North West Anglia NHS Foundation Trust

Hinchingbrooke Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Hinchingbrooke Hospital

Requires Improvement ➔➔

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 Hinchingbrooke hospital.

We inspected the maternity service at Hinchingbrooke Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

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

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

Hinchingbrooke Hospital is in Huntingdon in Cambridgeshire and is part of the North West Anglia NHS Foundation Trust. The maternity division is configured over 2 sites and the current birth rate at Hinchingbrooke Hospital is 1925 births for year ending March 2023. The hospital serves a lower proportion of mothers in the 1st, 3rd & 4th deprived deciles at booking compared to the national average. A higher proportion of mothers were in the 2nd most deprived decile, 13% compared to 12% nationally.

Maternity services offered by the hospital included antenatal clinics, fetal medicine, complex antenatal care, a maternity triage service, acute intrapartum care, a midwifery led birthing unit and postnatal inpatient services. Women and pregnant people accessed their personal care records via a digital application.

Our rating for maternity is Good.

We did not review the overall rating of the location therefore our rating of this hospital stayed the same

Hinchingbrooke Hospital overall rating is Requires improvement.

We also inspected one other maternity services run by North West Anglia NHS Foundation Trust. Our reports are here:

Peterborough Hospital – https://www.cqc.org.uk/location/RGN80

How we carried out the inspection

This maternity thematic review was a focused inspection; we inspected the domains of safe and well-led using the CQC's specific key lines of enquiry designed to support the National Maternity Services Inspection Programme.

Inspectors visited maternity services on 5 April 2023. We spoke with 20 staff and reviewed 10 sets of patient care records. We looked at a wide range of documents including audits, standard operating procedures, meeting minutes, risk assessments and recently reported incidents.

Our findings

After the inspection we requested further documentary evidence to support our judgements including training records, staffing roster, reports, and quality improvement initiatives.

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.

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Good ↑

Our rating of this service improved. We rated it as good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. The service controlled infection risk well. Staff kept good patient care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They 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. All staff were committed to improving services continually.

However:

- Staff did not always complete all aspects of risk assessments for women and birthing people so there was a risk of missed opportunities to escalate care when needed.
- Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk of not having a required supernumerary shift leader on labour ward and there were delays such as discharge home.
- Not all staff had received updated safeguarding training in the timeframe expected.

Is the service safe?

Requires Improvement → ←

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

Mandatory training

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

Midwifery and nursing staff received and kept up to date with their mandatory online training. The maternity services training was comprehensive, met the needs of women and birthing people and included a mixture of online courses and face to face multi-professional simulated training. Ninety one per cent of staff at Hinchingbrooke Hospital had completed all 39 mandatory online training courses which aligned to trust targets.

Medical staff received and kept up to date with their mandatory training. Ninety percent had completed all mandatory training courses.

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The service made sure that staff received multi-professional simulated obstetric emergency training. Training included fetal surveillance in labour, a cardiotocograph (CTG) competency test, obstetric skills and drills training and neo-natal life support. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. Records showed that 91% of midwives and 92% of doctors had completed their emergency multi-professional training. However, the trust provided 'pan-site' data which showed total compliance to fetal monitoring study day was 84%, with 79% of midwives completing their CTG competency test only 77% of doctors had completed their competency test. The impact of cross site data is that local leaders have lack of local oversight to training compliance and the figures meant some staff reviewing CTG's may not be competent to do so.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service aligned training modules to the requirements of the Clinical Negligence Scheme for Trusts (CNST) which contained the saving babies lives care bundle and recommendations from the Ockenden review. The education team reviewed the training needs analysis to make sure it reflected the needs of the service and learning from incidents, they monitored compliance and kept a record of online training data for maternity services trust-wide. Staff received email alerts to renew their training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that overall safeguarding training compliance was 87% which just fell short of the trusts 90% target. Records confirmed that 100% of midwives were compliant but only 67% of junior doctors were compliant. Also, records from June 2022 to March 2023 showed that most midwives had not attended their safeguarding supervision sessions.

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

Staff received mental capacity and deprivation of liberty training as part of the safeguarding training days. Maternity services also provided staff with perinatal mental health training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. When staff identified safeguarding concerns women and birthing people had birth plans reviewed by the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Staff recorded their safeguarding concerns and reported them to the safeguarding lead who arranged support for women, families, and their babies.

Staff followed safe procedures for children visiting the ward. Staff accessed ward areas with their staff identification cards and visitors used a buzzer to gain access.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and staff monitored the entry and exit system. The service had practised a simulated baby abduction within the 12 months before inspection.

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. Ward areas were spacious and clean and there was a system to monitor cleanliness.

