Medway NHS Foundation Trust

Medway Maritime 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 Medway Maritime Hospital

Requires Improvement 

Pages 1 and 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services.

We inspected the maternity service at Medway Maritime Hospital, managed by Medway NHS Foundation Trust, 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.

Our rating of this hospital is requires improvement overall.

Our rating of the Maternity service is good. We rated safe as good and well-led as good for maternity.

How we carried out the inspection

We visited the hospital and spent time in all of the maternity areas. There was a Maternity Care unit (MCU), fetal medicine and antenatal clinic area. We also went to The Birth Place, which was the midwifery-led unit. Whilst visiting the delivery suite, we also visited obstetric triage, obstetric theatres and Maternity Enhanced Care Unit (MECU) which was a four-bedded bay offering support to women and birthing people who may need additional care. We visited Pearl Ward which was a ward for antenatal care and contained eight transitional care beds. Induction of labour were also managed from Pearl Ward. Kent Ward was for postnatal care and elective caesarean sections were managed from here.

Following our arrival at the hospital, we observed the morning handovers between midwives and medical handovers.

We spoke with 8 pregnant women or mothers whilst we were on site. We also ran a poster campaign during our inspection to encourage pregnant women, birthing people and those who had given birth who had used the service to give us feedback regarding care. We analysed the results to identify themes and trends.

We also spoke with 26 members of staff, including service leaders, all grades of midwives, including some specialist midwives, obstetric staff, the director of midwifery, the head of midwifery, the general manager, the non-executive director safety board champion and the chair for the maternity voices partnership.

We reviewed performance information about this service before and after our inspection. We reviewed 7 sets of maternity records plus eight prescription charts. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, incidents and audit results.

Our findings

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

Maternity

Good

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

Staff understood their safeguarding responsibilities and had access to guidance on how to protect women, birthing people and babies. Infection control measures were in place to keep people safe. The design of the environment followed national guidance. The environment was spacious and well maintained. Processes were in place to assess women and birthing people to determine the level of risk and plan to keep them safe. Patient records were kept securely and were complete, although were documented in multiple places such as paper records and different electronic systems. Safety incidents were reviewed and responded to appropriately.

There were facilities and support available to women, birthing people and their families in the sad event of a baby loss.

Leaders were visible. The service had an audit schedule covering each year. The trust had an overall vision and strategy for what it wanted to achieve. The maternity service was part of this vision and was further developing its own strategy. Specialist midwives were also in place to support the service. The service had received feedback about some negative culture in the service and had acted swiftly to consider this further and address this. A risk register was in place to identify and track the progress in addressing risks. Women and birthing people were asked for their opinion and engaged in the service. Leaders encouraged innovation and participation in research. The service collaborated with researchers to support research studies.

However:

Whilst staff were offered training, which had a multi-disciplinary approach and there was flexibility for staff to attend a range of drop in courses, the service had failed to meet its targets for all mandatory training courses. Staff had also not completed level 3 safeguarding adults training.

Staff understood their safeguarding responsibilities and there was an established process to assess young women and birthing people who may be at risk of child sexual exploitation. However, in accordance with trust policy, not all indicated staff were aware they could conduct these assessments themselves and assessments did not have to be conducted by a specific department or job role.

The service had issues with staffing levels caused by sickness, recruitment and retention of staff. Staffing levels did not always match the planned numbers which could put the safety of women and babies at risk.

Some medicines storage was not in line with the service's policy around secure storage and management of expiry dates.

Is the service safe?

Good

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

Maternity

Mandatory training

The service provided mandatory training in key skills to all staff however not all medical staff were compliant with this.

Staff received and mostly kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of women, birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. The service had developed 'masterclasses' in various aspects of CTG training. Midwifery staff met the trust target of 90% for mandatory training with 91% compliance. However, medical staff did not keep up to date with mandatory training, with a compliance of 79%.

Midwifery and obstetric staff completed an assessment following CTG training to ensure they were competent to interpret CTGs. Midwives were 96% compliant with CTG training, with 91% of those staff passing the assessment. Doctors in training were 96% compliant with CTG training and all had passed their assessment. However, consultants did not meet the trust target of 90% with 84% of consultants completing the training and 88% of those consultants passed the assessment.

Data received from the service showed midwifery staff at Medway Maritime Hospital had met the trust target for adult resuscitation for basic life support for adults. The midwifery staff were only just below the trust target of 90% for paediatrics and neonatal babies with 89% compliance. However, medical staff had not met the trust target in adult or neonatal resuscitation training with 75% compliance in adult life support and 79% compliance for neonatal life support.

The service made sure that staff received annual Practical Obstetric Multi-Professional Training (PROMPT). There was an overall compliance rate for PROMPT training which was 93% for all maternity staff. Midwives were 93% compliant, maternity support workers 94%, obstetric consultants 94%, obstetric registrars and SHO's 95%, theatre nurses and operating department practitioners 91% and anaesthetist consultants were 100% compliant.

There was an emphasis on multidisciplinary training leading to better outcomes for women, birthing people and babies. Staff were able to access training at a location away from the hospital. This meant staff would be less likely to be asked to support clinically and could concentrate on the training and team building.

The service was in the process of ensuring all maternity staff had completed simulated pool evacuation training. Multiple midwives, maternity support workers and student midwives had been involved in simulation training for pool evacuation. Those who had not completed the training had access to a training video and current guidance. The pool evacuation training was to be included in monthly PROMPT training sessions from January 2023.

Staff attendance at training sessions was recorded and monitored by the maternity education team. The team booked all maternity staff onto mandatory training. Staff also had the option of attending 'pick and mix' sessions to cover the areas they needed to, on a range of dates to enable flexibility for staff.

