Sherwood Forest Hospitals NHS Foundation Trust

King's Mill Hospital

Inspection report

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Date of inspection visit: 22 November 2022
Date of publication: 23/02/2023

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	**Good** ●
Are services well-led?	**Outstanding** ☆

Our findings

Overall summary of services at King's Mill Hospital

Outstanding ☆ ➔➔

Sherwood Forest Hospitals NHS Foundation Trust has 3 Hospital sites. Maternity services are based at King's Mill Hospital. Newark Hospital provides comprehensive facilities for antenatal and postnatal care, including ultrasound.

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

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

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

We did not change the rating of the hospital at this inspection. The previous rating of Outstanding remains

How we carried out the inspection

During our inspection of maternity services at King's Mill Hospital we spoke with 16 staff including leaders, obstetricians, midwives and maternity support workers.

We visited all areas of the unit including the birthing centre, maternity triage, day assessment, postnatal ward and neonatal unit. We reviewed the environment, maternity policies while on site as well as reviewing eight birthing people's records. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

The inspection team included six CQC inspectors and two specialist advisors with expertise in midwifery.

The inspection was overseen by Carolyn Jenkinson Head of Hospital Inspection as part of the national maternity services inspection programme.

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:

The service had enough staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risk to women, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Leaders ran services well and supported staff to develop their skills. 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 receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women 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:

Leaders recognised they needed to make improvements regarding how they communicated with staff when making changes to their vision and plans for the future of the service.

Not all staff had completed mandatory training. Staff did not always document effectively in triage to enable appropriate prioritisation and audit. Information systems were in their infancy and needed to be embedded into practice to support service improvement.

Is the service safe?

Requires Improvement ➔

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

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff had completed it.

Staff received but were not up to date with mandatory training. The staff training compliance data for October 2022 showed not all staff groups were compliant with all mandatory training.

For medical staff, compliance with mandatory training modules ranged from 50% to 93%. For all groups of midwifery staff compliance ranged from 39% to 100%.

The mandatory training was comprehensive and met the needs of women and staff. Multi professional training (PROMPT) update October 2022 demonstrated that overall, 90% of midwifes and 87% of Obstetricians were compliant. The remainder of the staff were booked in for their updates on 16 November 2022.

Maternity

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. As part of their mandatory training staff were trained to support women with mental health needs, as well as any drug and alcohol dependency needs.

Managers and practice development midwives had recognised that not all staff were compliant with their mandatory training and had training sessions and plans in place to improve compliance.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Although not all staff were complaint with safeguarding training, they knew how to recognise and report abuse.

Despite some staff not being compliant with Safeguarding training, those we spoke with, understood their roles and responsibilities. Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff did not always receive training specific for their role on how to recognise and report abuse. Data from October 2022 showed compliance with adult safeguarding training ranged from 46% to 100% for the different groups of maternity staff, and 71% for medical staff. Compliance with safeguarding children training ranged from 80% to 100% for the different groups of maternity staff and 71% of medical staff.

The service had a safeguarding training schedule, which identified which groups of staff were required to attend level 1, 2 or 3 children and adult safeguarding training, in accordance with the national intercollegiate guidelines.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction training.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. However, we saw isolated incidents of dusty windowsills and damaged paintwork, which meant they were not wiped clean.

The service shared monthly infection prevention and control (IPC) audit result summaries for August through to October 2022. These audits covered maternity, and outpatient (OPD) clinics and looked at hand hygiene, PPE, environmental, urinary catheters, intravenous cannulas and linen. Compliance for hand hygiene, PPE and linen was 100% in all areas. Environmental compliance ranged from 94% to 100%. Compliance for intravenous cannulas ranged between 40% and 50% for maternity. Compliance for urinary catheters showed 0% compliance in maternity during October 2022.

Maternity

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

Staff cleaned equipment after contact with women. Cleaning logs were maintained by staff and showed the cleaning regime for all equipment in the maternity unit. The trust also had a sticker system to show equipment was clean and ready to use. However, this system was not always followed by staff.