Cleaning records were up-to-date and demonstrated that staff cleaned all areas regularly. The service employed housekeepers to clean ward areas and their managers completed regular audits to ensure compliance.

The service performed well for cleanliness. The service linked to the trusts infection control nurse who completed unannounced ward rounds to check cleanliness compliance. Cleaning audit data confirmed that labour ward scored 99% for cleaning score.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed staff completed hand hygiene audits every month in all maternity areas. In the last year compliance was consistently above 100%

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches and other observation equipment between use in the antenatal clinic and it was clear equipment was clean and ready for use.

The service had no incidents of nosocomial infections from October 2022 to March 2023.

Environment and equipment

The design, maintenance and use of facilities, premises kept people safe most of the time. Staff received training on how to use patient equipment. Staff managed clinical waste well. However, the trust was in the process making improvements to their estates so that staff stored medicines safely.

The design of the environment did not follow national guidance. Wards were undergoing structural improvements to make sure they conformed to the latest national safety standards. For example, the maternity inpatient ward at Hinchingbrooke Hospital did not have a clinical room with a lock to store medicines safely, this was a known issue the CQC reported during our previous inspection in 2018. After the inspection trust leaders informed us that the estates work had been completed on the Lilac ward which now had a clinical room to store medication.

The maternity unit was fully secure with a monitored entry and exit system. The service comprised of antenatal clinics, a maternity day assessment unit and freshly decorated triage area on the ground floor. Labour ward was co-located to the birth centre with one birthing pool and the 24 bedded in patient ward was accessible on the same floor and included 3 side rooms.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

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Staff completed environmental audits to ensure that the areas complied to health and safety standards. For example, they checked to see if the bed space around beds was free from clutter and furniture was in good order. Data for February 2023 identified areas for improvement for example, furniture that needed replacing, toilets that need to be free from inappropriate equipment and reported this to service managers.

Staff conducted daily safety checks of specialist equipment. Midwives completed checks on vital equipment during night shifts and each piece of equipment had a checklist and sign off sheet. Records showed staff completed resuscitation equipment most of the time. The March 2023 resuscitaire checklist showed staff checked 98% of resuscitaires at every shift. However, we were not shown annual audit data for equipment checks.

The service had a system to ensure all beds were serviced and all equipment had been PAT (portable appliance testing) tested. Stickers were dated and displayed on all equipment.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply. Birthing pools had evacuation nets and equipment sited close to hand and the service had completed evacuation of the pool training from the period April 2022 to March 2023.

The service 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.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

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

The service used a central system to monitor fridge and freezer temperatures and deviations were fed back to ward managers when necessary.

Staff understood the ligature risks within the department. The trust had completed a ligature risk assessment across all their locations to identify ligature points that may be a hazard.

Assessing and responding to risk

Staff completed, updated the relevant risk assessments, and took action to remove or minimise risks most of the time. Staff identified and quickly acted upon women and birthing people at risk of deterioration. However, records showed that staff missed opportunities to review care at every point of contact with a health care provider.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools to assess and monitor women and birthing people during the antenatal period.

Staff risk assessed women and birthing people at booking and used the five elements of the ‘Saving Babies Lives Care Bundle version 2’ which are.

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1. Reducing smoking in pregnancy
2. Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction
3. Raising awareness about fetal movements
4. Effective monitoring of fetal monitoring during labour
5. Reducing preterm birth

To initiate good health and raise awareness on fetal wellbeing during pregnancy and labour. However, a recent Clinical Negligence Scheme for Trusts (CNST) compliance review across both sites highlighted that staff missed opportunities during the antenatal period to have repeated conversations about all aspects of the saving babies lives care bundle. Records we reviewed showed that the maternity safety champions completed an assessment of compliance to the saving babies lives care bundle to make sure staff accurately risk assessed women and pregnant people throughout pregnancy. Managers completed a risk action card in December 22 regarding Saving Babies Lives risks and records confirmed this. Several key issues had been identified for governance and education leaders to implement changes to practice and make sure the service met accreditation standards. For example: to address the ultrasound capacity as the sonographer staff levels had reduced; to increase the specialist fetal wellbeing midwives hours of attendance; to improve the low completion of carbon monoxide (CO) risk assessments and to take account of reduced fetal medicine consultants with care pathways for preterm and multiple birth women.

The service had not achieved all 10 safety actions in line with the requirements of year 4 of the Maternity Incentive Scheme for trusts because 3 Safety Actions (SA) had not been met. Two related to assessing risk echoed what managers had found through audit.

Safety action 3 related to ATAIN (avoiding term admissions into neonatal units) data showed the post-delivery reviews of care were not always completed in time.

