always aligned with the main risks leaders described. Leaders told us the top identified risk was in relation to new resuscitaires; specifically, how the machines blended medical gases, and not having enough gas ports in the delivery rooms to ensure all machines had a continuous supply. Leaders had managed this by introducing adapters and commissioning new gas ports, and work was ongoing to achieve this throughout the unit, and completed in January 2024. Other identified risks were creating a standardised job role for maternity support workers, and a national patient safety alert around the electronic records system. We saw documentation showing that the electronic record system safety alert had been comprehensively addressed in terms of identifying implications and risk controls for mitigation and putting these in place. However, leaders were unable to confirm their assurances that the electronic systems and general record system processes were functioning correctly and effectively.

There was a local service specific risk register that fed into the corporate risk register, which contained 11 items. These were managed through the incident management software and updated by service leaders before feeding into the corporate risk register if required. Staff told us risks on the maternity risk register would be reviewed by maternity governance, and those identified as high risks escalated through the safety and quality standards committee.

Risks were reviewed at clinical governance meetings, where staff also reviewed audit results, key performance indicators, feedback and complaints, and other issues affecting the service. There was a maternity services dashboard which contained data about the service and its outcomes in order to identify areas of risk and improvement and monitor performance. Maternity dashboard data showed the service had consistently higher numbers of term babies admitted to the neonatal unit compared with average in the local maternity and neonatal system (LMNS), and taking into account

the local birth rate. The LMNS average was 4.3% term babies admitted to the neonatal unit. However, between July and November 2023, data showed on average admission rate to the service neonatal unit was 4.8%, and 5.8% in October 2023. This was not recognised by the service, and it was unclear what measures the service had taken to investigate potential reasons for this.

Stillbirth rates were low at the service. Between July and November 2023, less than 1% of births was a stillbirth, against a local average of 4.3%, and a national average of 3.9%.

Local and national maternity dashboard data showed the service as a negative outlier (performing worse than the national average) in breastfeeding and postpartum haemorrhage (PPH) more than 1500mls, as well as recording an average rate of 29% of births having a postpartum haemorrhage of 500-1500mls. The service had recognised the high rate of PPH, but had not definitively worked out why this was happening. Actions designed to produce improvements in PPH rate had been identified, but had not yet evidenced significant change in a desirable time frame, although monitoring continued. There was a high rate of episiotomies performed at the service (29% in November 2023). However, the incidence of 3rd and 4th degree tears was much lower than the national average.

Some areas of the dashboard had not had data collected since September 2023, including data on workforce, Saving Babies' Lives (SBL) metrics, safeguarding, infant feeding, and patient experience. The impact of this was an incomplete picture for analysing service performance, and a missed opportunity to identify improvements and maintain safety standards.

The service participated in relevant national clinical audits. Conclusions on outcomes for women and birthing people were not able to be drawn, as the service was newly reinstated from June 2023, and audits had not been completed and analysed yet.

Managers and staff showed us a comprehensive programme of repeated audits designed to check improvement over time. However, since reopening the service, 1 out of 18 planned audits had been completed, 5 were overdue completion, and 12 had been registered and were in progress. The service defined overdue as the audits not having proceeded within the initial expected timescales planned, due to other competing priorities. The impact of overdue audits, or audits with long timescales, was that the service did not respond in an agile and timely manner to any identified risks.

There were rolling audits in place to check documentation and other aspects of safe care. Audit results were not always presented in a clear and concise way, which posed a risk of incorrect interpretation, and a lack of understanding of challenges within the service. Audits were accompanied by action plans to improve services on the basis of results, but these did not always address all of the issues found, because of the way results were recorded and interpreted by staff.

However, following the inspection, leaders responded positively to some of the concerns raised, and provided evidence of their thematic review of post-partum haemorrhages, a triage quality improvement plan, and the details of their most recent monthly fetal surveillance compliance (January 2024).

The service was not fully compliant with the Saving Babies' Lives (SBL) care bundle version 2 or 3. There were plans in place to become fully compliant with 5 out of 6 streams of the care bundle by March 2024, and compliance with the remaining stream was not applicable to the service, as they did not accept any diabetic referrals. The service had raised this non-compliance with SBL diabetes care with the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICS). There was a comprehensive working action plan and progress document for the board and LMNS to monitor and gain assurance of implementation and compliance against SBL.

Maternity

The service was not registered with the Maternity Incentive Scheme (MIS), which provides services with a reduction on indemnity payments if they comply with 10 safety measures, due to the consultant-led intrapartum service being non-operational during the COVID-19 pandemic, and only reopening in June 2023. Leaders made the decision to self-assess against the 10 safety measures for Year 5, in preparation for compliance with the safety measures for Year 6. The service self-assessed as compliant with 5 measures and partially complaint with the remaining 5 as of December 2023. The service was monitoring progress against plans to become compliant where possible, and leaders had sight of this.

The service had identified the 7 immediate and essential safety recommendations in the Ockenden report (2020 and 2022) on maternity care. The service was compliant with 2 actions: PMRT reviews and Maternity Incentive Scheme evidence, and was partially compliant in the remaining 5 actions. These were past their target completion date and the service said this was because they were still in the embedding stage following the reopening, and it needed more time to collect data.

There was a monthly patient safety incident oversight sub-committee held monthly where serious incidents for the trust were discussed. We saw minutes from the September, October and November 2023 meetings, which were limited in references to maternity incidents. However, the November meeting included a HSIB (MNSI) report which had been presented by the head of midwifery, with discussion around this case.

There was also a weekly executive led incident check and review panel meeting, which aimed to ensure timely review and scrutiny of draft patient safety incident investigations and patient safety reviews, action plans and learning to be shared. According to the agenda for one of the September 2023 meetings, a maternity patient safety investigation and a safety review were for discussion.

There was a maternity specific risk management strategy that comprehensively set out the response to risk and key staff roles in this area. A trust wide patient safety incident response plan was in place; it was a strategic document and covered maternity incident management at a strategic level. The trust had adopted the Patient Safety Investigations Response Framework (PSIRF) to investigate, review and manage identified risks. The framework sets out best recommended practice for incident management, to learn compassionately and promote open culture, instead of attributing blame.

Service leaders monitored maternity staffing ‘red flag’ data, however some issues with correct reporting had been identified in October 2023. There was an action plan related to staff training on categorisation of events, but the action plan did not recognise that 44% of events were delayed inductions of labour, or set out any mitigation to ensure the safety of women, birthing people and babies who were subjected to any delays. This showed an incomplete response to risk, and the unit was not doing enough to provide assurance that the service remained safe during these events.

Information Management

Systems were evolving which meant the service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated, but were secure.

The service did not always collect reliable data and analyse it. There was a live dashboard of performance data which was accessible to senior managers. Key performance indicators were displayed for review, and managers could see other locations for internal benchmarking and comparison. However, not all sections of the dashboard had data input, and triage audits did not audit all the required details.

Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. For example, there were concerns the electronic record system was not fit for the purpose of the demands of maternity, and that some modifications were needed.

The information systems were secure. However, the service used a combination of electronic and paper systems, which was a risk due to possible inconsistencies, staff accessibility, and a lack of up-to-date information in an emergency.

Engagement

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

Leaders worked with the local Maternity & Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. MNVP leads told us there was a positive relationship with the service; the MNVP had been involved in the planning and reimplementation of the service, and leaders were responsive to concerns raised by them since reopening. However, we saw 2 action logs relating to MNVP work kept by the service, one of which was poorly maintained. A list of contact details and job roles at the service was requested by the MNVP in May 2023, and was not provided until 27 November 2023. An action log dated November 2023 contained more detail and tasks undertaken between the MNVP and the service.

The service worked with the local maternity and neonatal system (LMNS) and ambulance service in creating an escalation document using Operational Pressures Escalation Levels (OPEL) specific to maternity services. This aimed to ensure active, effective communication between the maternity and ambulance services. The document clearly and comprehensively set out the process for escalation and de-escalation to ensure safety was maintained.

There was a maternity specific escalation policy that comprehensively set out assessing and responding to times of high acuity and low capacity on the unit, underpinned by OPEL, which used clear terms to describe and manage risk. However, the policy stated that consultant presence in times of out-of-hours escalation would be provided by non-working obstetricians, and there was not a clear framework to show how this would happen, how it was monitored, or how the service would ensure doctors were fit to work and able to have appropriate amounts of rest between shifts. Although we were told the consultant body was aware of the need for adequate rest before and after on call work to maintain patient safety, it was acknowledged that this may not always be the 11 hours of continuous rest in line with Royal College of Obstetricians and Gynaecologists recommendations on compensatory rest. We were told adequate compensatory rest was managed by an informal process when required, through understanding between consultants leading to alternative arrangements for cover by those available. However, this meant clinics were often conducted by senior middle grade doctors when consultants were absent, and that planned activities such as clinics or theatre sessions may be cancelled if there was not enough middle grade cover.

The regional escalation framework supported 4 hourly reviews of the maternity unit by the responsible person. This aimed to ensure oversight of emergent risks and aid communication between the regional units to collaborate and share work where it was clinically appropriate to do so, and to track women and birthing people who had been diverted to neighbouring units.

Leaders understood the needs of the local population. However, leaders told us more work needed to be done on tackling health inequalities, inclusivity and mental health provision.

Maternity

We saw a large number of trust- and service-produced newsletters sent to staff via email with updates on various topics. Newsletters often had a high word count, and did not always set out information in a concise, easy-to-read way, which meant it took a long time for staff to read and absorb the information. Not all information was relevant to ward staff roles. There was a risk that staff did not have time to engage with the numerous newsletters whilst also caring for women and birthing people and their babies, and therefore they may miss information or become disengaged.

We received 3 responses to our give feedback on care posters which were on display during the inspection. All were positive about the staff and the environment. Staff were described as fantastic and caring. Two people were unhappy about discharge procedures, and 1 felt there were not enough staff.

Learning, continuous improvement and innovation

Staff wanted to continually learn and improve services; however, this had not been as proactive as expected, which may be due to the demands of implementing the reinstatement process. They had an understanding of quality improvement processes.

Staff wanted to continually learn and improve services. They had an understanding of quality improvement processes. There was evidence the service was improving by learning when things went well or not so well, and promoted training, but some issues were not managed as proactively and definitively as they ideally should be. This may be due to the demands of implementing the reinstatement process.

Outstanding practice

The service had only been operational for 6 months prior to our inspection, previously it had not been operational for 3 years. Although the audit cycle and governance processes were still in their infancy we were encouraged to see the service was clear at what it wanted to achieve and a drive for imporvement.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure staff receive specific training for their role, including safeguarding, newborn life support, triage, Saving Babies' Lives (SBL) care bundle versions 2 and 3 training, and medicines management training and competency assessment. Regulation 12 (2) (c)
- The service must ensure daily checks of resuscitaires are carried out and that after use, resuscitaires are checked and left ready for the next person to use, wherever that may be. Regulation 12 (2) (e)
- The service must ensure people attending triage for assessment are subject to a standardised prioritisation process, and that triage telephone assessments are carried out in a confidential space. Regulation 12 (2) (a, b)

- The service must ensure compliance with Saving Babies Lives care bundles 2 and 3, including improving compliance with fetal monitoring (cardiotocograph monitoring). Regulation 12 (1) (2) (a, b)
- The service must respond comprehensively to delays in care identified by red flags. Regulation 12 (1) (2) (a, b)
- The service must continue to implement and embed, standardisation of key processes, audit of actions and outcomes, and processes and procedures. For example, but not limited to, a reduction in the rate of postpartum haemorrhage (PPH), and the admission of term babies to the neonatal unit. Regulation 12 (1) (2) (a, b)

Action the trust SHOULD take to improve:

- The service should ensure all staff are compliant with the correct removal of personal protective equipment to minimise risk of spreading infection.
- The service should ensure all areas of the service are compliant with cleanliness standards.
- The service should ensure compliance with keeping medical equipment and supplies clean when in open areas of the unit, for example corridors and nurse stations, to assure service leaders that equipment is clean and ready for use.
- The service should ensure a standard operating procedure for the opening of second theatre for concurrent obstetric emergencies is developed, implemented and embedded.
- The service should continue to ensure incidents and clinical outcomes are reviewed through the lens of equality, diversity and inclusion.
- The service should continue working to ensure compliance with national safety recommendation actions from Ockenden 2020 and 2022.
- The service should consider expediting a digital records solution to enable an overall point of single visibility of all care records.
- The service should enhance awareness of ligature risks amongst staff.

Our inspection team

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