The Education Development Midwife attended weekly multi-disciplinary meetings to discuss complex cases or cases where it was felt improvements could have been made. This meant any learning opportunities were swiftly identified and acted upon. Learning was also shared in a regular 'Friday's News' bulletin for all staff.

Safeguarding

Staff understood how to protect women, birthing people and babies 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, however staff had not been trained to level 3 in adult safeguarding.

Maternity

Staff received training specific for their role on how to recognise and report abuse. Training records showed midwifery and obstetric staff had completed level 3 safeguarding children training as set out in the trust's policy. The majority of midwives had completed this training at 95% and 90% of obstetric staff had completed it. At the time of the inspection, training was completed virtually, but there were plans to commence face to face training from January 2023. However, training records showed midwives and obstetric staff had only completed level 2 adult safeguarding adults training.

The service had a safeguarding lead who was new into the role. The new lead was currently being supported by the previous safeguarding midwife, to ensure continuity and support was in place. The safeguarding team completed daily check-ins with all wards to provide support and to highlight any women and birthing people with safeguarding support needs who had been admitted.

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 knew how to protect vulnerable groups of women and birthing people.

There was an established process available for staff to assess young women and birthing people who they suspected could be at risk of child sexual exploitation. However, not all staff were able to articulate their responsibilities with this process. Despite this, staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Women and birthing people were given the opportunity to raise concerns they may have about domestic abuse, at appropriate times. This was a mandatory question when women and birthing people were unaccompanied, so it could not be unintentionally forgotten by staff.

We saw an example of a woman who may be considered at risk and we saw appropriate action was taken to protect her. Over 90% of the midwifery and medical staff had completed equality, diversity and human rights training. Safeguarding concerns were recorded on women's electronic records which were 'flagged' to staff, so they were aware of them.

Staff discussed safeguarding concerns they needed to be aware of in handovers between shifts, to ensure information was shared. Staff were expected to attend compulsory safeguarding supervision sessions twice a year to ensure their practice remained up to date. The safeguarding lead told us there were drop-in sessions for staff if they had any questions or support needs outside of formal supervisions.

All midwifery and medical staff had access to an online safeguarding resource, called a 'padlet', which they could access at all times. The resource provided safeguarding guidance, local authority contact details to complete safeguarding referrals and safeguarding pathways for staff to follow.

Staff followed the baby abduction policy and undertook baby abduction drills and training. The last baby abduction drill had taken place prior to the COVID-19 pandemic and had involved local actors. Staff involved were not aware that this was a drill and we were told the training was received positively by staff. Senior leaders told us that any staff starting with the service after this time had not completed a baby abduction drill whereby staff were unaware of it being planned. However, since the drill there had been tabletop exercises and training about the baby abduction guidelines in February 2022. The service conducted annual refreshers of the abduction training. We found access to maternity areas were secure, monitored and controlled to reduce the risk of baby abductions.

Cleanliness, infection control and hygiene

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

Maternity

Maternity areas were clean and had suitable furnishings which were clean and well-maintained. For example, we saw a schedule for changing curtains in clinical areas and cleaning schedules completed to show areas had been cleaned.

Floors in all maternity areas were clear of any storage and allowed for effective cleaning. Cleaning records we saw on the maternity unit were up to date. Staff cleaned equipment after contact with women and birthing people and used 'I am clean' stickers to indicate what equipment had been cleaned.

During the inspection we saw staff follow infection control principles including the use of personal protective equipment (PPE). Aprons and gloves were stored on wall mounted displays throughout the unit. Hand sanitiser gels were available throughout the areas. Staff were bare below the elbow and there were appropriate hand washing facilities within rooms, as necessary.

Staff told us senior leaders completed regular infection prevention and control and hand hygiene audits. Data received by the service showed hand hygiene audits in September 2022 were 100% complaint, October 2022 were 89% compliant and in November 2022 were 87% compliant in areas checked. Environmental audits also took place regularly, however, they were generally not fully completed. The service explained this was due to not being able to access certain areas as they were in use, but the auditor would try to alternate where they checked to cover all areas.

Environment and equipment

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

The design of the environment followed national guidance. The environment was spacious and well maintained, although we observed one staff area where handovers took place had a damaged wall. The service had suitable facilities to meet the needs of women's and birthing people's families. The maternity wards were secure with a monitored entry and exit system.

Emergency equipment was checked daily or weekly as per guidance and we saw that all checks had been completed. However, when The Birth Place was not in use, there was confusion as to who carried out the checks on equipment to ensure it remained ready to use should the unit be used. The Birth Place was the midwifery-led unit where lower risk women and birthing people could have their baby. Checks on equipment in the delivery suite was completed by the delivery suite coordinator.

We saw one recorded incidence of a CTG machine running out of paper. Following our feedback, the service explained there had been a lack of spare paper with the CTG machine, but the staff member had continued to monitor the baby's heart rate until a replacement CTG could be sourced. Staff also told us there had been instances of CTG paper not being available, however the service explored this and could find no reported instances of a lack of paper. The service took action to reduce the risk of CTG paper being unavailable.

There were resuscitaires within each room on the delivery suite, so they were easily accessible in an emergency. Resuscitaires are to assist if a baby becomes unwell. There were also resuscitaires available in the post-natal and antenatal wards if needed. Adult emergency equipment, such as resuscitation trolleys, were also available in all areas. Staff, including permanent, temporary or agency staff, received an induction to highlight where emergency equipment was stored. Staff could not be allocated shifts without this induction being given.