Safety action 6 related to the Saving Babies Lives Section (lb) which requires the trust to record CO levels at 36 weeks of pregnancy. The impact of this was that leaders could not be assured that all women and pregnant people were being fully risk assessed at each appointment.

Staff used the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people when they arrived at triage or during labour most of the time. We reviewed 8 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. Staff in triage completed a monthly audit of all admissions to check compliance to using MEOWS and escalated appropriately. Audits from February 2022 to February 2023 showed that staff compliance to using MEOWS was 77%, which was lower than the trust target of 100%.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Leaders implemented an evidence-based, standardised risk prioritisation assessment tool for maternity triage during October 2022. This meant staff had a target to review women within 15 minutes of arrival and leaders monitored the arrival and wait times to make sure targets were met.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed times and national targets. The maternity triage waiting times for review audit from February 2022 to February 2023 included 2 sets of data. These were:

1. Time seen within half and hour of arrival and staff achieved 80%.

2. Time seen within 15 minutes of arrival and staff achieved 75%.

The triage unit was new and staffed with band 7 midwives and a recently appointed ward clerk helped staff book patients onto the system during the day.

The service had a standard operating procedure for the 'Maternity Helpline' to make sure that clinical staff manned and answered all triage calls to risk assess and prioritise women and pregnant people. However, Staff in triage told us that during busy periods support staff answered the triage phone and relayed messages to the midwives who then provided 3rd party assessments. This does not reflect best practice.

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

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. The lead midwife for perinatal mental health along with the consultant for mental health and other members of mental health services to completed multi-professional risk assessments on women and birthing people in need of additional support. Managers on the ward made sure they provided around the clock monitoring for women with severe mental health issues.

The service had a lead midwife for learning disabilities who worked closely with the trust learning disability team and other members of a multi-professional team to make sure that the correct support systems were available to help neurodiverse women and pregnant people when the baby was born.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. For example, staff used a tool to complete Venous Thromboembolism (VTE) risk assessment throughout the antenatal period, during labour and prior to discharge. Recent data confirmed that 94% of staff completed risk assessments correctly.

Staff reviewed blood screening and scan results to help inform decisions around care and staff members were responsible for checking their own results.

Staff used a formal process to assess women admitted for an induction of labour. Staff gave women and birthing people a pre induction information leaflet to prepare them for the induction process. The service used a two tier system for induction of labour admissions. The service managed high risk inductions on the labour ward and women who were overdue (postdates) were admitted to the inpatient ward for induction and transferred to labour ward when they were in established labour.

The trust had created its own standard operating procedure (SOP) of intrapartum assessment of fetal well-being which reflected national guidelines to help the early identification of fetal hypoxia. The SOP included a standardised fetal monitoring tool in labour.

Staff used the fresh eyes approach to review fetal wellbeing safely and effectively most of the time. Leaders completed quarterly cardiotocograph (CTG) audits on staff compliance to effectively monitor fetal wellbeing during labour. The audit was broken down into 8 outcome measures and the October to December 2022 audit showed the following outcomes for a sample size of 10 deliveries per quarter.

1. Staff compliance to hourly 'fresh eyes' 79% of cases.

2. Staff compliance to hourly fresh care 51% of cases.
3. Staff compliance to an initial risk assessment 35% of cases.
4. Staff compliance to the recording pulse rates at the time CTG commenced 93% of cases.
5. Staff compliance to ensuring a CTG was clinically appropriate 100% of cases.
6. Staff compliance to documenting fetal status every 30 minutes 74% of cases.
7. Staff compliance to fetal heart rate documented on a labour form known as a Partogram every 15 minutes 53% of the time.
8. Staff compliance to escalating risk 100% of the time.

The audit included recommendations to improve compliance rates for all aspects of CTG interpretation. The recommendations included additional training during fetal surveillance training days, discuss findings during weekly updates and publish within the maternity service newsletter for all staff.

Staff did not always use a sepsis 6 care bundle and flow chart to implement care for women and pregnant people showing signs of sepsis. Records confirmed that from April 2022 to March 2023 only 65% of staff completed the care bundle correctly. Because compliance was low service leaders implemented sepsis training to make sure staff understood the process and guidance, and records showed that over 90% of staff had attended.

The service worked hard to improve the 3rd and 4th degree perineal trauma rate. Data showed that the rate was inconsistent from month to month. For example, in April, June and November 2022 the rate was over 4.5% which was higher than the national target. Because of service leaders had implemented an action plan that included additional training on perineal care which led to an improvement with the yearly average of 1.99% which was below the 2.8% national target.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Staff used the SBAR (Situation Background Assessment and Recommendation) algorithm to update their colleagues and handover care throughout the unit and recorded this on the electronic patient records. Records from the last documentation audit confirmed 91% of staff completed SBAR correctly.