Environment and equipment

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

On the day of inspection, the entrance door to the maternity ward, including triage and theatres was not secure. Staff told us this had been an ongoing issue with maintenance of the door. The leadership team assured us that whenever the door was not in working order a security person would be present, however, we did not observe this. Following the inspection, the trust provided additional assurance the door was in full working order, enabling staff to keep women, birthing people and babies safe.

Leaders had plans in place to improve the triage area of the maternity ward. Currently there was not a suitable waiting area causing the clinical triage area to become full. This posed a risk that women would not be seen in a timely way.

Specialist equipment such as emergency trollies and cardiac equipment were maintained by MEMD (Medical equipment management department) Equipment was stored in tamper proof trollies. The staff had access to spare equipment.

The service had suitable facilities to meet the needs of women and their families. As well as a birthing pool, birth balls and stools to support movement in labour there was a dedicated bereavement suite.

Women could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of women's families.

The service had enough suitable equipment to help them to safely care for women and babies.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

The use of risk assessments in triage was inconsistent and systems and processes in place had the potential to lead to delays in women being assessed and their needs escalated. However, across the service staff completed and updated risk assessments for each woman and took action to remove or minimise risk in a timely manner.

The lay out of the environment and staffing in triage meant that they had not been able to implement a nationally recognised tool in the maternity triage. Not all staff were aware of what systems they should be using in triage. The

triage phone line was not effective as there were multiple options that birthing people could choose when calling the unit. This meant they may be put through to the emergency phone on the Labour ward instead of triage. The midwife on the triage line said they were answering calls from post-natal women as well as women who could be in labour. Staff told us they would escalate clinical concerns as they knew how to prioritise women, but this was not always clearly documented.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment. However, we found the system was not easy to audit as staff were not always recording the time birthing people arrived and/or were seen. At the time of the inspection the service was implementing a new electronic records system. We were told this system would make auditing waiting times more effective.

The trust was already aware that there were improvements needed to the triage system, they were working on ways to move their improvement plans forward. This included a separate waiting area and more midwives based in the triage area.

Staff knew about and dealt with any specific risk issues, for example, staff used a 'fresh eyes' approach to ensure fetal monitoring was carried out safely and effectively. Managers audited compliance with women having continuous CTG monitoring during labour. Data showed between June 2022 to September 2022 there was appropriate interpretation and management plans following CTG in 100% of cases. Also 'fresh eyes' were completed at each hourly assessment in 100% of cases and that 80% of cases the 'fresh eyes' maintained hourly during labour.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used maternal early obstetric warning score (MEOWS). Records we reviewed showed staff used MEOWS effectively.

Staff completed risk assessments for each woman antenatally, on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring as part of the Saving Babies Lives version 2 care bundle. The trust had recognised that their birthing population were more likely than the national average to be smokers and had a team of support staff including a midwife to support people to stop smoking during pregnancy.

If women and birthing people had concerns about their pregnancy and were 20 weeks pregnant or more, they could call a maternity helpline that was open 09:30 – 19:30. Outside of these hours the calls were picked up by the 24hour maternity triage service. If staff identified concerns following an initial call woman were asked to attend day assessment unit or maternity triage.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of deteriorating mental health during pregnancy. Staff screened women for depression using the 'Whooley questions.'

The service had access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. Staff had access to perinatal mental health midwife whose role also incorporates support women who need support relating to drug and alcohol misuse.

Staff shared key information to keep women safe when handing over their care to others. Staff used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover

information. Managers monitored the effective use of handover of care and the SBAR tool. Data from the May to July 2022 audit showed handover was carried out using the SBAR format in 86 % to 94% of the time. Audits were not carried out in August 2022. When audits continued in September and October 2022 the SBAR format was used between 94% to 97% of the time.

Records reviewed showed staff in maternity theatres used World Health Organisation (WHO) surgical safety checklist. However, the trust used a system to show compliance with WHO that they recognise is not an audit. There was work being undertaken to audit the use of WHO trust wide, including the Obstetric theatres.

Staff shared key information to keep women safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep women and babies safe.

Midwifery Staffing

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

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Data showed us that the service had enough qualified nursing and midwifery staff. However, the COVID-19 pandemic had impacted negatively on the maternity workforce resulting in staffing gaps and the wellbeing of staff, which had resulted in additional strain on the service. In addition to the impact of COVID-19 leaders told us more women and birthing people were choosing to birth at King's Mill hospital which was affecting the capacity of the service.

The maternity unit closed 11 times during November 2022 and staff told us they did not feel there was always enough staff to meet demand in service.

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. In October 2022 there were 37 occasions where there was a delay in artificial rupture of the membranes (ARM) and 16 occasions when the labour ward coordinator was unable to maintain supernumerary status. There were no occasions when staff were not able to provide one to one care during established labour. Nor were there any occasions when there had been a delayed recognition of and action on abnormal vital signs, such as sepsis.

Leaders at the trust had used 'BirthRate Plus' an evidence-based methodology based on national standards for workforce planning. Due to this the team had applied a 10% uplift to the midwifery staffing establishment to support the increase in activity. A revised BirthRate Plus review was currently being performed. Bank midwives from within the trust who knew the service well were used to support staffing levels. There was a recruitment and retention midwife to monitor and improve staffing. By consulting with staff, the trust had adapted where possible to retain, retired and returned staff. The trust were looking into an apprenticeship scheme for Maternity Health Care Support workers. As well as recruiting international midwives, the trust has successfully recruited five midwives who were due to start in the new year and four registered nurses were due to commence Midwifery training programme in January 2023.

Leaders had looked into supporting midwifery staff by having a registered nurse on every shift on the maternity ward. This was originally introduced as a pilot. However due to the success and appreciation of the support the nurse provided the midwifery team, it had been decided to embed this role.

Staff told us managers supported them to develop through yearly, constructive appraisals of their work.

Managers made sure staff received any specialist training for their role.

The sickness rate for nursing and midwifery staff within the maternity core service reduced from 12% in January 2022 to 2% in May 2022, however there was an increase in 6% in July 2022.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. However, due to the increase in demand at the service as well as an increase in elective caesarean sections, leaders were working on improvement plans.

Medical staff expressed concerns around the number of elective caesarean sections and how they were able to staff this. Leaders informed us that they had secured funding in order to manage the demands of the service. Leaders were carrying out listening events across the maternity department and reflected that they needed to reassure the whole staff team that they were aware of current pressures and that they had plans in place to make improvements.

Labour ward had a consultant available 24 hours a day. During the week the Consultant covering the night-time would be available in the hospital till midnight. At weekends the consultant would be available in the hospital until 18.30. Junior Doctors told us on call consultants came to the hospital when needed and that when there had been a few consultants who had been reluctant to come in that this had been raised with them.

Leaders told us Junior Doctors had raised issues around Consultant cover for antenatal clinics. They had listened and improved the clinic times.

The sickness rate for medical and dental staff within the maternity core service reduced from 5% in March 2022 to <1% May 2022 before increasing to 2% in July 2022

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. Staff were implementing a new electronic system.

Women's notes were comprehensive, and all staff could access them easily. On the day of inspection, the service had just started to implement a new electronic system to record all maternity records. Leaders had planned the crossover of records well and had increased staffing to allow staff the time to embed the new system.

When women transferred to a new team, there were no delays in staff accessing their records. The new system would allow all departments access to the woman's records, including neighbouring trusts. The trust had worked closely with a neighbouring trust to ensure both trusts were rolling out the same electronic system at the same time, to enable records to be accessed at all sites.

Women and birthing people were able to access their own records on electronic devices such as mobile phones. Where electronic devices were not available the trust was able to provide one for the period in which it was needed.

During the inspection we found records were stored securely.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, however, these were not always effective.

Staff followed systems and processes to prescribe and administer medicines safely. Midwives completed medicines management competency testing and the practice development team arranged this. Staff also completed a competency assessment in patient group directions (PGDs a group of medicines that can be administered by midwives without the need for a doctor or nurse prescriber).

Staff completed medicines records accurately and kept them up to date. All the medicines records we reviewed 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.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services.

Staff did not always store and manage all medicines and prescribing documents safely. We found a medicine fridge where temperature recording had not always been recorded, nor had action been recorded or been taken when staff found the temperature to be outside of a safe range.

During the inspection we found not all medicines were dated when opened as required.

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 honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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. The trust reported two maternity serious incidents in the last six months, they were both in relation to babies being stillborn and both occurred in May 2022. These two maternity serious incidents were reported to Healthcare Safety investigation branch (HSIB) One is currently ongoing and the other one concluded with no recommendations for the trust.

Managers shared learning about never events with their staff and across the trust. The practice development midwife would address any learning from events in training they delivered.

Staff and managers, we spoke with understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Staff received feedback from investigation of incidents, both internal and external to the service.

Maternity

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

The service had not reported any maternal deaths from April 2022 to November 2022. There were two neonatal deaths.

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

King's Mill Hospital maternity services were managed as part of the women and children's services.

The director of midwifery reported to the chief nurse and the trust board. They were supported by a consultant midwife, deputy head of midwifery and three matrons. At the time of the inspection there was an open vacancy for a head of midwifery. Supporting the team were specialist midwives for diabetes, infant feeding, perinatal mental health and substance misuse and antenatal screening coordinators.

The director of midwifery met with the board maternity safety champion every month. The maternity board safety champion was well-sighted on issues relating to the quality and safety of the service and a strong advocate for the service at board level.

The triumvirate met bi- monthly for discussing and escalating risks and issues. The meetings had a clinical chair supported by roles, such as divisional clinical and general managers, as well as the director of midwifery and head of service for obstetrics and gynaecology. Leaders told us they were supported and had direct contact with the executive board.

Staff told us they felt listened to by the leadership team. They felt action was taken when concerns were raised. However, some of the concerns raised with us during the inspection were already being actioned by the leadership team but staff were yet to have fully understood the impact of action taken. The service leaders had links with the Maternity Voices Partnership (MVP) and during the inspection we spoke with the MVP chair; despite issues outside of the trust's control, trust leaders, safety champions and the MVP had developed good relationships and spoke about ambitions for service user voices driving forward changes and improvements.

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 were 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 trust worked closely with the Local Maternity and Neonatal System (LMNS) to understand local challenges, support local trusts and to align local plans for a consistent approach.

The trust had a strategy which incorporates Nursing, Midwifery and Allied Health Professional Priorities 2022-2024. But we did not see evidence of a separate strategy for maternity.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women 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, their families and staff could raise concerns without fear.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and women received feedback from managers after the investigation into their complaint.

We asked for and received evidence regarding complains made in the 3 months prior to our inspection. Information shared with us showed complaints were investigated, and women were supported by Patient Advice and Liaison Service (PALS) to make complaints when appropriate.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff told us they were proud to be working for the trust. Most staff had been with the trust a long time. Although they had become a lot busier in the last few years, they were happy and wanted to remain with the trust.

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.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance.

The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues. There were clear links to the Local Maternity and Neonatal System (LMNS) and local system.

Serious incidents were discussed in the LMNS, including incidents referred to HSIB. Meetings were held monthly and included peer reviews, trust presentations of incidents across the local area and a local learning log which supported shared learning across trusts.

Management of risk, issues and performance

Maternity

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions. However, there was not always evidence that these actions had been effectively embedded or that follow up audits had been undertaken to ensure compliance.

Leaders were aware that improvements were needed to some audit processes and felt these processes would improve with the implementation the new electronic recording system.

The service participated in relevant national clinical audits. However, increase in activity at the service had meant they were behind with some of their auditing programme. Leaders also recognised that their system was not supportive of audits but that this would improve with their electronic records system.

Outcomes for women were positive, consistent and met expectations, such as national standards. Leaders benchmarked the service against the most recent 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE-UK)

Managers and practice development midwife shared and made sure staff understood information from the audits.

We were given information relating to spot check audits following a serious incident. This audit had highlighted actions that had needed to be taken. However, we did not see any evidence of these audits being repeated and the actions being embedded into the staff team's way of working to ensure improvement is checked and monitored.

There was a robust policy in place to manage the department when it was in escalation which was in line with the national Operational Pressures Escalation Levels Maternity Framework. The policy gave the staff clear guidelines to decide and seek support when needed.