Based within the delivery suite area was the Maternity Enhanced Care Unit (MECU), which was a four-bedded bay offering support to women and birthing people who may need additional care. Obstetric triage was also a dedicated

area within the delivery suite. Obstetric theatres were close to the delivery suite. One theatre was used for elective caesareans and one theatre was for emergencies. Pearl Ward was centred on antenatal care, postnatal care and had eight transitional care beds. Induction of labour were also managed from Pearl Ward. Kent Ward was for postnatal care and elective caesarean sections were managed from here. All these areas were based in close proximity to each other. The Maternity Care Unit (MCU), fetal medicine and antenatal clinic area were based on a separate floor. There was waiting space for women and birthing people to wait to be seen and there they could be observed by staff based on MCU. Staff told us they had trialled being able to move women and birthing people from the MCU up to the delivery suite in the event of an emergency. A trolley was ready and there was close access to a prioritised lift to transport the woman or birthing person, if needed.

Staff regularly checked birthing pool cleanliness and the service had a contract for testing for Legionella.

The service had enough suitable equipment to help them to safely care for high and low risk women and birthing people during labour and birth. For example, in the rooms which contained a birthing pool, there were pool evacuation nets.

Staff disposed of clinical waste safely. There was correct segregation of clinical and non-clinical waste. This was in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. Sharps bins were labelled, and no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks.

There was a dedicated bereavement space for women, birthing people and their families who had experienced baby loss. The environment was to an exceptional standard. The development of this space had been supported by a local charity, who offered ongoing support to bereaved families. The bereavement room was in a private area and not close to labour rooms, reducing the possibility of seeing other families with babies. There was no medical equipment kept in the bereavement suite so that the room had a more homely and comforting feel. There was a bedroom and lounge area for families to spend time in. There were dedicated specialist bereavement midwives who supported women and birthing people. Follow up appointments and support from the bereavement midwives could also be held in the bereavement suite (when it was not being used by other families), so families had continuity.

The service worked with local and national charities to offer counselling sessions and to support women, birthing people, birth partners and their families through baby loss. The area had food storage, and refreshment facilities. Rooms included cold cots and cuddle cots, memory boxes and teddy bears were available for parents to take home. There was also a charity book scheme called Butterfly Books, where parents could read a book to their baby and keep the book as a memory and lasting connection to their baby. Memory boxes were tailored for women, birthing people and families of a variety of faiths to ensure inclusivity.

In addition to this, there was a Thrive specialist mental health midwife to support women and birthing people who were experiencing psychological trauma, as a result of, or having been triggered by the perinatal context such as birth trauma and/or perinatal loss. Perinatal loss may include early miscarriage, recurrent miscarriage, stillbirth, neonatal death, termination of pregnancy, IVF treatment and parent infant separation at birth.

Assessing and responding to patient risk

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

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately at each point of care. Staff used various tools to identify women and birthing people at risk of deterioration throughout their pregnancy and during childbirth.

Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman and birthing person. We reviewed seven MEOWS records and found staff had completed them correctly. Senior leaders completed monthly spot checks on the completion of MEOWS to check they were fully completed and escalated appropriately. Audits for October and November 2022 scored 100%.

The service had a target to review and assess women and birthing people within 15 minutes and a plan of care to be made within the hour. The service completed audits for waiting times in triage every six months. The audit showed from January 2022 to June 2022, 50% of women and birthing people had their observations reviewed within 15 minutes of arrival onto triage, and 35% were reviewed within 16 to 60 minutes. Women and birthing people were seen by a midwife within one hour of arrival 71% of the time. Staff used MEOWs and their clinical judgement to prioritise risk. However, due to the delays in some women and birthing people being reviewed in a timely manner it meant women and birthing people could be left at risk in that time (12% waited over an hour to have their observations taken and 3% there was an unknown wait time).

The MCU saw women and birthing people who did not fall within the obstetric triage criteria. Staff in MCU documented arrival times and followed the service guidelines to assess women and birthing people. Staff used a red, amber, green (RAG) rating system for women and birthing people based on their arrival time into the MCU. The target was to review everyone within 20 minutes of their arrival time (green). For those who waited between 20-40 minutes, they became amber risk. For anyone waiting over 40 minutes to be seen, they became a red risk. The same process was followed here, by using MEOWs to assess and prioritise women and birthing people. Staff working on MCU collected data about how quickly women and birthing people had their observations taken following their arrival. For the whole of November 2022, women and birthing people had their observations taken within the service's target of 20 minutes (green) 50% of the time, those seen within 21 to 40 minutes (amber) was 22%, those seen within 41 to 60 minutes (red) was 11% and there were 8% seen who had waited over an hour. In addition to this, 9% of attendees did not have a time recorded so we could not be sure how long they had waited.

Women and birthing people were complimentary about the maternity triage phone service, called 'Call The Midwife'. They felt this was a useful and positive resource. This service provided a 24 hour a day, seven days a week dedicated telephone helpline, which was answered by band 6 experienced midwives. To protect their time, staff allocated to the helpline were able to work from home. Midwives signposted women and birthing people to various services and clinics during these calls. This line was also used to assess women and birthing people in labour. Women or birthing people in labour were advised to attend the delivery suite. The delivery suite would be notified the woman was to be expected and given a handover from the 'Call The Midwife' service.

The service held various high-risk antenatal clinics which were consultant-led, these included, a perinatal mental health clinic for women and birthing people who had been diagnosed with moderate to severe mental health illness. A multiple births clinic for women and birthing people who were pregnant with twins, or more. There was also a clinic for women and birthing people who experienced severe complications in previous pregnancies and a multi-disciplinary medical team clinic for women and birthing people with pre-existing health conditions, like epilepsy, cardiac problems and thyroid problems. There was also a diabetic clinic.