Theatre staff completed a World Health Organisation (WHO) checklist when women and birthing people arrived in theatres. Staff recorded swab counts on the electronic paper record.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found staff shared key information to keep women and birthing people and babies safe. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person. However, we found that external staff interrupted the safety huddle on 3 occasions which may lead to key information not being handed over. We fed this information back to the service at the end of the inspection.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Staff risk assessed babies at birth and referred at risk babies to the neonatal team for additional care and treatment. The service provided transitional care for babies who required additional care via a 4 bedded bay on the inpatient ward and provided additional training to staff caring for these babies. However, a recent CNST review of staff compliance to the

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ATAIN (Avoiding Term Admissions into Neonatal Units) programme had identified that managers did not complete multi-professional reviews of neonatal care for babies over 37 weeks within set time periods. Therefore, maternity leaders had implemented an action plan to increase training and awareness, and the service continued compliance monitoring this aspect of care.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure they informed third party organisations of the discharge. Midwives completed discharges based on clinical outcomes and the recommendations from doctors. The discharge process was time consuming because of the complexity of patients and the need for additional referrals and prescription medication. Also, there were times when discharges were delayed due to workloads and different priorities. However, staff gave women and birthing people a discharge information pack, completed a discharge discussion and were provided with the contact details of the community midwifery services. Discharge information was sent to GP's and health visitors on the day of discharge.

Midwifery Staffing

The service had issues with recruitment and retention and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. However, leaders had developed a strategy to fill vacancies by spring 2023 and the vacancy rate was improving.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. On the day of inspection midwifery staffing should have been 12 midwives plus 1 supernumerary coordinator but it was 8 midwives plus 1 supernumerary coordinator. Staff told us when there were low numbers of staff it made them feel unsafe. The service provided one to one care during labour.

Leaders recorded lack of staffing as a risk and produced bi-annual reports which were presented to the trust board to make sure they had oversight of the current workforce challenges.

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. Leaders produced a bi-annual staffing report of staffing from October 2022 to March 2023 reported 87 red flag incidents. These included 10 incidents of delays or cancelled time critical activity.

Managers accurately calculated and reviewed the number and grade of Midwives, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in March 2021. This review recommended 63.44 whole-time equivalent (WTE) midwives band 3 to 8 compared to the funded staffing of 61.46 WTE, a shortfall of 1.98 WTE staff at the time of the report. However, due to people leaving this figure had increased over time.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. However, records for October to March 2023 showed 59 occasions when the labour ward shift co-ordinator was not Supernummary, meaning they didn't have full oversight of the shift all the time. This meant that the service had not met all ten safety actions of the Maternity Incentive Scheme because they had not achieved supernumerary status of the labour ward shift co-ordinator.

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

The number of midwives and healthcare assistants did not always match the planned numbers. Inspectors found that in all areas there was information on staffing, which included the planned numbers versus the actual number. For example, on the inpatient ward planned staffing during the day was 3 midwives one nursery nurse and 2 maternity care assistants. The actual staffing was 2 midwives one nursery nurse and 2 maternity support workers. This led to delays in discharging women and pregnant people home. Staff told us this was very common and meant flow through the unit was blocked.

The service had a reducing vacancy rates, turnover rates, sickness rates and high use of bank nurses. Records confirmed the current vacancy rate was 12.54 whole time equivalent and staff told us that sickness, annual leave, and maternity leave rates added further pressure on the service.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The maternity service made sure staff were competent for their roles. Band 5 midwives placed on a detailed preceptorship programme to make sure they were trained and given exposure to all aspects of midwifery care. The education team and the professional midwifery advocate supported them to sign off their competency document before they were awarded a band 6 role.

The service had recruited a cohort of overseas midwives and had provided them with a detailed induction which included supervised practise. Leaders had highlighted that a cohort of midwives needed additional fetal surveillance training which led to an extended induction time to improve safety in the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. The education team and the professional midwifery advocate (PMA) supported midwives. Records showed that managers had given 65% of staff their annual appraisal within set times. The team acknowledged the barriers to improving appraisal rates were the current workforce challenges which led to managers working clinically to backfill shifts when required.

Managers made sure staff received any specialist training for their role. For example, the service was training 4 staff on the professional midwifery advocate course.

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, medical cover in the triage and maternity day assessment unit was not consistent and did not meet the national recommendations for round the clock medical presence in these areas.