During the inspection process the trust had received the pathways to excellence accreditation. This was an internationally recognised accreditation recognising a health care organisation's commitment to creating a positive practice environment that empowers and engages staff. It focuses on six key areas of work within nursing and midwifery, with a focus on showcasing the quality that exists in each of these areas and identifying any gaps and areas for improvement. This was a trust wide achievement.

Information Management

The service was in the process of embedding a new electronic records system. Leaders felt this would enable them to collect and analyse data more effectively.

The trust had identified the need for an electronic records system and had recorded this on their risk register. The trust was working alongside neighbouring trusts to implement electronic records at the same time in order to support women who live in bordering areas.

Engagement

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

Maternity

The service welcomed feedback from women, birthing people and families. People could feedback to the service through surveys, complaints and through the local maternity voices partnership (MVP). Both the trust and the MVP had recognised that working together had been difficult during COVID-19 and were looking forward to improved engagement.

As well as working with the MVP the trust had also employed a Maternity Voice's Champion. The post holder already worked for the trust as a pharmacist and had lived experience of maternity services. The post originated when the MVP was undergoing restructure to ensure parents voice were heard onsite. The role entails, walking the patch, in both the acute and community settings. They have set up community listening clinics in order to reach harder to reach groups of people such as young mums, homeless people. They have worked with established community groups in order to reach ethnic minorities. This role has formed a key part of the maternity and neonatal safety champion structure. The chair of the MVP told us that they were also working with community groups in order to engage with ethnic minorities and were very keen to recruit volunteers from all areas to ensure people felt represented.

The NHS staff survey results for 2021 showed for Maternity and Gynaecology services an improvement in team relationships and staff feeling valued, as well as an improvement of managers being supportive. However, there was a decrease in the engagement of staff with the survey from the year before.

Leaders had reflected and recognised that they needed to improve their communications with staff to ensure staff were on board and aware of changes being implemented to improve.

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.

Managers audited the service following incidents and shared the learning from these audits with staff.

The trust had recognised they had a higher than national average of women and birthing people who were smokers at maternity booking. This had led to being early implementors for incentive work encouraging and supporting people to stop smoking.

The trust had recognised following a self-assessment tool that they needed to improve on ways in which they shared learning with the whole staff team. Action was taken for publicly visible quality and safety board's outside each clinical area.

We saw evidence of feedback from staff being used to drive improvements. For example, leaders were reorganising the way in which theatres for elective and emergency sections were staffed and managed.

Leaders had recognised that they had not always been as effective as they could have been when communicating plans for improvement with the staff team. They were looking into improving their communication boards.

Leaders had reviewed junior and senior doctor cover in response to feedback from junior doctors. There were plans to introduce a twilight shift to support the junior doctors after six o'clock at night. These plans also included to recruit an additional doctor to cover obstetricians and gynaecology to ensure there was separate cover for both areas.

Maternity

Outstanding practice

We found the following outstanding practice:

The trust was supportive and educated new mums around the challenges of feeding a new-born. For example, we found 2am bags in a feeding area on the antenatal ward. These bags had been made up to make women feel they were not alone when feeding a baby in the middle of the night.

The trust had listened to staff returning from maternity leave about the challenges they had when wanting to express milk for their baby. This had led to a feeding pod in the main entrance of the hospital accessible for staff visitors and patients.

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:

The trust must ensure staff complete mandatory, safeguarding and maternity specific training in line with the Trust's own target. Regulation 12(1)(2).

The trust must ensure they implement a robust system in maternity triage to include escalation process, monitoring and documentation. (Regulation 12(1)(2).

Action the trust SHOULD take to improve:

King's Mill Hospital

The trust should ensure all medicines are stored safely and appropriately in line with trust policy.

The trust should continue to implement their new electronic system. To support auditing the quality of the service. When issues are identified from audits action is taken further auditing cycles are undertaken to demonstrate if improvements and changes in practice have improved patient outcomes and improved practice.

Leaders should continue to implement improvements to how they effectively communicate any changes in service provision with staff.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, five other CQC inspectors There were two specialist advisors with expertise in maternity. The inspection team was overseen by Carolyn Jenkinson, Deputy Director.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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