Maternity

Women and birthing people with a high body mass index (BMI), difficulty with previous surgery, back problems, cardiac problems and various other conditions that may have been affected by anaesthesia were seen in the anaesthetist run preoperative clinic.

Staff knew about and dealt with any specific risk issues. Staff completed a holistic risk assessment at antenatal booking to identify maternal, psychological, physical and social risks. Once this had been established women and birthing people were put on the corresponding care pathway and their risk was identified in their patient record. Screening was done for carbon monoxide to ensure this was in safe parameters. Baby growth was monitored on a chart to ensure this remained in line with recommendations.

The delivery suite had centralised continuous cardiotocograph (CTG) monitoring and practice was well embedded. In the last year, the service had recruited three fetal wellbeing midwives who supported their colleagues in reviewing and making decisions about fetal wellbeing. Staff used the 'fresh eyes' approach to safely and effectively carry out fetal monitoring. Leaders audited how effectively staff monitored women and birthing people during labour, with 30 women or birthing people reviewed in November 2022. The audit showed the CTG was monitored correctly 80% of the time during the first stage of labour and 62% during the second stage of labour. Correct labelling of CTGs, using stickers, was done 100% of the time. Recommendations were made at the end of the audit to improve compliance. These included embedding this within training, adding to handover as a reminder and there was a planned launch in February 2023 of a new way of using stickers on CTGs, with a new audit to take place to check compliance.

Staff referred women and pregnant people for their routine antenatal scans to the fetal medicine unit. Staff on the fetal medicine unit reviewed scans and reported on the findings. The service did not use the 'Gap Grow' model to review fetal growth. However, unlike the 'Gap Grow' model which only highlights risky women and pregnant people for a 36-week scan, at Medway Maritime Hospital, every woman and pregnant person was offered a 36-week growth scan. This reduced the risk of reduced fetal growth being missed.

Staff took routine screening bloods and entered the details on a central checking system so that blood results were reviewed in a safe time frame.

Staff completed assessments, in conjunction with women and birthing people, for those thought to be at risk in relation to their mental health. All women and birthing people were asked about their mental health. Staff shared key information to keep women and birthing people safe when handing over care to others.

Shift changes and handovers included necessary key information to keep women, birthing people and babies safe. During the inspection we attended staff handovers and found key information was shared. The handover shared information using a format which described the situation, background, assessment, recommendation for each patient (SBAR).

Staff completed new-born risk assessments at birth to identify those babies at high risk of developing complications, using recognised tools, such as the Neonatal Early Warning Scores (NEWS). New-born babies had their care recorded on a 'Yellow Card' and new-born babies were RAG rated at birth. The service also carried out Newborn and Infant Physical Examination (NIPE) checks, as per national guidance. The service monitored compliance of these checks being carried out. Between 3 September 2022 to 3 December 2022, 99.8% of new-born checks were carried out on time, not including babies born onto the Neonatal Intensive Care Unit (NICU) who may not have been well enough for a check to take place on time. The trust target was over 95% of checks to be on time.

Maternity

The service provided transitional care for babies who required additional care. A neonatal nurse was available to look after the babies in transitional care with a midwifery support worker who supported the women and birthing people. Babies were reviewed daily by the NICU team.

Women and birthing people were given some choice over the place where they gave birth. This was dependent on their wellbeing risk assessment at 36 weeks, when all women and birthing people had a 'birth planning' appointment with their midwife. Place of birth was discussed, as was pain relief during childbirth and information about what to expect. The service offered homebirth as a choice and monitored how many babies were born outside of hospital. The service also had a well-equipped midwifery led unit, called The Birth Place, which was designed to cater for women and birthing people who wanted an active low intervention birth. However, due to workforce pressures the unit was not always able to offer this service as an option for childbirth. The obstetric delivery suite did have a pool room for women and birthing people who were low risk and opted for a low intervention birth although staff told us this was not often used.

The obstetric labour ward catered for women and birthing people who had pre-existing conditions that required high levels of care. There was also a four-bedded 'Maternity Enhanced Care Unit' for seriously ill women and birthing people. This was fitted with intensive care equipment and staffed by midwives who received additional training to care for critically ill women and birthing people. The service used a maternal sepsis care bundle to identify women and birthing people at risk of sepsis.

Midwives completed discharge notifications when mothers and babies were fit for discharge and sent them electronically to the local community teams who visited them at home.

There was a maternity dashboard in use which monitored the activity of the maternity service and the attainment against the services targets. Areas for improvement were also highlighted.

Midwifery Staffing

The service did not always have enough maternity staff. However, those working on the unit had the right qualifications, skills, and experience to keep women and birthing people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. 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.

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. The service used the Birthrate Plus tool, which is an assessment of workforce requirements as recommended by the Royal College of Midwives (RCM). The review was completed in June 2022 and found the service had not achieved their recommended ratio of staff due to staffing vacancies and staff absence. The service explained some shortages were mitigated by the use of bank and agency staff. At the time of the service desktop staffing review, there was a shortage of 27 whole time equivalent (WTE) midwives. Since the review, the service had recruited more midwives to reduce staff shortages. However, there was still a shortfall of 13.02 WTE midwives, specialist midwives or band 5 midwives or nurses and a shortfall of 3.5 WTE midwife support workers. The service explained this was a low vacancy rate in the current staffing climate nationally. The sickness rate had also been above the trust target of 4% between June 2022 to September 2022.

Maternity

The Birthrate plus acuity tool was used by leaders to review staffing every day. The tool checked the number of women and birthing people giving birth at that time and the number of midwives available to support them. If there were shortages, this could be escalated via safety huddles, and plans put in place. We were told there was a mixture of huddles in each area and a larger huddle incorporating multiple areas of maternity services, including those based in the community.

There was also a supernumerary shift co-ordinator on duty on the delivery suite, around the clock, who had oversight of the staffing, acuity, and capacity. When there were shortages, it often resulted in staff being moved to other areas, which caused pressures in the areas staff had been moved from. Despite this, the service reported they were able to offer one to one care to women and birthing people in labour 100% of the time. The service's process indicated when the delivery suite or The Birth Place closed, this should be recorded on the trust's electronic incident reporting system. However, due to midwives often being redeployed to support the delivery suite, staff told us The Birth Place was frequently on internal divert and this came to be considered 'normal,' so staff felt the recording of these diverts was not always being done. We asked the trust about this and they explained The Birth Place had been on divert to the delivery suite on numerous occasions in the last 12 months but had not formally closed for a protracted period of time. Therefore, an incident report had not been required or completed. The diversions were recorded along with clinical activity and staffing levels.

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 November 2022 there were 75 red flag incidents and in October 2022 there were 81 red flag incidents. The movement of maternity staff to support the delivery suite was on the trusts risk register. The service had plans to recruit more staff to fill current vacancies.

The service were aware their largest proportion of red flag incidents were delays to inductions of labour, due to low staffing levels. This was on the risk register and a project was planned to consider what improvements could be made to avoid delays.

Staff in the MCU documented arrival times of women and birthing people. We were told the target was to review everyone within 20 minutes of their arrival time. However, due to the acuity and capacity the services' target time frames could not be adhered too during busy periods and this information was escalated to midwifery managers and service leaders.

Student midwives had also fed back during listening events arranged by the service, that when there were staffing shortages, they were not always supernumerary and being expected to work as midwifery support workers and staffing shortages impacted on the support given to them. Feedback from women and birthing people also recognised there were staffing shortages and some interactions felt rushed.

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.

Managers supported staff to develop through appraisals of their work. Overall, 84% of all levels of staff had received their annual appraisal. The Education Lead explained measures were in place to support staff, particularly newly qualified staff, such as wellbeing kits and dedicated wellbeing days. Newly qualified midwives had a period of preceptorship in order to welcome and integrate new staff into their team and place of work. Staff who were new to the role wore a red badge so they could be identified as new. Staff generally told us they felt well supported.

Maternity

A practice development team supported midwives. The service had multiple specialist lead midwives. These included specialists in bereavement, diabetes, screening, governance, safeguarding, fetal medicines, infant feeding, mental health, fetal wellbeing and a digital midwife.

Medical staffing

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

The service had enough medical staff to keep women, birthing people and babies safe. Data provided by the service showed the medical staff very closely matched the planned number. There were 59.68 WTE in comparison to the budgeted 60.65 WTE.

There was still the use of bank and locum staff to ensure safe staffing levels. The service always had a consultant on call during evenings and weekends. Medical staff told us that they felt supported in their role.

There was dedicated consultant cover for the delivery suite, with a consultant present from 08:30 to 21:30 each day, with an on-call facility for nights. There was a standard operating procedure to guide the consultant and staff as to what the consultant would attend the delivery suite for during the night. A rota was devised for daily ward rounds in all maternity wards, including the delivery suite, ante-natal and post-natal wards. However, on Kent Ward there was a document to record when the daily ward round had taken place. This was poorly completed so did not always show consultants had attended.

There was a Registrar assigned to work with midwives on obstetric triage between 08:30 to 17:00. Between 17:00 to 21:00, staff called the registrar bleep holder and during the night staff relied upon the on call registrar to attend. Staff did not raise concerns with us about a registrar attending, although the out of hours on call registrar was shared with gynaecology.

There was a separate dedicated team, called ‘Team Aurelia’, who focused on elective caesarean sections. This included medical and midwifery staff and supported the continuity of care for women and birthing people.

Records

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

Women's and birthing people’s notes were comprehensive. The service used a combination of paper and electronic records. However, due to this combination and multiple electronic systems in use, staff told us they found it difficult at times as multiple places needed to be checked for information. The service was aware of the risk associated with multiple electronic systems in use. The maternity service had a draft digital strategy in the process of being approved, in order to improve systems.

Midwives in the community experienced connectivity issues so they could not always access information on electronic systems. However, the service was aware of this and had determined it as one of their top five risks and were working on solutions to this. We reviewed seven women’s and birthing people’s records where six contained complete information between the paper and electronic systems. However, there was one record with missing information, where carbon monoxide monitoring was not recorded.

Records were stored securely. Staff locked computers when not in use and identity cards were required to access electronic records. Electronic records flagged when there were safeguarding considerations staff needed to be aware of.

On the day of our inspection there was an IT system outage caused by a third-party supplier, meaning some policies and guidance documents were not as easily accessible as normal. Senior leaders explained staff had been emailed to make them aware of the system outage and how to access systems and policies which were affected by the outage. Despite this, some trainee staff were not aware of how they would access these documents. Patient records were unaffected. To reduce the risk of system outages in the future, the trust has approved a plan to upgrade its internet system.

Staff completed venous thromboembolism (VTE) risk assessments at initial booking, 28 and 36 weeks of pregnancy and during childbirth. VTE is a blood clot which starts in a vein. Outcomes were documented on the digital patient record to help inform decisions around the management of VTE. Staff followed internal operating procedures to implement medication for those women and birthing people identified at high risk of blood clots.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. Medicines were not always stored and managed in line with trust policy.

Overall, medicines were managed safely. However, there were some areas which required strengthening. We found within Kent Ward (the post-natal ward) medicines were not always stored within a locked cupboard. Trust policy stated medicines should be stored in locked cupboards. A senior manager explained this was an isolated incident. The Birthing Centre (the midwifery-led unit), had aromatherapy oils which had expired in November 2021. Manufacturers expiry dates should be complied with in case the efficacy or safety of the product could be affected. One fridge which was specifically for storing women and birthing people's milk contained out of date milk; once we raised this it was removed. In Pearl Ward (the ante-natal ward), we found the medicines room and medicines fridge was mostly checked daily. Checklists showed the medicines room temperature was over the specified maximum temperature of 25C from November 2022 to December 2022. The medicines fridge temperature was above the safe maximum of 8C from the start of November 2022 to December 2022. A senior manager explained fridges which were able to connect to the Wi-Fi internet, were monitored remotely to check they remained in a safe range. Fridges which could not reliably connect to the Wi-Fi internet would need to be manually monitored by staff. The fridge in Pearl Ward had handwritten monitoring records in place. There was no documented action taken for temperatures outside of safe range and therefore we could not be assured medicines were stored safely.

All other medicines we checked, including controlled drugs, were stored securely and checked appropriately. Controlled drugs are medicines which have extra measures in place for storage and stock checking.

Staff followed systems and processes to prescribe and administer medicines safely. There were medicines rounds, in which women and birthing people were supported one at a time, to reduce the risk of errors. Prescription charts were stored securely, and checks were made to ensure the correct number of charts were in stock. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed eight prescription charts and found staff had correctly completed them.

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

An internal assurance visit had identified the service needed more timely access to the pharmacy to ensure medications were dispensed on time and discharge waiting times for women and birthing people were reduced. However, the service had been honest in that they had not yet achieved this action due to a lack of funding for a dedicated pharmacy role. This action remained on their action plan and was being tracked.

Incidents

The service managed safety incidents appropriately. 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.

Staff knew what incidents to report and how to report them. Staff knew how to escalate their concerns and how to report incidents. Staff followed trust guidelines on how to identify and report incidents. The service used an online incident reporting system and updated national Strategic Executive Information System (STEIS) if a serious incident was declared.

Incidents were reviewed within the monthly quality and patient sub-committee maternity report which was presented to the trust board. The report provided the trust with oversight of all perinatal incidents, risks and actions relating to maternity quality and safety.

Data received showed there were 1362 incidents reported from July 2021 to June 2022, with the highest percentage of incidents were due to post-partum haemorrhage (PPH). Information on the NHS digital dashboard showed the rate of women and birthing people who had a PPH of 1,500ml or more was higher than the national average with 46 per 1,000 births compared to the national average of 30 per 1,000 births. The service'ss perinatal surveillance tool report showed learning from the high incidences of PPH was shared with staff and the PPH audit was to be ongoing.

A serious review declaration panel was called together to review a serious incident within 48 hours of an incident being declared. Risks and timelines were reported to the panel and a decision was made as to whether the incident would be declared a serious incident. A 72-hour report was completed by the serious incident investigator.

The serious incident review group reported on incidents and the divisional governance team ensured completion of the serious incident report and sign off for the information presented, prior to sending to the patient safety team. There were four serious incidents reported from April 2022 to October 2022.

Managers debriefed and supported staff after any serious incident. Staff met to discuss the feedback and look at improvements to the care of women and birthing people. There was a weekly multi-disciplinary meeting called the Clinical Review of Incidents Group (CRIG) whereby incidents or learning opportunities were discussed. The group reviewed notes, discussed what went well and what could be improved. The group decided how the learning could be shared with all staff and any further work which needed to be done. These meetings were also documented to evidence learning following incidents.

The service had no 'never' events on any maternity wards in the previous 12 months. A 'never event' is a serious incident that is preventable as there is national guidance in place which trusts should be using in order stop 'never events' from happening.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. This included daily checks to ascertain whether there had been any incidents which needed acting upon and swift reviews were

undertaken in the event of serious incidents. The Standard Operating Procedures (SOPs) to guide staff about reporting and reviewing incidents were under review to provide staff with guidance around procedures and incident management in the interim, as the trust's previous incident management had changed significantly. They were awaiting agreement via the trust's governance processes.

Managers investigated incidents. They involved women, birthing people and their families in these investigations. Staff reported serious incidents clearly and in line with trust policy. There was a mechanism to record learning points following incidents and to cascade this learning to staff.

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

Staff received feedback from investigation of incidents. For example, staff discussed incidents at the weekly CRIG meeting and learning from these were shared in the 'Friday's News' bi-weekly newsletter.

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, birthing people and staff. They supported staff to develop their skills and take on more senior roles.

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

Leaders were visible and approachable in the service for women, birthing people and staff. Staff used the term 'flattening the hierarchy' to describe that managers of all levels could be approached, and staff generally agreed this to be the case.

The maternity team leadership structure included the chief nursing officer, divisional director of nursing, director of midwifery and head of midwifery. The team was also supported by a consultant midwife who was due to start in January 2023, acute matron, antenatal clinic/fetal medicine matron and community midwifery/birth centre matron. The service also had a number of band seven specialist midwives.

Leaders were respected, approachable, and supportive. The non-executive maternity safety champion visited wards on a regular basis. The non-executive director (NED) was a maternity safety champion and was there to provide objective and external challenge. Their remit was to understand the current outcomes of the service, review services, current maternity risks and report to board.

The service 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 trust had an overall vision and strategy for what it wanted to achieve. The maternity service was part of this vision and was further developing its own strategy.

There was an overall strategy for the entire trust, including the maternity service, called 'Patient First', with the aim to, "by providing the best of care through the best of people providing excellent care, every time." The maternity-specific vision and strategy was being drafted following engagement meetings. There were priorities in place regarding patient safety and plans in place to reduce risks. The trusts Quality Account for 2021 to 2022 listed six maternity key safety priorities, these were: Better information and communication, reduced waiting times and care delays, inclusive website, protected staff training, recruitment and shared learning and transparency. A number of the senior managers had started at Medway Maritime Hospital in 2022; they told us they felt they worked well together and had a similar vision but needed time to develop this.

The service had included the Ockenden report from 2020 and 2022 actions into the maternity quality improvement plan.

Culture

Concerns had been raised about the culture of the service and swift action was taken to explore and address this. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, birthing people their families and staff could raise concerns without fear.

Concerns about the culture of the service in relation to racism had been raised by some staff in December 2022. Once this feedback had been received, the service acted swiftly to identify actions to address concerns and make improvements to the service. This included actions such as further listening events, addressing concerns with individual members of staff, promote feedback channels and to link with black, Asian and minority ethnic networks to support improvements. The service had only recently received this feedback so their action would take time to address issues and embed improvements. Staff did not raise concerns with us on site.

Staff were generally positive about the service and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Multiple staff, from different roles, told us they loved their job. Staff felt good practice was celebrated, there was good support and good teamwork. There was a 'Greatix' scheme to acknowledge when staff had done a good job. Negative or untoward incidents or near misses were recorded on an electronic incident reporting system to investigate and track themes, so this was called 'Greatix' to celebrate successes.

Women, birthing people and birthing partners recognised staff were sometimes under pressure which led to some rushed interactions. However, women and birthing people were largely complimentary of the level of kindness and respect from staff. There was repeated feedback from women and birthing people about overnight visiting restrictions for birthing partners following the baby being born. Some women and birthing people fed back they felt having their birthing partner be able to stay overnight with them would help them with feeling more supported and alleviate pressure on staff, as visitors could support them. The service had worked with the Maternity Voices Partnership (MVP) to look at solutions to this and developed guidance for visitors who wished to stay overnight.

Maternity

Women and birthing people told us they knew how to raise a complaint or knew where to find information about making a complaint. Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Some women and birthing people were offered de-briefs after their births in order to answer questions they may have, and for staff to listen to their experience and identifying learning opportunities. The feedback was shared with other staff in order to improve patient care.

Leaders understood the local demographics and how health inequalities affected treatment and outcomes for women, birthing people and babies from ethnic minority and disadvantaged groups in their local population. For example, there were specialist midwives to address the high level of smoking in the area. There were also focus groups for women and birthing people to feedback about their care, which also included a group for black, Asian and minority ethnic groups.

Governance

There was a defined programme of audits. 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.

The service had an audit schedule covering each year and had further improvements planned to expand this and capture all work ongoing within the maternity service. For example, there were audits about: the reasons for readmissions to hospital for women, birthing people and babies, the quality and content of patient records and verifying the correct checks took place, when required, checks on equipment and cleaning audits and hand hygiene audits. There were also checks on both obstetric triage and the Maternity Care Unit (MCU).

It was explained to us there were planned changes to the corporate governance team due to an internal restructure. The Governance and Risk lead midwives were not part of the re-structured team and it was unclear how the maternity specific Governance and Risk midwives would be supported in their roles. These specialist midwives, along with multiple midwives in specialist roles, were asked to work clinically when there were staffing shortages, which impacted on their availability to carry out audits. This had been acknowledged as a risk in the 'Maternity Workforce Report' shared at the trust board meeting in October 2022, so was a known concern. A senior manager told us these instances of specialist midwives have to work clinically were 'rare'. This meant there was an increased risk that necessary audits may not be carried out and areas for improvement not always identified as there was a lack of structure. For example, we found improvements were needed to medicine storage and monitoring, however this had not been identified by the systems the service already had in place. Systems in place also did not identify gaps in the checking of some equipment in The Birth Place when it was not in use.

The service participated in relevant national clinical audits, such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) and perinatal surveillance audits.

The service had a clear governance reporting structure, with assurance groups for both the clinical negligence scheme for trusts (CNST) safety compliance group and Ockenden review group. They reported into the Ockenden peer assurance group, training assurance group, quality assurance group and then into the operational board. This information also fed into the speciality and sub speciality meetings which reported to the Women's and children's care group and management board, divisional management and governance board and alongside the maternity and neonatal safety champion assurance board. Information was then reported into the quality assurance committees and then the trust board.

Staff followed up to date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Policies had review dates clearly recorded on them. One policy had passed its documented review

date, but the service explained this had been reviewed and was awaiting agreement through their governance processes. The policy was still in use until the reviewed version had been agreed. To avoid policies going out of date in the future, there was a newly devised process to ensure new national guidance was recorded and actioned. This process had been reviewed in September 2022 but had not yet been finalised.

The service had carried out an Internal Assurance Visit (IAV) in August 2022 to monitor their compliance with CQC key questions. The IAV had identified 49 actions they felt needed completing. An action plan had been developed and by the time of our inspection the review of their plan identified 40 of the 49 actions had been completed.

An action plan was in place to review the services Ockenden Assurance Insight visit. The maternity leadership team undertook a review of the Ockenden actions completing a benchmark and gap analysis to identify actions required to achieve compliance against the 15 Immediate and Essential Actions (IEAs) within the final report. These actions were included in and monitored via the Maternity Board Assurance Framework Quality Improvement Plan whilst awaiting the national recommendations.

The service's was working collaboratively with neighbouring trusts to improve the sharing and comparison of data.

Management of risk, issues and performance

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

There was a maternity risk register which was risk scored via a green, amber and red system. Examples of the risks on the register were maternity equipment not receiving annual checks, movement of staff within the unit due to low staffing creating risks within other areas of the unit and the unit not being able to meet the induction of labour demand due to capacity and staffing issues.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in the regular Clinical Review of Incident Group (CRIG) meetings as well as monthly quality and patient sub-committee maternity reports which was presented to the trust board.

There were plans to cope with unexpected events. The unit had a maternity action plan which detailed the pathway taken when the decision was made to close and divert maternity care. The decision was made through agreement with the on call consultant obstetrician, head of midwifery and on call consultant neonatologist.

The plan had a risk rated escalation process which was based on, green being the normal operation of maternity services. Amber was staffing levels and skill mix were not appropriate for the workload and maternity activity was prioritised. Red was unable to provide safe care for women, birthing people and babies. Finally, black was decisions were taken to suspend maternity services due to not being able to manage demand. From December 2021 to November 2022 the maternity unit was closed three times.

The service carried out an internal assurance visit in order to ensure that all women and birthing people had access to safe, effective and personalised care. The visit identified areas for improvement and actions that needed to be taken. An action plan had been developed in response and progress monitored. Improvements were needed to obstetric theatres and an action plan had been developed to address this.

Maternity

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Data or notifications were consistently submitted to external organisations as required. The service reported mostly in a timely manner, as required, to 'Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries' (EMBRRACE) about babies who had passed away. The service had recognised they needed to improve the accuracy of the data they supplied to the Maternity Service Data Set (MSDS). MSDS is patient-level data that captures information about activity carried on within maternity services. This was on the risk register. However, actions had been identified and progress made against those and this was being monitored to ensure action taken was sustained.

Wards displayed their own audits results so staff could see what they did well and what could be improved.

The maternity service measured key performance through the maternity dashboard. The dashboard was presented to enable it to be used to challenge and drive forward changes to practice. The dashboard had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts.

The service employed a digital midwife who supported staff with training and updates on the electronic patient record.

Engagement

Leaders and staff actively and openly engaged with women, 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.

The service made available interpreting services for women and birthing people and collected data on ethnicity. Staff arranged face to face interpreting services for non-English speaking women and birthing people during the booking process and throughout pregnancy. Staff on the delivery suite and wards accessed a telephone interpreting service. Staff told us they sometimes asked family members to interpret, however for safeguarding reasons this was not best practice because women and birthing people are not able to discuss their concerns in private.

Leaders engaged with the Maternity Voices Partnership (MVP), were interested in what women and birthing people had to say and helped make decisions about services. There was a presence on social media and a dedicated website for the MVP which shared information and asked for feedback. The MVP also attended the Safety Champion Board to share feedback. They had undertaken a 15-step challenge which was discussed. The 15-step challenge is a toolkit to look at maternity services from the point of view of those who use them. Maternity services also had a dedicated social media page which shared information and statistics as to the activity in the previous month. These posts had prompted engagement from the public.

Women, birthing people and their families were offered the opportunity to debrief following their delivery. This gave women and birthing people the chance to ask questions to better understand their experience and for the service to learn from areas to improve. This information was discussed at the Safety Champion Board and acknowledged when things could have been communicated better to women and birthing people.

Maternity

Leaders understood the needs of the local population. Work was ongoing to improve access to feeding back for those communities who may be harder to reach, such as black, Asian and other minority groups. Listening events had been set up targeting those women and birthing people and learning was taken from these events to improve them for the future and encourage further engagement.

Learning, continuous improvement and innovation

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.

Leaders encouraged innovation and participation in research. The service collaborated with researchers to support research studies. For example, the service partnered with other UK hospitals, the Twin Trust and international research projects. There were dedicated midwives who had additional qualifications in research. This showed a dedication to learning and improving care, both for women and birthing people now, but also for the future.

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and were aware of where they could access updates and learning, such as 'Friday's News' and the 'Top Five' during handovers. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had an education lead midwife and team who were involved in weekly incident review meetings so learning could be embedded into training plans. New ways of sharing learning and guidance were also being considered, such as podcasts, to increase engagement with staff.

Outstanding practice

The bereavement facilities were exceptional. There was dedicated, sound proofed space, which was well decorated and a calming environment for women, birthing people and their families to spend time after a sad baby loss. There was dedicated support for women and birthing people who'd had traumatic birth experiences or perinatal losses. The trust worked with charities to extend the support available to women, birthing people and families.

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 SHOULD take to improve:

- The service should have a process in place to ensure checks are made on necessary equipment in areas when the areas are not in use, to ensure they remain ready to use.
- There should be sufficient CTG paper available and accessible to necessary staff at all times to ensure ongoing monitoring of babies when required.
- The service should ensure, in line with trust policy, all indicated staff are trained to adult safeguarding level 3 and that staff are aware of how they can assess young women and birthing people at risk of child sexual exploitation.
- The service should continue to improve staffing and recruitment to ensure a fully staffed service.

Maternity

- The service should follow its medication policies in the safe storage and monitoring of medicines and homely remedies.
- The service should continue to develop an effective maternity-specific annual auditing programme.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors. Two Specialist Advisors (SpAs) also supported the inspection. A SpA is a person with specialist knowledge to support inspections. The inspection team was overseen by a Head of Hospital Inspection.

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