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The service had enough medical staff to keep women and birthing people and babies safe most of the time. The medical staff matched the planned number. The service had low vacancy, turnover, and sickness rates for medical staff. However, medical cover in the triage and maternity day assessment unit was not consistent and did not meet the national recommendations for round the clock medical presence in these areas. The trust was working towards ensuring that the current level of cover increased.

The service had low rates of bank and locum staff. Managers accessed locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The service followed their 'Guidance on the engagement of locums in maternity care' operating procedure to recruit and manage Locums.

The service always had a consultant on call during evenings and weekends. The service made sure there was a consultant on site from 08:30 am to 9 pm from Monday to Friday and at weekends consultant presence was from 08:30 to 11 am and 7:30 to 9 pm. Consultants managed the rest of the on-call cover from their home location which was within half hour of the hospital site.

Leaders followed the Job Planning Policy for Consultants and SAS Doctors Version 7. The job planning process was part of the overall trust governance process and the policy included regular reporting to assure the trust board that the job planning processes in each service reflected this policy.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. Registrars and senior house officers (SHO) supported the service. There was a single registrar supported by a SHO on call around the clock and during the week separate registrars covered the maternity day assessment/triage and elective caesarean section list. Also, anaesthetic cover for the unit was around the clock.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and managers gave them opportunities to develop. Staff we spoke with chose to work at the unit and said that consultants supported them and gave them the necessary exposure to all aspects of obstetric care.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive and all staff could access them easily. The trust used electronic records for most aspects of care. We reviewed 10 electronic patient care 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. The service used electronic records. However, for safety women carried a paper overview of their care in the event of them changing NHS trusts or catastrophic IT failure.

The service stored records securely. Staff locked computers when not in use and stored paper records in locked cabinets most of the time. Staff had access to mobile computers and smart pads so that they could record care by the patient

bedside. However, we found 8 medical prescription cards on the labour ward were stored in an unlocked cupboard and we fed this back to service leaders because this practice does not reflect the General Data Protection Regulation (2016). After the inspection we fed this back to managers who said they would make sure that staff were updated and provided evidence to the CQC that they emailed staff to remind them to keep notes locked away in the correct notes cabinets.

Medicines

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

Service leaders had completed a risk assessment of the storage management and storage of medicines after our last inspection in 2018 highlighted that the storage did not follow national guidance within maternity. Medication is stored in locked cupboards and the shift leader holds the keys.

Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

The trust offered medicines optimisation training which included a competency test every 3 years.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines during their admission.

Staff reviewed each person'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. Staff recorded medication checks in the prescription charts we checked.

Staff completed medicines records accurately and kept them up to date. Medicines records were clear and up to date. The service used a paper prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

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 on both paper and digital systems for the 10 sets of records we looked at were fully completed, accurate and up to date.

Staff learned from safety alerts and incidents to improve practice. The quality safety boards throughout the unit reports on drugs errors when applicable and records confirmed that medication errors were minimal on the ward.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers implemented actions from incident reviews and monitored effectiveness.

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. There was a healthy reporting culture, clinical governance staff notice boards in all areas and on the day of our inspection 19 incidents had been reported on the maternity ward since January 2023.

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Staff reported serious incidents clearly and in line with trust policy. We reviewed 4 incidents reported in the 6 months before inspection and found them to be reported and reviewed correctly. However, prior to the inspection we found that some incidents reported via National Reporting and Learning System (NRLS) system did not state which location the incident had occurred at, which we fed back to managers.

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

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers 'triaged' incidents every Monday to make sure the right person completed the investigations. Also, the service held monthly risk meetings where they discussed serious incidents and incident reviews including those referred to the Health and Safety Investigations Branch (HSIB) and the National Perinatal Mortality Review Tool (PMRT) designed to provide parents with high quality investigations and highlight lessons learnt.

Managers updated a PMRT tracker monthly which included serious neonatal incidents including outcomes, lessons learnt and changes to practice and education. Stillbirth rates were 2.6% which was under the national average of 3.5%.

Managers investigated incidents thoroughly. They involved women, birthing people, and their families in these investigations. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 3 investigations, managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. For example, the rate of women who had a post-partum haemorrhage (PPH) of 1,500 millilitres or more was higher than the national average and in the highest 25% of all organisations. Further education and training was introduced to make sure practice was embedded to reduce the incidence of PPH. The leadership team had approved an external review by utilising their external obstetrician and an external midwife. The lead anaesthetist for maternity was also involved in the review.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitored staff compliance to abiding to duty of candour regulations.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed a serious incident and shared learning at an obstetric clinical governance meeting in risk meeting in February 2023 and leaders reminded staff of the importance of following the sepsis 6 care bundle. Throughout the unit Maternity Safety Champion Board Education & PMA Team updated quality boards with current information, shared learning and the most recent themes highlighted in recent reviews.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people.

