Warrington and Halton Teaching Hospitals NHS Foundation Trust

Warrington Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Warrington Hospital

Good ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Warrington Hospital.

We inspected the maternity service at Warrington 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 Warrington Hospital provides maternity services to the population of Warrington and Halton.

Maternity services include an early pregnancy unit, an antenatal day unit, triage assessment unit, a joint antenatal and postnatal ward (c23), birth suite, midwifery led birthing centre (The Nest), two maternity theatres, 1 high dependency room or enhanced maternal care room on the birth suite and a bereavement suite. There are approximately 2600 babies were born at Warrington Hospital per year.

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

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

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

- Our rating of good for maternity services did not change the ratings for the hospital overall. We rated safe as good 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 service, birth suite, midwifery led birthing unit (The Nest), The bereavement suite, theatres, and the antenatal and postnatal ward (C23).

We spoke with 4 doctors, 11 midwives, 1 maternity support worker, 2 domestic members of staff, 2 women and birthing people and 1 birthing partner. We received 27 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 12 patient care records including observation and escalation charts and 5 medicines records.

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

Our findings

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 ➔➔

Our rating of this service stayed the same. We rated it as good because:

- Staff understood how to protect women and birthing people from abuse. The service was visibly clean and staff controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. Medicines were managed well. The service identified, recorded, and responded to safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were passionate about the care they provided and were engaged in improving the service further. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued by the leadership team. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- Not all staff had completed the required mandatory training and there was no evidence of how many staff had completed skills and drills training and when. This included the completion of safeguarding training which was raised at our last inspection of the service.
- Policies were not always in place or did not reflect current practice or provide sufficient guidance for staff.
- The implementation of transitional care as per the service policy was not well understood by staff and therefore not embedded in practice.

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service offered mandatory training in key skills and made sure most staff completed it. There was a plan and trajectory in place to meet the trust training target in some areas; however, staff were not currently meeting the target.

The training needs analysis identified maternity specific required training. The service offered 4 types of mandatory training. These were maternity specific; trust wide core skills; safeguarding and role specific training.

Not all midwifery staff completed their mandatory training, 71% of midwives had completed the newborn life support training and 74% of midwives had completed the acute illness management training. The trust target for training was 85%. However, as part of the inspection process the trust provided more recent data which showed 88% of midwives, 93% of medical staff and 72% of agency staff had completed their training.

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The service provided staff with Practical Obstetric Multi-Professional Training (PROMPT), which was delivered over 3 years with 4 out of 8 simulated scenarios delivered each year. This had been completed by 75% of obstetric consultants, 67% of all other obstetric doctors, 76% of obstetric anaesthetic consultants, 87% of midwives and 89% of midwifery support workers. Following the inspection, leaders provided additional compliance evidence which showed 90% of midwives, 83% all medical staff had completed their PROMPT training since our onsite inspection.

Staff spoke positively about the training provided within the service. New midwives told us how they received a 6-week period when they started to complete training, shadow other staff, and learn about the service and trust, during this time they were supernumerary. We also saw and heard about situational training sessions called “training train” in which a trolley would be taken to the ward areas and short training refreshing sessions were provided to staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was shared at governance meeting which was escalated up to the board.

Safeguarding

Most staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. However, a low percentage of medical staff had completed their safeguarding training on how to recognise and report abuse. Not all staff understood the systems to report safeguarding concerns.

Training records showed that staff were provided with both level 3 safeguarding adults training and level 3 safeguarding children training in line with their roles as set out in the trust's policy and in the intercollegiate guidelines. Eighty eight percent of midwifery staff and 62% of medical staff had completed the level 3 safeguarding children training. Seventy six percent of midwifery staff and 54% of medical staff had completed the level 3 safeguarding adults training. The trust target was 85%. The trust told us that training for doctors had been booked but attendance was impacted by recent strike action. Trajectories for completion were in place and we saw these had been reported to the trust board in December 2023.

Following the inspection, leaders provided additional information regarding the alternative methods of supporting and educating the workforce and provided examples of strategies to strengthen the knowledge of the workforce. For example, a regular 7-minute briefing was shared with staff from local safeguarding partnerships, safeguarding midwives had weekly drop-in clinics to offer safeguarding supervision, and there was monthly safeguarding supervision. However, attendance was not recorded and monitored.

Leaders told us that in January 2023 every midwife was given a safeguarding resource pack and competency checklist. However, the strategies appeared to focus mainly on midwives which meant we were not assured the medical staff had the same insight and knowledge. There were plans to implement this with medical staff, however, no timeframes were provided.

Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Equality Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team and this was communicated in handovers.

Maternity

Staff we spoke to knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke to explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. We saw how the safeguarding team carried out a daily walk around of the clinical areas to offer support and advise as needed.

The service was using up to 3 electronic systems in relation to safeguarding. This required staff to check 2 separate systems for any safeguarding concerns and make referrals on a third system, this had the potential for missed opportunities and human error. Not all staff we spoke to have a good understanding of the different systems despite training being in place. Safeguarding alerts/flags on one electronic system did not always pull through to the second electronic system to alert staff of concerns. We raised this with the digital midwife who told us they would look to resolve this to prevent any missed opportunities. We also raised a concern around how failure to attend appointments was documented and followed up as this can lead to safeguarding concerns. We were assured that the trust was aware of this, and work had already started to resolve the issue.

Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff were aware that a baby abduction policy was in place and the trust told us that 12 staff members had participated, however, we saw no evidence of this. Staff were able to explain the baby abduction policy. However, we raised a concern that one emergency door was a potential security risk and the trust responded promptly to rectify this issue. All other doors and ward areas were secured with swipe card access, and doors were monitored by CCTV.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves, and others from infection. They kept equipment and the premises visibly clean.

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. The triage area, midwifery led birthing unit and bereavement rooms had recently been refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned and checked regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular hand hygiene audits and data showed hand hygiene audits were completed every month in all maternity areas with staff overall performing well. We requested Infection prevention and control (IPC) audits and cleaning audits for the last 3 months; additional information was provided following our initial inspection findings. These showed that all areas of the service were regularly audited and fed back to senior leaders.

Action plans shared from infection prevention and control audits showed action was taken in a timely manner where issues were identified.

Staff cleaned equipment after contact with women and birthing people and used “I am clean” stickers to indicate when equipment was clean and ready for use.

Environment and equipment

Maternity

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

We saw that call bells were accessible to women and birthing people if they needed support and we saw that staff were responsive to call bells on the day of inspection.

The triage area had recently been relocated following feedback from staff and people using the service. Initial feedback from staff about the new triage area was positive. The environment allowed for better visual oversight of women waiting in a more comfortable environment that was fit for purpose. The service had plans approved and money allocated to relocate the induction of labour bay to a more appropriate area as part of a quality improvement piece of work and feedback from staff and people using the service.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment across the service were checked daily. However, the service was using an online app to document checks of some emergency boxes such as the sepsis bag, in one area we found gaps in those checks as staff had not had access to login details. Staff recorded that they had completed an incident report on these occasions.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply with domestic staff responsible for the regular flushing of water.

The birth partners of women and birthing people were supported to attend the birth and provide support. Following feedback from women and birthing people the service had started to allow birthing partners to stay overnight, this was based on an assessment of individual circumstances. The service acknowledged that due to limited number of side rooms, and limited facilities including sleeping facilities for partners this was not ideal or encouraged.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, there were pool evacuation nets in all rooms with a birthing pool. Staff had access to a portable ultrasound scanner that was moved from one area to another to facilitate a scan. There were cardiotocograph (CTG) machines and other physical health observation monitoring equipment available in all areas as needed.

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

Assessing and responding to risk

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

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

Maternity

We reviewed 4 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff if required. Staff completed a monthly audit of MEOWS records; this was initially of 10 records per month which was increased in the last 2 months to 20 records to reflect 10% of the number of births per year. Audits were to check they were fully completed and escalated appropriately. Audits for June 2023 showed overall compliance of 90%, July 2023 scored 87% and August 2023 scored 93%.

We raised concerns with the service about the lack of clarity, policy, and communication around when and how a woman or birthing person who needed a higher level of care would be looked after. The trust provided assurance and created a policy that outlined the pathway, criteria, and location of a designated side room on the birthing suite to provide level 1 critical care to women and birthing people. At the time of inspection, 74% of midwives had completed a competency based “acute illness management” training course. Since the inspection more midwives have completed this training. Additional courses are also being completed to further enhance the skill set of midwives in looking after more seriously ill women and birthing people.

Staff used an evidence-based, standardised risk assessment tool in maternity triage, which prioritised attendees in order of importance based on the symptoms they presented with. The audit which looked at maternity triage waiting times for review by a midwife between June and August 2023 showed midwives reviewed 91% of women and birthing people within 15 minutes of arrival and 97% were seen within 30 minutes of arrival.

Cardiotocography (CTG) is used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a "fresh eyes" or “peer review” hourly for regular review of CTGs during labour. The trust shared the CTG and fresh eyes retrospective audits for April to August 2023 which looked at a random selection of 100 records and found that on average over the 5 months, CTGs review compliance was 67% and compliance with "fresh eyes" or "peer review" of the CTG was 37%. Due to the low compliance rates the frequency of the audit increased to monthly. In July 2023 additional training and communication was implemented and compliance for CTG reviews went from 65% in July 2023 to 75% in August 2023 and for fresh eyes there was an increase from 30% to 70%. Further work was needed to improve the compliance around CTG reviews and peer reviews, the service had rated this risk amber.

Training figures provided after the initial request for information, for CTG and competency assessment showed 91% of midwives had completed the CTG training with 64% successfully completing the competency assessments. Ninety six percent of doctors had completed the training and 62% of those had successfully completed the competency assessment. An action plan was shared to improve training and competency assessment figures by January 2024.

At the time of the inspection there was a consultant obstetrician allocated as the interim fetal surveillance lead whilst recruitment for a new consultant was on-going and there was currently no specialist midwife for fetal surveillance although the post was out for recruitment.

The service had a higher number of women and birthing people experiencing a post-partum haemorrhage (PPH) than the national average for a service of their size.

Leaders had recognised there had been a spike in March 2023 and a retrospective “deep dive” review of records from January and February 2023 had been carried out as a result. Actions were put in place, but no further audit had been carried out despite a slight increase month on month.

Cases of PPH were however being recorded and monitored. A weekly intrapartum review group had been set up to include review of cases of PPH over 1500ml with findings shared more widely across the maternity service.

Staff told us medical staff did not attend these meetings and we saw from minutes provided that out of 8 meetings reviewed, medical staff had only attended once, whilst the terms of reference did not mandate their attendance, medical opinion on cases would have been beneficial.

Learning taken from the weekly case reviews were circulated monthly in Intrapartum review group learning messages as well as being included in safety briefings and a monthly 1-page briefing called “our wise learning” which highlighted shared learning and areas for improvements.

The policy for management of obstetric haemorrhage (2021) did not provide guidance to staff on how to document risk assessments and at what stage to sufficiently mitigate risk. It was also not clear in the policy how staff should manage PPH, for example we were told staff should weigh all blood loss, but this was not outlined in the policy, and total blood loss was not always documented in incident reports. This was shared with the trust and leaders responded to our request to update their guideline for the management of obstetric haemorrhage.

The newborn early warning trigger and track (NEWTT) tool is designed to be used by healthcare professionals working in areas caring for newborns in the early and ongoing postnatal period to identify babies at risk of clinical deterioration and provide a standardised observation tool to monitor clinical progress. The service audited NEWTT. We requested audits for the last 3 months from the trust but received audits for June and July 2023. Additional information was provided for August 2023 following the initial request. Audits showed over the 3-month period 61% of newborns received the first set of observations within 30 minutes of birth. In July 2023 only 40% of newborns had 2 hourly observations for 10 hours. In August 2023, 1 out of the 2 cases which required review by a paediatrician within 15 minutes was not achieved. The service scored 100% in all other areas where the newborns observation levels were outside of the normal range and required increased observations and/or escalation to a paediatrician.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service completed WHO checklists online which then generated an audit. WHO checklists were completed fully 100% of the time.

The service told us they provided transitional care. This is additional care for babies that can be provided on a postnatal ward in conjunction with the neonatal team, rather than on the neonatal unit to prevent separation from the parent. At the time of inspection, it was unclear how the transitional care pathway worked and how this was communicated with staff. Staff we spoke with told us transitional care was a step-down service for babies who has been admitted to the Neonatal Intensive Care unit (NICU). We raised this with the trust and changes were made to the policy, and the communication tools used. Additional training and support were also provided to staff to aid their understanding of the policy and pathway. Further work was being carried out regionally with the Northwest Neonatal Operational Delivery Network which the service was a part of.

Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. The service had a full-time perinatal specialist midwife in place to offer support and we observed this happening on the day of inspection. The service also worked closely with an organisation called “Parents in Mind” which aims to support women and birthing people from pregnancy or within 2 years of birth. Changes to the trusts electronic referrals process had seen an increase by 4 times the number of referrals made and accepted.

Staff also told us about the positive working relationship and outcomes they had achieved for a pregnant person with complex mental health needs who resided at a local mental health facility. Learning from this experience had led to positive changes in practice for those unable to care for their babies after birth.

Maternity

Staff shared key information to keep women and birthing people safe when handing over their care to others using the electronic care record.

During the inspection we observed staff handovers and a safety huddle, the staff handovers discussed specific patients and their needs, whereas the safety huddle was to discuss the staffing and bed pressures across maternity. We found all the key information needed to keep women and birthing people and babies safe was shared.

Each member of staff had an up-to-date handover sheet with key information about women and birthing people, this included any safeguarding concerns, levels of observations, and any outstanding assessments required. The handover sheets were disposed of at the end of each shift in confidential waste.

The service also completed an audit of their handover format to ensure it reflected an SBAR model (Situation, Background, Assessment, Recommendation). We reviewed audits from a 3-month period June-August 2023 and found the service were on average 90% complaint with use of SBAR handovers when required.

Midwifery Staffing

Staffing levels did not always match the planned numbers; however, the staffing position was due to improve by Autumn 2023.

On the day of inspection midwifery staffing met the planned staffing required and all staff were contracted staff. The service made their planned verses actual staffing levels publicly available on the trust's website. This showed that for the month of July 2023 the actual registered midwifery hours for the month across the day for the antenatal ward, the birth suite and the nest were 1022.5 hours less than the planned hours.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4, Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between January and June 2023 there were 66 red flag incidents. In June 2023 there were 27 red flag incidents. Over that 6-month period, 4 of these were occasions where the birth suite coordinator was not supernumerary. On 7 occasions the midwifery-led birthing unit was on divert in response to staffing levels. There were no red flags reported for a midwife being unable to provide 1:1 care to a woman or birthing person in established labour.

Managers accurately calculated and reviewed the number and grade of midwives, and midwifery support workers needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in January 2022. This review recommended 116.70 whole-time equivalent (WTE) midwives' band 5-7, this also included 10.61 WTE Midwifery support workers, compared to the funded staffing of 122.22 WTE, a surplus of 5.52 WTE staff.

The service had worked to improve recruitment and reduce turnover within the midwifery establishment. At the time of inspection, the vacancy rate was 17.55 whole time equivalent (WTE), with 17.17 WTE in the recruitment pipeline due to commence in Autumn 2023.

All but 1 Band 7 Specialist and Ward Manager roles were recruited into alongside two Matron posts, a deputy head of midwifery post had also been recently filled.

Turnover for all permanent staff had decreased from 29% in August 2022 to 17% in May 2023, for registered staff this figure has reduced from 30% in August 2022 to 20% in May 2023. For non-registered staff, turnover is 8%, which is below the Trust target of 13%.

Service leaders told us the continuity of care model had been phased back from 7 continuity teams to 4 continuity teams and 2 traditional community teams to ensure safe staffing levels within the hospital. This decision improved recruitment and retention within the midwifery cohort. Also, to support enhanced care for those families living in areas with higher deprivation, the service was recruiting additional midwifery support workers to provide additional support in those areas. In addition, as part of the implementation of the birth availability model the service focused on key geographical areas, as national data evidence highlighted that these measures improve outcomes for the most vulnerable families. Staff, women, and birthing people spoke positively about this model and in 2022 the service received the NHS Parliamentary Awards in recognition of the Warrington and Halton Hospitals continuity of carer service.

There were 6 continuity of carer teams, 4 teams were based on post code areas, 1 team was for those women and birthing people choosing home births and 1 team supported more vulnerable or high-risk women and birthing people. Two of those teams worked a traditional community midwife rota and the remaining 4 had adapted the CoC model.

There was a supernumerary band 7 or above midwife who took the role of “bleep holder” Monday- Friday in-hours. Their role was to oversee staffing, acuity, and capacity across the maternity unit, taking action to mitigate and escalate concerns as needed. Outside of hours the Birth Suite co-ordinator took on this role, escalating concerns as needed. Further work was on-going to add to the out of hours support available from band 7 midwives.

Staff told us that recent changes to the location of the triage unit from being located on the birth suite to its re-location next to the Nest (midwifery led unit) as well as the changes to the staffing levels, had reduced the impact on staffing and how often staff would be moved. However, staff on the antenatal and postnatal ward said they were more likely to be moved to support in other areas which impacted their staffing levels. Staff also told us that the number of staff on the antenatal and postnatal ward had recently been increased by 1 midwife. The bleep holder and birth suite coordinators moved staff according to the number of women and birthing people in clinical areas which including the use of specialist midwives and community midwives if required.

Staff told us that when they fed back concerns around staffing, they were listened to and supported.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. On the day of inspection, we saw one bank member of staff on the postnatal ward.

The service made sure staff were competent for their roles. Staff’s work performance and appraisals were not always carried out with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. However not all midwives had received an appraisal in the last year. 79% of midwives had an appraisal, the service had booked 18 midwives to receive their appraisal in September 2023 to meet the trust target of 85%. A practice development team supported midwives. The team included 1 full-time practice development lead midwife and 1 practice education midwife and a team of 6 professional midwifery advocate roles with a further 4 being trained.

Managers made sure staff received specialist training for their role. For example, midwives had been supported and funded to obtain masters level qualifications and midwifery support workers were being supported on apprenticeship courses. Members of the management team were also taking part in a new Perinatal cultural leadership program to further develop their leadership skills.

Medical staffing

The service 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. However, mandatory training was not completed by all medical staff.

The actual number of medical staff on duty matched the planned numbers. The service had 9 substantive consultants; however, the recently increased funded establishment was 11 substantive consultant posts. They had successfully recruited 1 consultant and were awaiting their start date; and were in the process of advertising for another consultant to support the workload and on-call arrangements currently in place. The trust was working towards eventually have 12 Consultants in the future. The service had low vacancy, turnover, and sickness rates for medical staff.

The service had low rates of bank and locum staff but those that were used were regular locums who had previously worked or trained at the service. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. A recent change to deployment of medical staff in line with the changes to the location of the triage area had been positively received by staff.

The service always had a consultant on call during evenings and weekends. There were 2 consultant led ward rounds per day 7 days a week. This is in line with Ockenden (2022) recommendations. We found the Handover and Ward Round Standard Operating Procedure despite acknowledging the recommendation from the Ockenden Report (2022) for twice daily handovers 7 days a week, contained a scheduled timetable which contradicted this. It did not include consultant led ward rounds at a weekend. The trust provided evidence of consultant led handovers at the weekend and told us they would be amending the Standard Operating Procedure to reflect current practice.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job and the management team were supportive and listened to feedback on areas for improvement through clinical supervision.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and available to all staff providing care, however, more work was required on the integration of systems.

Maternity

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used electronic records for the maternity notes, however neonates still mainly used paper notes. The service recognised this was an area for improvement and had requested funding for better electronic record systems, however this had not yet been approved. For those babies under transitional care there would be both paper and electronic notes which staff told us leads to duplication of work and increases the risk of missed information.

The main hospital used a different electronic records system and whilst maternity staff could access this system, more work was needed and was on-going around how the systems communicated with each other. Maternity staff told us that at times they would need to access up to 3 different electronic records systems. The digital midwife was working with the trust to address any shortfalls and look at how this could be improved.

We reviewed 12 patient records and found records were clear and complete.

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

Women and birthing people had access to their patient records online and this was now available in 13 different languages to support non-English speaking women and birthing people.

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

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 5 prescription charts and found staff had correctly completed them.

Staff reviewed each woman's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed.

Medicines records were clear and up to date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit. However, we found that the persons weight was recorded on a separate electronic system to the medicines records, this is a potential risk where medicine dosage needs to be amended to reflect the persons weight.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and we saw how action had been taken to escalate concerns when temperatures were out of range.

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

Incidents

Maternity

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured actions from safety alerts were implemented and monitored. However, we raised concerns regarding the categorisation of incidents.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed the summaries of over 200 incidents reported in the 3 months before inspection and found them to be reported correctly. However, the incident level grading was not always aligned to Regulation 20 Duty of candour of the Health and Social Care Act (2008) which defines moderate harm as harm that requires a moderate increase in treatment'. We found incidents in which women had lost a high volume of blood and 3rd degree perineal tears requiring further treatment which were graded as no harm and/or low harm.

We reviewed the reporting of incidents in relation to post-partum haemorrhage (PPH) and found that where a women or birthing person had experienced a PPH over 1500ml this was not always recorded as an incident as per the policy. Incidents of PPH did not always clearly outline the amount of blood lost which could potentially impact on the severity of the incident and further action needed.

The service had no 'never' events on any wards.

Managers reviewed incidents on a regular basis so that they could identify potential and immediate actions. Incidents were investigated and responded to in a timely way; there were no incidents open over 40 days. The service told us they achieved this by having a designated team and allocated time to dedicate to the review and management of incidents.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. We reviewed 6 incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 6 investigations, managers shared duty of candour and reports with the families for comment. Managers looked at the persons ethnicity and whether they spoke English as part of these reviews to identify any potential health inequalities.

The service reviewed all neonatal deaths by a multidisciplinary group and used the Perinatal Mortality Review Tool. We reviewed 9 sets of perinatal mortality tools, and we saw they had been completed appropriately.

In the last 6 months 4 incidents had been referred to the maternity and newborn safety investigation (MNSI) formally the Healthcare Safety Investigation Branch (HSIB) for investigation. However, 2 of these referrals had been rejected due to the criteria not being met or families not wanting an investigation and the other 2 were still in-progress. We reviewed 1 report and the associated action plan. The trust told us an action had been reviewed and agreed under governance processes 3 months after the report was received from HSIB and a completion date was set for a further 4 months. This was documented and monitored on the trusts incident reporting system.

The service used closed social media groups, emails, newsletters and seven-minute briefings to share learning from incidents. These included investigations completed both internally and externally.

Maternity

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

Staff told us that they received feedback from the investigation of incidents. For example, staff told us about the monthly safety brief. Staff also told us they have weekly and monthly reports on learning from incidents. They receive a weekly email report from the Director of Midwifery and a safety brief from the ward manger about all incidents that month, learning from these and the outcomes.

A closed social media group was also used to share safety briefs with students and staff told us about examples of learning shared from recent incidents to improve practice.

Staff told us that they felt supported by managers and that debriefs were provided as needed after any serious incident.

Is the service well-led?

Good

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 mostly understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. We saw how changes to the triage area had been shared with staff and how feedback to the changes were being sought and acted on. Further estate changes to the induction of labour area had been approved and were on-going, and staff were updated on the progress and timeframes around this.

Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers, matrons, and the director of midwifery. The executive team completed ward rounds on a regular basis, these had re-started recently following a pause during COVID-19. Staff told us they could approach the executive team if they needed to and spoke of how accessible and encouraging they were. Staff gave us examples of how they had escalated staffing concerns and received a positive response from managers. There was clear shared culture of team working and support across the wards and staff spoke positively about their colleagues.

The service was supported by maternity safety champions and non-executive directors who completed a monthly walk around of the service. We saw posters on the wards to raise awareness of their roles with contact details.

Leaders encouraged staff to take part in leadership and development programmes and we saw how staff had progressed to more senior roles internally.

Maternity

Vision and Strategy

The service had a nursing and midwifery vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The specific maternity vision and strategy was not yet finalised.

The service had an overarching nursing and midwifery strategy for 2022-2025 of what it wanted to achieve across the trust and a strategy to turn it into action. This had been developed with relevant stakeholders. The nursing and midwifery strategy 2022-2025 did not include maternity specific information or any reference to national reports and recommendations for improvement within maternity services. However, the maternity service was in the process of developing and having approved the midwifery specific strategy for 2023-2025. Whilst this had not yet been finalised and approved, we reviewed the draft and found it had aligned the objectives with the Trust's strategic objectives.

The maternity strategy draft document had also considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and these were included within the strategy alongside other national reports and best practice guidance aimed at driving improvements within maternity services.

There was a clear plan of how to apply the vision and strategy within the service and monitor progress. The trust told us the document would go through a process to engage and consult with relevant stakeholder before it was finalised and published.

Culture

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

Staff recognised that there had been a positive improvement in the culture of the service in the 2 years prior to our inspection and spoke positively about the department and its leadership team. Staff told us they felt able to speak to leaders about concerns and when things went wrong.

Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. The service was aware of the further work they needed to do to improve women and birthing people's experiences and were passionate about driving those improvements.

Leaders and staff understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population.

The service had implemented the "Continuity of Carer" model of care to support the most disadvantaged groups within the local community and those at higher risk of poor outcomes. Staff and people using the service told us how this had positively impacted the care provided and helped to reduce barriers to care.

Incidents were reviewed to monitor outcomes and investigate data to identify whether ethnicity or disadvantage affected treatment and outcomes, which they then shared with teams to help improve care. We saw how there was a drive to improve the use of interpreter services and pre-book these for planned appointments. The service had also implemented electronic patient records which were available to women and birthing people in 13 different languages.

For women and birthing people who were non-English speaking the service had also developed a “river pass,” which helped people quickly communicate to staff that they needed a translator and in which language this was needed.

The service had an equality, diversity and inclusion policy and process and separate strategies for staff and the workforce and patients. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement included which acknowledge the impact on pregnant and birthing people. Staff told us they worked in a fair and inclusive environment and no staff that we spoke to felt they had experienced discrimination.

The most recent staff survey in 2022 showed there had been a slight decrease in response from staff compared to the previous year. The service had developed an action plan which looked to improve opportunities for staff to work flexibly; improve the response rate for future staff surveys and replicate methods of staff reward and recognition in place within maternity across the rest of women's and children's clinical business unit.

Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

The service received 5 complaints in the 3 months before the inspection. We reviewed all complaints made in the 3 months prior to the inspection and found themes included communication and staff attitude.

The service acknowledged that there had been an increase in the number of complaints within the maternity service in the last 12 months and completed a deep dive or thematic review of complaints over the last 12 months, from April 2022 - July 2023. The majority of maternity complaints related to the antenatal and intrapartum periods (93%). In total there were six key themes across the complaints. These were consent/communication, clinical care, delays in care, induction of labour, pathway issues, staff behaviour/attitude. As a result, the service was going to continue to review themes from complaints quarterly with learning feeding into service activity and governance processes.

The maternity and neonatal safety champions completed 3 walk arounds of the service in the last 8 months. We looked at meeting minutes from those walk arounds and saw how staff were given the opportunity to provide feedback both positive and negative. There were no areas of concern raised or issues that required escalation in the minutes we reviewed.

Oversight of safety in maternity services was reported to the board which met bi-monthly. Safety matters were also reported to a sub-committee to the board (Quality Assurance Committee), which met monthly. We reviewed the last 3 reports and found that risks and key performance indicators were escalated to the board appropriately. This included findings from internal and external reviews of information and national safety priorities. Information on the workforce including staffing recruitment and retention and training were also reported. Serious incidents, complaints and key performance indicators were discussed with actions plans which identified owners for each action.

The service felt that the staffing group was representative of the population they served. Staff told us that there were over 50 different nationalities that made up the workforce at Warrington and Halton Teaching Hospitals and this was something celebrated at an annual event.

The service had a focus on student experience and learning and the service received 95% Student Midwife satisfaction rates in July 2023. The service told us they consistently provided more student placements than neighbouring providers.

Maternity

Governance

Leaders mostly operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service, however there were some missed opportunities for improvement.

The service had a clear governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of structured governance meetings. However, the meeting minutes provided were inconsistent in time frames between each meeting, therefore we could not be assured that processes were well established and embedded.

Clinical governance meetings for the division were held monthly. We reviewed meeting minutes from the March to August 2023. We found there was a set standard agenda with papers shared for further information. There was also a red, amber, green (RAG) rated action plan with clear actions allocated to individuals. However, updates were not always provided at the allocated meeting due to time clinical pressures and priorities of those in attendance.

Senior leaders for the women's and children's division which includes maternity services met regularly. We looked at meeting minutes for the last 3 meetings which took place in June, August, and September 2023. These meetings looked at the risk register, staffing and training, compliance with Ockenden and Saving Babies Lives, training and any other issues which presented, for example, industrial strike action. There was evidence of staff being encouraged to raise any areas they felt needed to be added to the risk register and follow up of actions.

Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and management team. Information was shared back to sub-committees and to all staff through emails, newsletters, infographics on the units and informal training sessions held on the wards.

Staff were aware of how to access policies; however, these were not always available or reflective of the current practices within the service despite governance processes being in place to circulate and review prior to approval. We found the service did not have an enhanced maternity care/high dependency care of women policy, despite this being a provision offered on the birth suite. The management of post-partum haemorrhage policy also lacked detail and guidance for staff. We also found staff did not have a good understanding and were not following the policy and criteria around transitional care of babies. We raised this issue to ensure staff's knowledge understanding and implementation of this policy was better embedded.

We raised these issues with the trust, and they took action to make amendments and create new policies which reflected current practice.

Since the inspection, leaders provided further information and had continued to develop systems to monitor and review policies.

Management of risk, issues, and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Maternity

The service had an audit programme. This showed detailed registered clinical audits that reflected the requirements of national guidance and identified local trends which had been implemented in April 2022. Records showed 41% were completed, 52% were in progress and 7% had been discontinued. Further information was provided following the initial inspection process. The service advised us there was an additional programme of audits which was maintained by specialist midwives who recorded compliance with aspects of care like use of the maternity early obstetric warning score (MEOWS).

Audits were used to check improvements over time, however we found audits were not always consistently completed at regular intervals and not completed in all clinical areas. There was not always a clear action plans in place to address the shortfalls identified. For example, we requested NEWTT audits for the last 3 months and received audits for June and July 2023. Despite compliance being low in some areas there was no evidence of these being re-audited and no clear action plans to improve compliance with time frames and allocated staff to have ownership of any actions. We also found in the MEOWS audits that 1 measure to increase compliance was to increase staffing overnight, however, there was no evidence that a re-audit to provide assurance this measure was effective. We therefore could not be assured that the audit schedule was comprehensive and effective.

Managers shared and made sure staff understood information from audits. We saw how specific training had been provided following findings from audits to try and improve compliance.

The digital midwife also worked closely with the audit teams to improve the usability of electronic records systems both for staff completing care records and for those collecting data for audits.

The leadership team were responsive when staff identified where improvements could be made and took action to make changes. We saw how changes had been made to the triage area following risks identified through the incident management system and staff feedback. Plans for changes to improve the induction of labour experience were also identified and progressing.

The service had a risk register in place. We reviewed the risk register and saw 5 areas of risk within the women's and children's department.

There was 1 high risk, 3 medium risk and 1 low risk. All had a clear plan in place to mitigate the risk, working towards reducing these further in the longer term. There were clear risk owners allocated to each risk and these were regularly reviewed. Staff were encouraged to share concerns with managers which would be reviewed and could be added to the risk register.

There service had plans to cope with both known risks and unexpected events. The service had an escalation policy in place to proactively manage activity and acuity across the service and the trust which reflected the current staffing position. The service had supernumerary staff allocated daily to allow for a helicopter view of the staffing and acuity within maternity, responding to shortfalls and escalating risk locally and regionally as per the escalation policy. A RAG risk rating influenced the measures taken with escalation to more senior management as needed. Staff shortages and the impact on care were reported as "red flag" events which were shared with the board. Staff told us these measures worked well, and they felt supported to manage staffing shortages.

They also followed a standard escalation policy across the local area. All diverts were incident reported and a follow up investigation was completed. All women and birthing who were affected were contacted to check on their wellbeing and an apology letter was sent to them from the director of midwifery with a full explanation and apology provided. Leaders in the service monitored diverts through their dashboard and the cause was investigated and reported on. In the last 12 months, the unit had been diverted 5 times.

Serious incidents were reviewed in weekly safety oversight meetings and at a weekly patient safety summit. Incident investigations and reviews were carried out in line with the trusts incident reporting and investigating policy and the trust was in the process of embedding the new PSIRF (Patient Safety Incident Review Framework) model for investigations. We requested minutes for the last 3 meetings and received information for meetings held in June 2023 and August 2023 as there were no maternity serious incidents in July 2023.

The service presented a governance dashboard weekly to the executive team. Following the receipt of additional data from the trust an example of the dashboard was reviewed by us. This showed maternity was included within the dashboard.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service reported they complied with all 10 out of 10 safety initiatives. We saw they had provided sufficient evidence of their compliance to the trust board in January 2023.

The service provided up to date data to the national MBRRACE survey. The report from 2021 found from actions of the survey the trust was performing in line with the national averages in comparison to trusts of a similar size to Warrington.

The stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies was 0.73 per 1,000 live births. This was lower than the average for similar Trusts & Health Boards.

The service complied with all 5 out of 5 saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care.

The service had an NHS England assurance visit in July 2022 to assess compliance with the 7 immediate and essential actions from the interim Ockenden (2020) report. The visit findings included eight recommendations for the trust to consider making improvements. This included 4 should actions, 1 must action around the employment of a fetal surveillance obstetric consultant lead and two should without delay actions in relation to the review of estates/ environment and the availability of nicotine replacement therapies as part of the midwifery offer. The 7 immediate and essential actions had criteria and the trust fully met all 7 of the criteria.

Information Management

The service collected data and analysed it. Data was presented in easily accessible formats, to understand performance, make decisions and improvements. However, not all information systems were integrated. Data or notifications were submitted to external organisations as required.

They service contributed to the regional North-west maternity dashboard which tracked key clinical information on performance, and this was accessible to senior managers and discussed at governance meetings. We saw how managers discussed the regional dashboard and looked at other locations for benchmarking and comparison of their own performance.

Maternity

As part of the inspection, we requested and review the service's maternity dashboard. The information shared did not show evidence of internal benchmarking against set targets as a method of measuring performance and progress for clinical indicators of care.

Information was presented to staff in an easily accessible way across the service on the data they needed, to understand performance, make decisions and improvements.

The information systems were secure but not yet fully integrated as there were other information systems being used across the rest of the trust including in the neonatal department. Not all staff we spoke to were aware of the separate systems in use in other areas of the trust or how to access them. The digital midwife was knowledgeable about the current limitations of the systems in place and was working closely with other colleagues to address these and put measures in place mitigate the risks. For example, we were told about a change to the system in response to incidents and concerns about the manual inputting of bloods, to reduce human error this was now being done automatically by the laboratory.

Data or notifications were submitted to external organisations as required.

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to influence the provision of maternity services. MVP engagement meetings were scheduled quarterly and covered a range of topics including updates from the maternity service, feedback from women and birthing people, outcomes from any visits to the service, current and future engagement, and involvement from the community. We looked at minutes and action plans from meetings in January, March and July 2023 and saw that meetings were well attended, and actions were logged and reviewed.

We spoke with the MVP chair who spoke positively about the engagement and responsiveness of the service when issues or areas for improvement were raised. The MVP had a good understanding of the population they served and were passionate about hearing the voices of those at greater risk of poor outcomes. They had good connections to existing groups within the community and were looking to strengthen these further.

The service made available interpreting services for women and birthing people and collected data on ethnicity. The service was keen to increase their use of interpreter services where needed and encouraged staff to use the resources available. Communication cards called a "River Pass" were developed to help non-English speaking women and birthing people to alert staff to when they needed assistance with communication. The service also had electronic medical records available in 13 different languages.

Leaders understood the needs of the local population and were keen to try and address issues they faced such as deprivation. The service had introduced care packages for those in need which included essential items for parent and baby. Care packages included items such as sanitary products, baby bath, baby clothes, baby wipes and nappies. Other items such as prams had been sourced with support from local charities and the service had plans to further develop those relationships.

A continuity of care team was in place who specifically supported those at highest risk of poor outcomes because of deprivation, communication barriers or other vulnerabilities.

In the local area hotels were being used to house asylum seekers. The service worked closely with other agencies in the area to understand what women and birthing people's needs were and how these could be achieved. The service established both antenatal and postnatal maternity clinics in the hotels to engage with women and birthing people being housed there, to reduce any potential barriers to care. The service allocated a named midwife to build a relationship with women and birthing people who were at high risk and vulnerable. An interpreter app was used with face-to-face interpreters if needed. Women and birthing people would have any appropriate antenatal checks carried out at the hotel. They were supported with registering and booking appointments and support was provided to access transport to attend the hospital. They received very positive feedback from people who had been supported.

The senior leadership team had conducted walk arounds of the service in order to engage with staff. They also requested support from the MVP chair, as an independent party, to hold forum sessions with staff to get feedback. The Director of midwifery sent out regular engagement emails with updates and we saw a summer newsletter sent out to all staff providing feedback and celebrating success.

Each ward had developed their own ways of team building and celebrating successes both as a team and as individuals and staff spoke positively about the impact this had on them. The service had also been recognised in external awards, for example one Midwife was awarded NHS Hero Award category in the Warrington Guardian Inspiration Awards 2023 for their outstanding bereavement care.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had several quality improvement workstreams led by managers and matrons which also involved midwives of different bands. Quality improvement work which was on-going at the time of inspection included improving speed of discharge following caesarean sections, improving compliance of equipment checks, improving the response rate of friends and family test (a feedback questionnaire) on the Nest, review of obstetric hemorrhages over 1500mls and Postnatal re-admissions within 14 days.

The service was also involved in externally led quality improvement work. This included the MatNeoSip program, which aims to improve the quality and consistency of care provided in maternity and neonatal settings and contribute to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025.

The service was a pilot site for a safety culture program for maternity and neonatal board safety champions.

Leaders encouraged and celebrated innovation and participation in research. The service was heavily involved in research studies and had a research nurse and research midwife that worked with obstetric colleagues to support research across the division. The hospital was recognised as one of the highest recruiters to research studies in the Northwest.

Maternity

The service recently started participation in a nicotine replacement therapy trial aimed to review the way pregnant women were supported to stop smoking. This was an area of risk for the population of Warrington and Halton.

Outstanding practice

We found the following outstanding practice:

The trust demonstrated outstanding practice in relation to the commitment to the equality and equity agenda, working in collaboration with external stakeholders such as, people who use the service, Warrington Borough Council and integrated care boards. This had led to improvements in the offer available in the local communities and in people's homes. Specific pieces of work had been carried out to address the barriers faced by the community the trust served.

- The service had established an antenatal and postnatal clinic in a hotel which was housing asylum seekers in the local area, to reduce barriers to accessing care and support some of society's most vulnerable women and birthing people.
- The service created communication cards for non-English speaking women and birthing people to support them in communicating their communication needs.
- The service provided care packages of essential items for parent and baby, to support women and birthing people in need, working closely with local charities.

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.

Maternity

Action the trust SHOULD take to improve:

- The servcie should contine to improve training compliance rates for all staff in all relevant areas
- The service should ensure all poicies and procedures are in place and reflect current evidence-based best practice and are fit for purpose..
- The service should ensure that electronic patient records are integrated as far as is possible to avoid the risk of missed information.
- The service should continue to develop, communicate, and embed the transitional care provision.
- The service should ensure that all staff complete regular simulation training/Skills and Drills training, such as regular pool evacuation and abduction drills.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 midwifery specialist expert advisors, 1 consultant specialist advisor and 3 other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.