There was evidence that leaders had made the necessary changes following feedback. Staff explained and gave examples of additional training implemented following a medication incident.

Managers debriefed and supported staff after any serious incident. The professional midwifery advocate and consultants debriefed staff after serious events. Also, the trust had introduced a pastoral service for staff who may need additional support.

Maternity

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Maternity leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles. However, national gaps in the midwifery workforce meant that staff did not always have time to complete thorough risk assessments at every point of contact.

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

A leadership quartet managed the delivery of services across both hospital locations. The quartet included an interim director of midwifery, a clinical director, a general manager, and a head of midwifery specific to each location. The service appointed new leaders within the last year and worked together to review the maternity vision and strategy to ensure it reflected national recommendations, policies, and processes. A business co-ordinator and personal assistants supported the quartet. Thirteen consultant leads worked trust-wide to various aspects of maternity and gynaecological care. The service included 8 lead midwives a named midwife for safeguarding and various departmental managers.

At Hinchingbrooke Hospital leaders were visible and approachable in the service for women and birthing people and staff most of the time. Leaders were well respected, approachable, and supportive. Staff told us that their line managers were supportive. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

Maternity safety champions and non-executive directors supported the service. The chief nurse was one of 15 safety champions who worked across obstetrics and neonatal services and they were supported by a non-executive director. Their role was to act as ambassadors for safety and facilitate communication from ‘floor to board’.

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

Vision and Strategy

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

Maternity

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and had reviewed and written a draft of an updated vision and strategy to include these recommendations. The vision and strategy focused on sustainability of services and aligned to local plans within the wider health economy. The strategy contained 3 key priorities as follows: -

1. The women's voice and individual needs are embedded in all care.
2. Outstanding teams deliver outstanding services.
3. Safety is a key cornerstone in all that we do.

Various frameworks supported the strategy which included digital solutions, system working, robust governance, accountability, and learning. Leaders planned meetings with the local Maternity Voices Partnership (MVP) so that the proposal could be discussed and the final version was due to be published during April 2023.

Leaders understood and knew how to apply them and monitor progress. The plan reflected the NHS operational priorities like ensure all women have personalised and safe care throughout and deliver the actions from the final Ockenden review.

Culture

Staff felt respected, supported, and valued. Staff 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 did not always feel respected, supported, and valued**.**Most staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. However, the most recent staff survey which was broken down to separate services revealed that only 44% of maternity staff looked forward to going to work and only 32% felt involved in the decision making about changes that affected their working area. Most staff were unhappy with their level of pay which reflects the national picture and many staff felt they could not achieve a good work life balance.

The service cared about its staff and because of issues with retention and staff satisfaction had produced and implemented a cultural framework and leaders and human resources monitored this. Leaders made sure there were accountability pathways and different work streams to help recruit and retain staff and ensure that staff could access support when they needed it.

The professional midwifery advocate (PMA) had an open door policy and fostered positive working relationships. Their role was to provide visible leadership and act as a role model to promote effective safe care and treatment. The PMA listened to staff and would draw upon their knowledge skills and experience to empower staff in both their professional and personal development. They supported revalidation attended weekly meetings and had monthly catch up sessions with the head of midwifery and produced a quarterly report for the clinical governance team.

Maternity

Leaders celebrated success, implemented recognition boards, and encouraged the implementation of a staff council.

Staff focused on the needs of women and birthing people receiving care. 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.

Leaders 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. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. 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. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. Managers made sure all complaints and concerns were handled fairly, and the service used a formal approach to deal with complaints which meant complaints were delegated to managers in the area of concern who would then investigate the concerns and feedback to the complaints team. 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.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Managers investigated complaints, identified themes, and shared feedback with staff and used learning to improve the service. This was a fixed agenda item on each regular team meeting. The service received 2 complaints in February 2023 and one in March 2023. The patient advice and liaison registered complaints on the services complaints spreadsheet and allocated to managers for investigation.

Staff could give examples of how they used women and birthing people's feedback to improve daily practice. For example, staff on the postnatal ward and recognised that the discharge process was time consuming and often meant mothers and babies experienced delays going home. Because of this they reviewed the discharge process and were working to implement group discharge discussions.

Staff had access to counselling services. The service introduced a pastoral pathway last year to help staff, and patients recover from exposure to trauma. Leaders identified reductions in staff psychological resilience during the Covid-19 pandemic and implemented actions to improve the situation.

Governance

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

Maternity

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

Since our last inspection the service had strived to achieve numerous improvements and the work was ongoing, in an environment that had been subject to structural building work. Which had delayed some aspects of improvement like the safe storage of medication in some areas and the under use of the birth centre. The leaders were aware of the service safety actions in line national requirements and had actions to address current shortfalls.

The assistant chief nurse managed the governance lead who was also responsible for overall governance and compliance. Their role was to have full oversight of the service and manage the governance team. Managers discussed maternity risk at the monthly risk management meetings; moderate risk was reported to the trusts quality committee, high risks were reported and reviewed by the Medical Advisory Committee (MAC). High and significant risks were reviewed and challenged at the hospital management committee to ensure service leaders had meaningful conversations that highlighted gaps in care.

The education team was managed by the consultant midwife specialist midwives and clinical educators as well as a lead professional midwifery advocate and local professional midwifery advocates. The team supported the governance team to implement changes to practice and devise a training needs analysis that reflected the needs of the service. Also, the team ensured that staff were competent and had the knowledge and skills to carry out their role.

The service held various forums which fed into the maternity quality committee and were reported to the MAC. The review of risk management, guidelines and audits fed into the quality committees quarterly report.

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. 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 divisional management team. Information was shared back to sub-committees and all staff.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date.

Management of risk issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Some staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits like an audit of the National Pregnancy in Diabetes Audits, the Perinatal Mortality Surveillance report, and the National Maternity & Perinatal Audit - MBRACE. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards most of the time.

Maternity

The maternity safety team comprised of a band 7 risk midwife who was supported by 2 band 6 midwives and a band 5 analyst to support compliance analysis to the Clinical Negligence Scheme for Trust (CNST) and the Ockenden Review. Also, the service had recently employed a band 4 administrator to support the governance team. Their role was to investigate when things went wrong and to share learning and drive improvements to the service.

Managers and staff conducted a comprehensive programme of repeated audits to check improvement over time. The patient safety team monitored patient safety through audit and measured outcomes to prevent incidents from reoccurring and they worked closely with the education team. The maternity dashboard was displayed in all areas and used to measure performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes.

Managers shared and made sure staff understood information from the audits. Records confirmed that there were twenty-seven local maternity audits trust wide. The maternity safety team and education team won team partnership for the region in the East of England Maternity awards held in March 2023. The team were driven to improve practice through monitoring performance and outcomes and developed and implemented initiative to make sure staff understood the importance of risk management.

The maternity safety team delivered various awareness days like the ‘Shout out to safety’ training awareness day and plan to hold sessions throughout the year. The sessions included but were not limited to, never events and the learning, sepsis update, safety huddle and how to help you escalate and the golden hour for PPH – preventing maternal collapse or death. There were quality and safety boards in all areas and staff newsletters.

Also, in December 2022 the team held the 12 days of safety show. Each day they presented a different theme and walked the unit providing updates and key information.

Managers attended monthly risk meetings records showed that there was a clear agenda that reviewed outstanding actions, included a ‘Maternity Risk Tracker’ and mitigations. All risks were rag rated. Clinical staffing was a known risk throughout the trust, other risks on the current risk register included the PPH rates and showed that managers were reviewing an hourly ‘fresh care’ pathway.

Managers and staff used the results to improve women and birthing people's outcomes. The service strived to improve safety; we saw examples of quality improvements throughout the unit. For example, the current model of fetal surveillance to identify fetal hypoxia (restricted oxygen during childbirth) included a ‘Hypoxia in labour tool’ which was shortlisted in the Maternity and Midwifery initiative of the year category of 2021 of the Health Service Journal (HSJ) patient safety awards. However, the trust had acknowledged that its postpartum haemorrhage (PPH) and Obstetric Anal Sphincter Injuries (OASI) were higher than the national average. Because of this the education team had implemented additional education and monitoring to improve outcomes.

The integrated care board were informed and service leaders met with the integrated care board to make sure that actions were taken to fulfil all 10 safety actions.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Managers identified risk through the incident management system and reviewed and recorded outcomes in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make changes when they identified gaps in compliance or risks.

There were plans to cope with unexpected events. They had a detailed local business continuity and a local Maternity Escalation plan. Managers had recently reviewed the escalation plan and included information on how to risk assess the service using a colour coded rating system and provided key information of other services.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Service level managers worked with staff to identify areas for improvement and make the necessary changes to limit costs. Board minutes confirmed that maternity was given prime time to review the challenges and achievements.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Integrated digital systems supported the service and leaders submitted notifications to external organisations as required.

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

The service used integrated, safe and secure systems so that staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff used electronic patient records which were password protected to access all the information they needed, this included screening results and safeguarding information. However, the staff told us the use of paper records for medication was a barrier to speeding up the discharge process.

Leaders submitted data or notifications to external organisations as required. The service submitted data sets to third party organisations like the Clinical Negligence Scheme for Trusts (CNST), the Perinatal Mortality review tool, the local Integrated Care Boards and the CQC.

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 contribute to decisions about care in maternity services. Service leaders had built meaningful relationships with the local MVP and encouraged them to attend meetings on site, such as the labour ward forum. Service leaders had engaged with local people from diverse cultures to improve care and understanding. One trust wide project which was initially introduced at Peterborough Hospital was the ‘Raham project’ which aimed to support women and pregnant people and new mothers from the different ethnic backgrounds.to improve their experiences and tackle health inequalities. The service used various listening events, and social media platforms to provide advocacy and create a non-judgmental safe space. Since the project was launched, the service had also offered support to women and birthing people across the United Kingdom.

The Maternity Voices Partnership had completed a 15 steps tour of the maternity department in November 2022 to review service provision on behalf of service users. They produced a report on the aspects they felt were ‘good’ and the aspects that could be ‘improved’ in each area of maternity. The MVP submitted the recommendations to service leaders for consideration so that improvements were made to enhance services for women and pregnant people.

Maternity

The service always made available interpreting services for women and birthing people and collected data on ethnicity. The service used a digital online interpreting service that was accessed via smart tablets in all areas to facilitate safe conversations with non-English women and pregnant people.

Leaders understood the needs of the local population. They strived to engage the local community and service users. There were numerous ways the public could engage with the service. The service had set up the following services to encourage engagement.

- Virtual tours of the unit followed by a live questions and answer session.
- Dedicated information pages on their website to support women and pregnant people through all stages of pregnancy.
- Social media pages to encourage two way engagement.
- Specialist clinics such as a pre-term, smoke free pregnancy clinic.
- An equality, diversity and inclusion midwife was one of a small number that had been nationally appointed. This was because the trust cared for a diverse complex population and had links with a local female prison.

Staff were passionate and caring and records showed that women provided positive feedback. We reviewed 5 positive feedbacks letters to the service.

Learning, continuous improvement and innovation

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

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. The trust had been shortlisted in the HSJ ‘Digital Awards 2023 in the Digital Clinical Safety Category for the Digital Fetal Early Warning Score system initiative.

Outstanding practice

We found the following outstanding practice trust wide:

- The trust maternity safety team and education team working in partnership won team partnership for the region in the East of England Maternity awards held in March 2023. Because they worked together to deliver training and implement care bundles based on identified risks and made improvements to their preceptorship programme which supported new midwives to gain their competencies safely and effectively.
- The trust maternity safety and education teams had recently implemented the 3 peas in a pod initiative in collaboration with the emergency department because of a serious incident. The initiative reminded staff to think

'Chest' during pregnancy to rule out Cardiac conditions, lung disorders and venous thrombo-embolism. Think head in the postnatal period to rule out neurological and mental health conditions and for to think high risk and pick up the problem and escalate when required. Think 3 peas in a pod posters were in all areas. Also, when staff categorised women and pregnant people as high risk complications a pink pea assigned to their patient care records which remains after they have had their baby and highlights to staff throughout the hospital to consider complications associated with childbirth.

- The service had implemented a Digital Clinical Safety tool called the Digital Fetal Early Warning Score system to make sure staff acted on known risks to fetal health during labour. This year the system had been shortlisted in a health service publication Digital Awards 2023.

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 achievement and maintenance of national safety actions. Such as to include full risk assessments of all women and pregnant people at each appointment and improve all pre and post-delivery care documentation. As well as to complete and respond to audit findings. Regulation 12 Safe Care and Treatment (1)(2)(a)(b)

Action the trust SHOULD take to improve.

- The trust should ensure staff were up to date with their fetal monitoring competency test training.
- The service should ensure that all service staff attend their safeguarding training and are given protected time to attend safeguarding supervision throughout the year.
- The service should ensure that safety huddles are not interrupted so that patient reviews are completed safely without distraction.
- The service should ensure that only experienced healthcare professionals complete telephone triage calls to ensure safe telephone risk assessments recommendations are safe and accurate.
- The service should ensure that there is always a Supernummary labour ward shift co-ordinator.
- The service should ensure that it continues to improve the hours of obstetric registrar cover provided for around the clock in Triage and DAU.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 2 other CQC inspectors, 2 midwifery specialist advisors and one obstetrician. Carolyn Jenkinson deputy director of secondary and specialist care oversaw the inspection team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation