East Suffolk and North Essex NHS Foundation Trust

The Ipswich Hospital

Inspection report

Heath Road
Ipswich
IP4 5PD
Tel: 01473712233
www.ipswichhospital.nhs.uk

Date of inspection visit: 07 April to 15 April 2021
Date of publication: 16/06/2021

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at The Ipswich Hospital

Requires Improvement 

East Suffolk and North Essex NHS Foundation Trust (ESNEFT) provides both acute hospital and community health care and was formed on 1 July 2018 following the acquisition of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust. ESNEFT maternity consists of services at Ipswich, Colchester and Clacton.

At Ipswich Hospital, the delivery suite consists of six birthing rooms with three fully equipped obstetrics and gynaecology theatres, of which one is a dedicated emergency obstetric theatre to support consultant-led care and a three bedded midwifery-led birthing unit for women identified as low risk of complications. The triage area contains three beds, with two assessment rooms and a quiet room which can be used for bereaved families. The maternity ward has 23 beds and accommodates both antenatal and postnatal women. In addition, specialist midwives for cardiotocography, bereavement, clinical effectiveness, practice development, mental health, birth choices, safeguarding, smoking cessation, antenatal and new-born screening and infant feeding work within the multi-disciplinary teams. Ultrasound is provided at Ipswich and Colchester sites and includes fetal medicine specialist services.

From April 2020 to March 2021 there were 3137 deliveries at Ipswich Hospital.

We last inspected the maternity service at Ipswich Hospital between 11 June and 18 July 2019. The report was published on the 8 January 2020. The maternity service was rated good overall, with safe rated as requires improvement, effective, caring and well led rated as good and responsive rated as outstanding. The trust was issued with two requirement notices in relation to breaches in Regulation 12 of the Health and Social Care Act (RA) Regulations 2014 and was told to improve.

We carried out this unannounced, focused inspection of maternity services because of emerging concerns in relation to the safety and quality of the services.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. We carried out a focused safety inspection of maternity services related to the concerns raised, this does not include all our key lines of enquiry (KLOEs).

How we carried out the inspection

As part of this inspection we visited the following areas within the maternity services; maternity triage, the consultant-led delivery suite, ante-natal and post-natal ward and maternity theatre. We spoke with 26 members of staff; including service leads, matrons, midwives, doctors, maternity care assistants and administrative staff. We observed care, attended two handover meetings and ward rounds and reviewed 10 sets of maternity records. We reviewed two emergency trolleys and carried out medicine checks on two ward areas. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information about this service.

Our findings

Focused inspections can result in an updated rating for any key questions that are inspected if we have identified a breach of regulation and issued a requirement notice. In these cases, the ratings will be limited to requires improvement. Because of this, there were changes to ratings for maternity services. Safe remained the same but well led went down giving an overall rating of requires improvement for maternity services at Ipswich Hospital.

Our rating of services went down. We rated them as requires improvement because:

- Staff did not always feel respected, supported and valued by the leadership teams. Staff were not clear about their roles and responsibilities. Staff we spoke with told us morale was low and there was a disconnect between unit staff and the leadership team.
- Leaders and teams did not always use systems to manage performance effectively. There was insufficient oversight and management of risks. The risk register was not up to date and leaders were unaware that mitigating actions were not being carried out. Some incidents were graded as no harm thereby potentially missing the opportunity to review the incidents in greater detail and improve practice.
- The service did not have 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. The number of midwives and maternity care assistants on duty did not match the planned numbers.
- Not all staff had completed mandatory training or specialist training in line with trust requirements. Compliance rates for medical staff were low. Managers could not be assured that medical staff were competent in key aspects of their role due to failure to complete this training.

See the Maternity section for what we found.

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

Requires Improvement 

- Staff did not always feel respected, supported and valued by the leadership teams. Staff were not clear about their roles and responsibilities. Staff we spoke with told us morale was low and there was a disconnect between unit staff and the leadership team.
- Leaders and teams did not always use systems to manage performance effectively. There was insufficient oversight and management of risks. The risk register was not up to date and leaders were unaware that mitigating actions were not being carried out. Some incidents were graded as no harm thereby potentially missing the opportunity to review the incidents in greater detail and improve practice.
- The service did not have 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. The number of midwives and maternity care assistants on duty did not match the planned numbers.
- Not all staff had completed mandatory training or specialist training in line with trust requirements. Compliance rates for medical staff were low. Managers could not be assured that medical staff were competent in key aspects of their role due to failure to complete this training.

However:

- Staff we spoke with told us they felt supported by their peers and they worked well as a team. They were focused on the needs of women receiving care and providing the best care possible.
- Managers and staff carried out a comprehensive programme of audits and quality improvement work to improve maternity care. The trust was trialling autistic support plans developed using experiences of caring for women with autism and were designed to enhance maternity care for women with autism or those who had learning disabilities.

Is the service safe?

Requires Improvement 

Mandatory Training

The service provided mandatory training to all key staff, however not everyone completed it.

Mandatory training was suspended during the pandemic with the exception of basic life support and neonatal life support training. Suspension of training had affected the number of staff compliant with the usual requirements. The service set a target of 95% for the completion of mandatory training. However, of the 22 mandatory training modules, none of these had achieved the target rate. For example, information provided by the service following our inspection indicated that 59% of staff had completed adult basic life support, 55% had completed blood transfusion training, 66% venous thromboembolism (VTE) awareness and sepsis completion rates were 80%. The compliance rate for cardiotocography training; training for electronic fetal monitoring was 83%. On 14 April 2021, the average completion rate for staff across all mandatory training was 79%. This was not in line with local policy and meant some staff did not have the key skills in those areas to keep people safe.

Maternity

Compliance with training for the growth assessment protocol (GAP) to understand measuring fetal growth training was 73% which meant staff compliance was not in line with national guidance (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)).

Safeguarding

Staff understood how to protect women 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, compliance with safeguarding training was below the trust's target of 95%.

Not all staff were up to date with their training, specific to their role, on how to recognise and report abuse. All safeguarding training had been suspended during the pandemic and level 3 safeguarding training was being delivered by virtual means instead of face-to-face. The service set a target of 95% for the completion of safeguarding training.

Following our inspection, we asked for compliance rates for safeguarding training for adults and children. Compliance rates were low with 29% of medical staff and 75% of midwifery and nursing staff having completed level 3 safeguarding childrens training. The Intercollegiate guidance states level 3 training should be completed, or a plan should be in place to complete by August 2021 for registered health care staff who engage in assessing, planning, intervening and evaluating the needs of children and adults where there are safeguarding concerns. Compliance rates for safeguarding adults training level 3 were not provided.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse; initial data received indicated 87% of nursing and midwifery staff, and 71% of medical staff had completed the relevant safeguarding training. During our inspection staff were able to give us examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to tell us how to make a safeguarding referral and who to inform if they had concerns.

On the day of our inspection, we asked about the baby abduction policy and staff were unable to show us where to find this. The trust had restricted visiting at Ipswich Hospital during the pandemic, which included birthing partners. Following our inspection, we asked for details of the last two abduction drills and information provided showed abduction drills had not been carried out. We reviewed the baby abduction plan and there was no reference or link to abduction drills. Therefore, we were not assured that staff would know the appropriate actions to take should a baby abduction take place which meant a potential risk to the safety of babies in the unit.

Cleanliness, infection control and hygiene

Staff followed infection control principles including the use of personal protective equipment (PPE) and staff were bare below the elbows. Ward areas we visited were visibly clean and had suitable furnishings which were well-maintained.

Hand washing and personal protective equipment (PPE) audits were carried out regularly although hand hygiene audits did not follow World Health Organisation (WHO) guidance. Following our inspection, we reviewed three audits for hand hygiene, handwashing and PPE. PPE audits were undertaken by the shift co-ordinator who observed staff between January and March 2021 and found 99% compliance rates. Hand hygiene records from October 2020 to January 2021 did not measure all the World Health Organisation 5 moments for hand hygiene measures. The moments when handwashing should take place are before touching a patient, before clean/aseptic procedures, after body fluid

exposure/risk, after touching a patient, and after touching patient surroundings. Audits were carried out monthly and measured staff compliance in some of the areas. For example, in November the audit recorded how many staff cleaned their hands after patient contact. In January records showed the number of staff who had cleaned their hands after touching the patient surroundings. In December the audit showed staff compliance in four out of five of the 5 Moments for Hand Hygiene had been recorded. There was no data for hand hygiene records in February 2021 due to pressures arising from the pandemic. Following our inspection, we asked for handwashing audits from January to March 2021. Information provided by the trust showed 100% compliance for midwifery staff and maternity care assistants. However, data which had been collected for the handwashing audit in March 2021 had been misplaced by the trust. This meant the trust could not be assured that staff were complying with infection control measures and that patients and staff were protected from infection when audits carried out were lost or did not include all aspects of the WHO guidance.

Environment and Equipment

The design, maintenance and use of facilities, premises and equipment did not follow national guidance.

The trust mitigated risks by using control measures such as staff training and evacuation drills although these were not always carried out. The design of the environment was not in keeping with the Department of Health, Health Building Note 09-02. Health Building Note 09-02 states there should be functional relationships between all birthing facilities areas, easy access from the main entrance and birthing rooms. The location of the obstetric operating theatre being critical, with theatre(s) close to the neonatal unit, for ease of transfer of the baby, with good access to adult critical care facilities.

At Ipswich hospital maternity services were located in a tower block with the obstetric theatres on level eight and the delivery suite on level four. The midwife-led birthing centre and antenatal and postnatal wards were located on floors two and three. Birthing rooms on the delivery suite did not have ensuite facilities. There were six delivery rooms, two assessment rooms and one quiet room which was also used as a bereavement room. The antenatal and post-natal wards contained 23 beds with five for induction of labour. On the day of the inspection we reviewed the emergency trolley and found daily checks were carried out with no gaps. We reviewed equipment including the resuscitaire, delivery trolley, glucose machine, grab bag, oxygen and sepsis box and saw these had been checked daily.

Access to the unit on all floors was by a lift which was also used by the public. This meant there was a potential risk of delay to transfer from one area to another. The location of maternity services and resulting environmental risks had been included on the trust risk register. Leaders at the trust had mitigated environmental risks by putting in place control measures such as using a card to call the lift in an emergency and providing training and simulation of evacuation drills. Following our inspection, we requested a record of the last two evacuation drills and saw these were carried out in February and March 2020; the risk register mitigation stated drills should be monthly. Both drill records showed two runs were carried out on each date with learning from the first drill applied to the second to increase efficiency and speed. We were concerned that a year had lapsed since the last evacuation drills which meant a potential risk to women's safety as new staff may not be familiar with the procedure. Visitors accessed the maternity unit through a buzzer system to gain entry or exit. Authorised staff were issued with swipe cards to access to the unit to ensure the area was secure.

Assessing and responding to patient risk

Staff did not always complete up to date risk assessments for each woman and take action to remove or minimise risks. Staff did not always identify and act upon women at risk of deterioration.

Maternity

At our previous inspection, between the 11 June and 18 July 2019, the trust was issued with a requirement notice. Improvement was required to ensure all risk assessments were completed for women and that all women had their physiological observations monitored in accordance with local policy. At this inspection we reviewed the care records of 10 women and found staff had completed risk assessments for nine of the women on admission / arrival, using the modified early obstetric warning system (MEOWS) and we found this was reviewed regularly. At Ipswich the service incorporated the Intrapartum Fetal Monitoring Risk Assessment tool into each woman's labour documentation. This was in line with Saving Babies Lives v2 (2019), which recommended that every woman is risk assessed on admission and throughout labour to guide the nature, frequency and interpretation of fetal monitoring.

Staff knew about and dealt with sepsis. Sepsis is a life-threatening reaction to an infection. However, staff did not always complete venous thromboembolism (VTE) risk assessments in line with the service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein. We reviewed the records of 10 women and found VTE risk assessments were completed in eight out of the 10 records. A 'fresh eyes' approach to cardiotocography (CTG) interpretation was in place for those women who required continuous CTG monitoring. This was in line with national recommendations (NHS England, Saving Babies Lives v2: A care bundle for reducing perinatal mortality (March 2019)). The 'fresh eyes' approach meant the CTG was reviewed by a different midwife to ensure it was correctly interpreted and where appropriate was escalated. The 'fresh eyes' approach had been performed in five out of the six records we reviewed. The service carried out an audit which found the mean percentage of correct number of fresh eyes stickers used in relation to the length of labour was 85.6%.

Staff used the World Health Organisation (WHO) and five steps to safer surgery checklist 'in obstetric theatres. Staff completed the surgical safety checklist and audits showed completion rates for the period September 2020 to February 2021 were 99.8%. Swab counts were performed and signed by two professionals.

The service monitored the incidence of puerperal sepsis and other puerperal infections within 42 days of delivery and readmission rates for infections in mothers and baby. Information provided by the trust showed there had been nine incidences of puerperal sepsis which had led to a re-admission from October 2020 to March 2021.

The maternity triage system had been introduced to assess women 16 weeks pregnant and onwards, 24 hours a day, seven days a week, who required further care or assessment. On the day of our inspection, the unit was staffed by two midwives, one student midwife and one maternity care assistant and the triage area included three beds. The unit was supported by the obstetric team which reviewed women once they had been assessed by the midwives. Staff were responsible for answering telephone calls from women with concerns and all telephone calls from women were diverted to triage to assess their requirements. Staff used a red, amber, green (RAG) rating system to ensure women were treated according to priority of need. Staff working on the triage unit carried out the maternity early obstetric warning system (MEOWS) observations and undertook a full antenatal examination.

Data submitted by the trust following our inspection demonstrated staff provided one-to-one care for women for 99% of the time from April 2020 to March 2021. The National Institute for Health and Care Excellence (NICE) guidance recommends one-to-one care 100% of the time as it aims to ensure each woman has a good experience of care and reduces the likelihood of problems for the woman and her baby.

Following our inspection, we asked how the service monitored delays to induction of labour. Information provided by the trust demonstrated that staff used an electronic reporting system and incidents were continuously monitored. However, due to pressures on staffing during the pandemic, quality improvement work was unable to continue for the auditing of delays to induction of labour after the last audit in July 2019. Audits had been carried out yearly from 2014 to

2019 prior to this audit. The last audit in July 2019 showed a decrease in red flags and an increase in normal vaginal deliveries between 2018 and 2019 which coincided with the opening of the Nova induction suite. The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The Acorn team supported vulnerable women.

The midwifery coordinator in charge of the labour ward should have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is effective oversight of all birth activity within the service. Staff told us the delivery suite coordinator was not supernumerary. "To ensure 24-hour managerial cover, each labour ward must have a rota of experienced senior midwives as labour ward shift coordinators, supernumerary to the staffing numbers required for one-to-one care. Their role is pivotal in facilitating communication between professionals and in overseeing appropriate use of resources." 'Safer Childbirth recommendations' (October 2007). This meant the service was not compliant with 'Safer Childbirth recommendations, October 2007, which states that each delivery suite must have a rota of experienced senior midwives as delivery suite shift coordinators, supernumerary to the staffing numbers required for one-to-one care.'

Midwifery and Nursing Staffing

The service did not have enough maternity staff 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 using an acuity tool. There were high rates of bank staff which relied on current staff working extra hours.

Managers accurately calculated and reviewed the number and grade of midwives, nursing assistants and maternity care assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of women. However, the number of midwives and maternity care assistants did not always match the planned numbers. For each 24-hour period, 28 registered midwife shifts of 11.5 hours and 11 maternity care assistant shifts of 11.5 hours were required to fill the template. Information provided by the trust showed that in January 92% of hours for midwives and 84% for maternity support workers were filled, in February this was 91% and 87% respectively and for March 90% for both midwives and maternity support workers. This meant managers could not be assured there were sufficient numbers of staff to care for women and to keep them safe.

Following our inspection, we asked the trust for further information about the last time the trust used agency staff and the reasons why agency staff were not used. Leaders told us they did not routinely use agency staff and no agency staff had been used during 2020. One agency staff member was used twice in March 2021 for a total of two shifts which did not align with information that had already been provided. Information sent by the trust told us agency use had been discouraged due to the increased risk of staff travelling from outside the local area during the pandemic. Even though hours were regularly unfilled leaving gaps, managers did not use agency staff to fill them. Information provided by leaders after the inspection and during the quality review process, indicated agency staff were sourced but were unavailable.

To help address staff shortages and to provide mitigation, the service used bank nurses. Information submitted following our inspection, showed the service used high rates of bank nurses from January to March 2021. Staffing was a risk listed on the service' risk register and planned bank staffing use was intended to cover staff breaks as well as increase resourcing. From January to March 2021 bank staff made up 19% of midwives and 27% of maternity care assistants. Bank staffing relied on current staff working extra hours and staff told us they were exhausted. We were concerned that adding additional hours to already tired staff was not a sustainable solution and posed a risk to women's safety and staff wellbeing. Staff escalated staffing concerns by completing an incident report and ensuring senior staff were aware.

Maternity

The service had reducing vacancy rates. Vacancy rates for nursing, midwifery staff and medical staff from January to March 2021 were on average 4.7%; vacancy rates for the year from April 2020 to March 2021 were on average 3.8%.

The service had variable turnover rates. The staff turnover rate for the previous 12 months to March 2021 was 7.8%. The service had reducing sickness rates. Average sickness rates from April 2020 to March 2021 were 4.3%. Sickness rates were 2.5% for March 2021.

We reviewed the maternity dashboard data (February 2021) that detailed 14 diverts in total between March and December 2020, these figures were trust wide and therefore included Colchester General Hospital data. At Ipswich maternity services were placed on black alert and a divert was put in place on 6 April 2021, the day before our inspection, due to unsafe staffing levels. Information received from the trust showed there had been two additional diverts at Ipswich, in February and March due to high acuity women and staffing levels below those required for safe care.

At our previous inspection from 11 June to 18 July 2019, the service had developed the Nova suite which was an area where women could relax while waiting for labour to establish after being induced. During the pandemic, the Nova suite had been used to accommodate women who had tested positive for Covid-19. After Covid-19 levels reduced, the Nova suite had been due to re-open, but the re-opening date had been delayed as the service was unable to staff the unit. The Nova suite had been introduced following women's feedback of long waits and a poor environment for induction of labour. As the Nova suite was unable to open, this meant the options available to women were reduced and women's experience of labour and choices may have been adversely affected.

Medical Staffing

The service had enough medical staff to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and babies safe; when we reviewed the rotas, we found that medical staffing actual numbers matched the planned numbers. Rotas contained an effective skill mix of consultants, speciality registrars and core trainee doctors on each shift. The unit had consultant labour ward presence during weekday daytime working hours Monday to Friday in line with the Royal College of Obstetrician and Gynaecology guidance (RCOG) Providing Quality Care for Women: Obstetrics and Gynaecology Workforce 2016)). Antenatal clinics were staffed by consultants and registrars and obstetric rotas on call contained a mix of all three medical staff types with an additional second consultant on call. Staff had allocated administration time within the rota to ensure they kept up to date with administration tasks. There was an effective system of medical workforce planning to the required standard. The service had 0% turnover rate for medical staff and average sickness rates from April 2020 to March 2021 were 0.1%. The service had low rates of locum staff using on average 0.3 whole time equivalent (WTE) consultant cover and 0.8 WTE junior doctor cover from January to March 2021. On the day of our inspection we spoke with junior doctors who told us they felt supported and supervised.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always clear, up-to-date or easy to navigate but were stored securely.

Maternity

Women's notes were not always comprehensive. Staff used handwritten notes and forms which were not always easy to navigate or in an easily accessible order. Staff we spoke with told us information management systems in current use were time-consuming as well as inefficient and took them away from their role caring for women.

Women and babies individual care records, including clinical data, were not always managed in a way that kept them safe. We reviewed 10 sets of women's records that contained gaps and were not in line with records management code of practice for health and social care. In all 10 records, all entries were dated and signed but three were not timed. Records we reviewed showed women were not always asked about domestic abuse in two out of ten records, or mental health, one record, and fetal movements were not always recorded at each antenatal visit after 25 weeks in three of the 10 sets of records. Records were stored securely.

Incidents

Staff recognised and reported incidents and near misses. However, some incidents were graded as no harm thereby potentially missing the opportunity to review the incidents in greater detail and improve practice. 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.

Managers investigated incidents using the Patient Safety Incident Response Framework (PSIRF) which was introduced as a new framework for managing incidents in November 2020. The framework outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted.

Staff we spoke with told us they were encouraged to report incidents, they knew what incidents to report, how to report them and they received feedback about incidents they reported. The trust used an electronic reporting system which all grades of staff had access to.

Following our inspection, we asked for a list of all the reported incidents from 1 December 2020 to 31 March 2021. Incidents we reviewed including information that showed an apology was made to women in line with the duty of candour when care provided was below the level required. We reviewed 279 incidents for Ipswich from December 2020 to March 2021 and this included 24 post-partum haemorrhage (PPH) incidents with blood loss of 1500ml or more that were graded as no or low harm. By rating the PPH incidents as no or low harm, opportunities could be missed to review the incidents in greater detail, collate learning and improve practice. Women who experienced blood loss of 1500mls or more should have received follow up care to ensure they recovered fully. We were not assured that every woman who had experienced PPH received follow up care to ensure they had fully recovered. We saw PPH incidents were included on the maternity morbidity and mortality part of the maternity dashboard. Incidents involving PPH blood loss of 1000 to 1999mls were described as moderate and those of 2000mls or more were defined as severe. Information received from the trust showed that ESNEFT was an outlier for PPH and PPH is a high-risk emergency for women. Following the inspection, the trust told us that all incidents of PPH were reviewed irrespective of harm grading and that a PPH improvement plan was in place.

Following our inspection, we asked how incidents categorised as no or low harm were reviewed. Information received from the trust showed ward leads and the maternity governance team reviewed and were involved with the management of incidents. Any identified themes were shared with teams, for example, in the weekly 'Word on the Block' newsletter, at risk and governance meetings, clinical review meetings or at local level meetings. We reviewed risk and governance meeting minutes and saw serious incidents and incident reporting were discussed. The trust's patient safety team also reviewed all incidents reported.

Maternity

The service had no never events on any wards in the last twelve months. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Staff we spoke with told us they received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice, although performance was below targets set by the trust. Managers and staff carried out a comprehensive programme of audits. However, audits were not repeated to check improvement over time.

Information about the outcomes of women's care and treatment was routinely collected and monitored. The trust had a maternity dashboard in place based on the Royal College of Obstetricians and Gynaecology (RCOG) guidance, which was included in the Patient Safety Incident Response Framework (PSIRF) as part of the maternity assurance report. We reviewed the maternity dashboard, which was RAG-rated (red, amber and green) and displayed clinical data from April 2020 to March 2021. Targets were set in areas such as 1:1 care in established labour, post-partum haemorrhage (PPH) moderate (1000-1999mls), PPH severe (2000mls and over), smoking, intrapartum transfers of care, mode of delivery and neonatal morbidity and mortality. Analysis from the dashboard showed PPH moderate levels were rated red for 11 months out of 12, with the average rate of 9%. This exceeded the trust target which was to be less than 4%.

Data from the dashboard showed quality improvement (QI) projects aimed at reducing PPH levels had been paused during the pandemic and practical obstetric multi-professional training (PROMPT) compliance which covered PPH skills and drills and human factors was below trust requirements of 90%. PROMPT training helps midwives, obstetricians, anaesthetists and other maternity team members be safer and work together more effectively.

Information received from the trust prior to our inspection showed doctors were being booked onto PROMPT training courses and that trust compliance rates should be achieved by mid-July 2021. This demonstrated the service had taken action to improve compliance rates. Quality improvement (QI) projects were planned to be re-instated when it was safe with staffing and acuity to do so. Other areas identifying as red on the dashboard related to 1:1 staffing. Three out of the last twelve months on Deben ward and two out of the last twelve months on the Brook Birth Centre, staffing levels had dropped below 1:1 care. This was not in line with NICE guidance which recommends one-to-one care 100% of the time to reduce the likelihood of problems for the woman and her baby.

Although managers and staff carried out and we saw a comprehensive programme of audits, we were not able to see evidence of repeated audits to check improvement over time. Maternity services participated in four national audits although two were suspended due to the pandemic. The National Pregnancy in Diabetes (NPID) audit measured the quality of antenatal care and pregnancy outcomes for women with pre-gestational diabetes. Although this audit was currently suspended, we reviewed the audit carried out in 2019 to look at local outcomes. The audit considered types of delivery, glucose control and folic acid supplementation and trends in labour and delivery. Overall outcomes at Ipswich Hospital for women with pre-gestational diabetes were better than regional comparison and either in line with or better than national averages. Recommendations included continuing to work towards better blood glucose control in pregnancy and improving pre-pregnancy care by working with primary care and other agencies.

Maternity

Audits of monochorionic twins at Ipswich focused on monochorionic diamniotic (MCDA) twins. This type of twins has the highest risk of twin-twin transfusion syndrome (TTTS), which is an abnormality of the placenta, so more scans and monitoring are required. The audit reviewed data from January 2017 to July 2020 and reviewed compliance with five statements from NICE guidance and neonatal morbidity and mortality outcomes. Rates of compliance were high with 95% of women having participated in a discussion about preterm labour by 24 weeks and 98% of women with a multiple pregnancy having their fetuses labelled using ultrasound. Outcomes were mixed with 0% mortality in the neonatal period and 8.1% had severe morbidity, with all the latter group delivering before 32 weeks gestation. Recommendations included a re-audit in two years, setting up a twin clinic at Ipswich Hospital as per NICE recommendations and two weekly scanning in 100% of all MCDA twins.

The clinical effectiveness midwife had reviewed all unexpected term admissions to the neonatal unit (NNU). An unexpected term admission to the NNU is seen as an indicator that harm may have been caused at some point along the maternity or neonatal pathway. There was an ongoing audit in place which reviewed all unexpected term admission data for women between 37 and 40 weeks pregnant. The audit collected data daily which was then discussed at the term admissions review each week. An audit was carried out in September 2020 for the period August 2019 to July 2020. Themes were developed from the data which included poor communication, delays in care and temperature control. An improvement plan with actions was put in place to reduce unexpected term admissions. Actions consisted of room temperature audits, to continue the term admission audits and to keep transitional care midwives to provide effective care and support to both families and NNU team.

The smoking cessation specialist midwife at Ipswich reviewed data monthly from April to December 2020 and monitored smoking rates at the time of delivery. The Long-Term NHS Plan states smoking rates should be reduced to 6% by 2022. The audits showed smoking rates had been reduced on average from 8.3% from January to December 2019 to 5.1% from January to December 2020. Data contained in the audit also reviewed antenatal advice given and showed 685 contacts were made with no recorded advice out of 956 total contacts. This demonstrated in the majority of contacts between maternity staff and women, opportunities were not taken to discuss the dangers of smoking with women and the health implications. We saw the audit contained learning points for staff which included making every contact count as a discussion may be the first step to smoking cessation.

Following the inspection, we asked for further information about how induction delays were monitored. Senior staff told us induction delays were continuously audited and presented at obstetric audit afternoons and the labour ward forum. However, we saw the most recent presentation was in 2019 using data from March to June 2019. Audits had been carried out yearly from 2014 to 2019 prior to this audit. The latest audit compared data prior to the opening of the Nova suite to improve the induction of labour experience for women to after it had opened. Audit data reflected a decrease in red flags and an increase in vaginal deliveries following the opening of the Nova suite. Recommendations were to continue the audit with analysis every six months and to continue work towards offering outpatient induction of labour. Maternity services now offered outpatient induction of labour in order to avoid unnecessary hospital admissions and increase maternal satisfaction. Results showed all the women participating in the audit recommended this method of induction.

An example of cross-site improvement audit work was being carried out. This included a deep dive of all women coded as having sepsis during September 2020 was initiated and reported in January 2021. This was due to a disparity in sepsis rates at Ipswich and Colchester General Hospitals. Conclusions showed that 5 out of 14 women had been coded incorrectly with actions recommended to improve safety including improved decision to treatment time for neonates at risk of sepsis. Action plans resulting from the audit recommended a potential change to amber flag sepsis treatment, training and sharing sessions for staff and an increase in staffing to ensure blood cultures were completed in a timelier manner.

Maternity

The trust was trialling autistic support plan guidance developed by a midwife with autism and their maternity colleagues. They had developed three support plans: My Pregnancy Support Plan, My Birth Plan and Postnatal Information to give women important pregnancy information. The plans were developed using experiences of caring for women with autism and were designed to enhance maternity care for women with autism or those who had learning disabilities. The quality improvement team created and circulated a weekly newsletter 'Word on the Block' to remind maternity staff of procedures, support available to them and guidance.

The maternity service had previously received United Nations Children's Fund (UNICEF) UK Baby Friendly Initiative accreditation which is a nationally recognised mark of quality care. In January 2020, after a re-assessment, assessors found Ipswich Hospital had met some but not all of the standards for re-accreditation. Assessors found positive work was taking place although improvements in some areas was required before accreditation could be re-awarded. This meant standards had fallen below those previously found and UNICEF assessors were unable to accredit the unit as baby friendly. On the day of the inspection staff we spoke with told us an infant feeding midwife had recently been recruited following the retirement of the previous post holder, and was due to start the month following our inspection.

Competent staff

The service did not always ensure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

All new staff received a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff participated in annual appraisals; 85% of midwifery and maternity care assistants and 90% of medical staff had received an appraisal in the last year.

Staff were trained to deliver the practical obstetric multi-professional training (PROMPT) approach to obstetric emergency training. Information provided by the trust acknowledged there was poor obstetric compliance in attending the in-house PROMPT training which covered teaching on PPH skills and drills and human factors. At Ipswich PROMPT achievement rates were 73% for midwives, 16% for consultants, 11% for doctors and 8% for anaesthetists. Information received from the trust showed compliance rates had been escalated and all doctors had been allocated sessions to attend. Compliance rates should be 90% in all required staff groups. Information received following our inspection indicated that staff would achieve this rate by 15 July 2021.

Managers did not make sure staff received specialist training relevant for their role. Compliance rates for specialist training varied significantly across staff groups. For example, completion rates for GAP (Growth Assessment Protocol) training to reduce stillbirths were 15% for doctors and 81% for substantive and bank midwives and cardiotocography (CTG) training for fetal monitoring rates showed 37% of consultants, 79% of doctors and 85% of midwives had completed this. "The importance of good fetal monitoring during labour, in achieving delivery of a healthy baby, is underlined by data from the Royal College of Obstetricians and Gynaecologists Each Baby Counts report, showing that foetal monitoring was identified in 74% of babies as a critical contributory factor where improvement in care may have prevented the outcome." Saving Babies Lives version 2. The second version of the Saving Babies' Lives Care Bundle aims to achieve a 50% reduction in the rate of pre-term and stillbirths in the UK by 2025. A key element of this work is effective fetal monitoring. Managers were not assured that medical staff were competent in key aspects of their role due to failure to complete this specialist training.

The clinical educators supported the learning and development needs of staff. They led and were involved in quality improvement work. Specialist midwives including quality improvement and clinical effectiveness midwives provided specialist skills and knowledge to their maternity colleagues. Midwives with particular skills and experience developed autistic and learning disability support plans and guidance to enhance maternity care.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit women. Although staff held regular multidisciplinary meetings to discuss women, the meetings were unstructured, and attendance was inconsistent.

Multidisciplinary meetings were inconsistent, attendance was ad-hoc and meetings were not always formally structured. There were missed opportunities to work cohesively across the trust.
We observed several meetings/huddles throughout the day with medical staff and multi-disciplinary teams. Some were well-facilitated and involved all the key people with a clear format. Others were less well-managed and were conducted in a brisk manner. Staff who facilitated handovers did not a follow a structured format, for example, using a situation, background, assessment, recommendation (SBAR) format. SBAR is a tool used to facilitate prompt and appropriate communication between wards and services. This might mean key messages about women's care were not always shared to provide effective care.

Staff did not have regular cross-site multi-disciplinary meetings or interactions with Colchester General Hospital maternity unit with their colleagues in managing the care of women. Staff from each site used different policies and guidance documents despite being the same trust. This meant that staff worked together in different ways of working and they were not consistent and cohesively caring for women across the two sites.

Is the service well-led?

Requires Improvement 

Leadership

We were not assured that service leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety culture within the organisation. There had been significant change in senior leadership, resulting in vacant positions, which had led to a deficit in accountability and ownership. Leaders were not making a demonstrable impact on the quality or sustainability of services.

Maternity services sat within the women's and children's division in the trust's structure and was led by a divisional management team which comprised of a divisional director, an associate director of operations, a director of midwifery and a head of nursing. The divisional management team had oversight of the women's clinical delivery group which in turn oversaw both the Ipswich and Colchester operational groups.

At the time of our inspection, the director of midwifery post was vacant; however, this position had been recruited to and the new director of midwifery was due to take up their position in three months' time. The trust had a non-executive director with responsibility for maternity to provide challenge and independent oversight to the board which was a

required action from the last inspection between 11 June and 18 July 2019. There was a head of midwifery (HOM) in post who worked alongside several managers including an obstetric governance lead, labour ward lead and matron. Senior staff we spoke with identified that the addition of a clinical director within the divisional team to provide oversight and clear leadership, would be beneficial.

The 'Spotlight on Maternity' March 2016 stated 'to ensure that there is a board-level focus on improving safety and outcomes in maternity services, organisations should provide the opportunity for the medical director for maternity and the head of midwifery (HOM) to present regularly to the board.' The HOM did not have regular contact with the divisional director or have direct access to present regularly to the board in line with Spotlight for Maternity 2016. Information provided by the trust during our quality review stated the Director of Midwifery is invited to attend board assurance committees (when in post). The management structure did not provide an effective environment for maternity leaders to ensure maternity matters were given sufficient priority. We were not assured the senior team had a good understanding of the day to day pressures and risk. Staff we spoke with told us they had escalated staffing and safety concerns to the senior team. Concerns had been listened to but had not met a response which acted upon the concerns raised. Staff we spoke with told us the escalation pathway was not used. The people nominated were not able to respond to queries, so staff bypassed them and went directly to the matron or specialist midwife nominated next in line instead.

There was insufficient leadership capacity and a lack of stability in maternity services. The director of midwifery post had been vacant at the same time as the head of midwifery had been shielding during Covid-19 and the latter was due to retire in the next six months. The inpatient matron had also been vacant, although had now been recruited to and was due to start in May 2021.

Staff we spoke with told us the senior leadership team were not visible or accessible. Staff said they had seen the chief nurse who had visited the site and spent time in maternity services, and they were not aware they carried out the board safety champion role and what this involved but they had not seen other senior leaders. Most staff including the service's senior leadership team, midwifery staff and medical staff reported there had been a poor culture and challenging relationships over the previous eighteen months. All maternity staff we spoke with reported a disconnect and lack of regular and effective interaction with the divisional leadership team.

The Clinical Negligence Scheme for Trusts (CNST), developed in partnership with the national maternity safety champions, rewards trusts that met 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. One of the actions required trust safety champions to meet bi-monthly with board level champions. Meetings were taking place regularly with Ipswich trust and board safety champions and relevant staff were meeting monthly from 25 February 2021. The service had reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme which was another of the 10 actions. The trust had met some of the other eight actions including the maternity services data set, avoiding term admissions into neonatal units and additional midwifery staffing had been approved in January 2021. Action four which was neonatal medical workforce had not been met, MDT emergency training had not yet been met although was on target and action seven user feedback had been affected by the pandemic.

There remained no clear vision or strategy in place for maternity services**.** This had been raised as a concern during our previous inspection, between the 11 June and 18 July 2019. The trust had not acted on the actions required from the previous inspection to ensure the maternity service had a strategy, vision and values. We found there had been a lack of progress in implementing a service strategy. Information provided by the trust showed that maternity services were working across all acute and community services and with Maternity Voices Partnerships to deliver a strategic plan and maternity vision which addressed the needs of the diverse communities and their families, to enable ESNEFT to deliver a

truly person-centred service. There was no timeframe for this work to be completed. Without a vision or strategy, leaders and staff were unable to understand how their role fitted in to the organisation's aims and how progress in maternity services could be monitored and improved. Senior staff we spoke with told us a maternity strategy had previously been developed but had not been approved as there was insufficient focus on the local service and staff had not been fully consulted. We were concerned that there had been significant delay which meant staff were left without any clear strategic direction for the service.

We requested information about succession planning in maternity services and the trust responded by providing a recruitment update across different staff groups. There was very limited information about leadership roles. There was no reference to a plan for staff to be developed and to take on more senior roles with a view to succession planning for future trust leaders. The trust had known about leadership concerns but had been slow to action them. This demonstrated leaders did not understand the challenges to quality and sustainability as they failed to put in place the actions required to address them.

Culture

Staff did not always feel respected, supported or valued by managers and leaders within the trust. Staff we spoke with told us they felt supported by their peers and they worked well as a team. They were focused on the needs of women receiving care.

Culture at the trust did not always encourage openness and honesty. At the time of our inspection two external reviews had been instigated to consider culture, leadership and the continuity of care. There had been significant delays in organising these independent reviews. During one of our regular engagement meetings in August 2020, we were informed the reasons for the trust initiating the reviews was their commitment to improving the culture. The terms of reference were not formalised until December 2020 and the review started March 2021. We were concerned that delays to the reviews starting would further postpone the findings and any actions and improvements for staff and women.

We spoke with the head of midwifery (HOM), clinical leads and area leads, and staffing was their number one concern. Staffing levels were below the levels required to staff the unit safely on a regular basis. They also referred to the unsuitable environment and IT system which impacted on staff's ability to carry out their role effectively.

On the day of the inspection, staff welcomed us, were friendly and transparent. They spoke with us and shared how they loved their job and caring for women, but they no longer looked forward to coming into work each day. This included staff who had worked for the trust for a significant number of years. Staff discussed how their experience at work had deteriorated over the last eighteen months describing how this had affected their wellbeing and job satisfaction. Staff described how consistently low staffing had made them feel anxious.

Staff we spoke with told us they could raise concerns without fear. However, staff who raised concerns did not always receive feedback or understand why their concerns had not been responded to or actioned. They told us they had escalated concerns but there was a disconnect to leaders who did not understand fully or respond in an appropriate way. Staff we spoke with who had escalated concerns about staffing levels told us this did not lead to the provision of any additional staff.

Results from a survey of Ipswich Hospital maternity staff carried out in April 2019 showed 40% of staff often thought about leaving their job with 80% having the intention to leave. Seventy-two per cent of staff were frustrated by their jobs and 70% were exhausted, with 65% experiencing burnout. One hundred per cent of staff on Orwell, Brook and Deben

wards acknowledged they were feeling burnout. Staff responses to the survey showed they could speak up and people worked well as a team. Seventy-seven per cent said it was easy for personnel to ask questions when there was something that they did not understand and 64% confirmed in this work setting, it was not difficult to speak up if they perceived a problem with care women received.

Maternity staff set up and ran the positive working group in September 2020 to create a more positive working environment and to support each other and enhance team goals. They also worked on the actions resulting from the staff culture survey. We reviewed two meeting minutes and found staff engaged with actions resulting from the staff culture survey which focused on improving staff working conditions, staff satisfaction and improving care for women. Actions included introducing a dedicated support group for newly qualified midwives with protected time to attend, creating a debriefing standard operating procedure to standardise the expectation for staff support following incidents and stop the clock; performing quick 'board rounds' at time-points during the shift to re-evaluate progress and management plans.

Several staff we spoke with referred to bullying within the service and to a difficult working relationship with individual consultants. They referred to a lack of respect and professional differences which on occasion made providing the best care for women challenging. Other staff spoke positively about the culture and cited staffing pressures as the main cause of stress between individuals and staffing groups.

Trust leaders did not always promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi-professional training. There was an ineffective trust board oversight of performance. Compliance rates for specialist training were below the trust's compliance target of 95% for medical staff with significantly higher rates for midwifery staff. "Trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret CTG, use the buddy system at all times and escalate accordingly when concerns arise, or risks develop. This includes staff that are brought in to support a busy service from other clinical areas such as the postnatal ward and the community, as well as locum, agency or bank staff (medical or midwifery)." Saving Babies Lives v2. Practical obstetric multi-professional training (PROMPT) compliance rates for the last 12 months were low for medical staff (54%) and anaesthetists (25%); however, midwives had 91% compliance and support workers 81%. Completion rates for GAP (Growth Assessment Protocol) training to reduce stillbirths were 81% for substantive and bank midwives and 15% for doctors. Cardiotocography or fetal monitoring (CTG) training records showed 85% of midwives, 37% of consultants and 79% of doctors had completed this.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. Although they identified relevant risks and identified actions to reduce their impact, there was insufficient oversight and management of the risk.

Maternity performance, safety and outcome measures were reported through the maternity dashboard, with red, amber, green (RAG) ratings to enable staff to identify metrics that were better or worse than expected. Following our inspection, we reviewed dashboard information including the morbidity and mortality part of the maternity dashboard. Incidents involving postpartum haemorrhage (PPH) blood loss of 1000 to 1999mls were reported as moderate and those of 2000mls or more were defined as severe. Information received from the trust showed they acknowledged that ESNEFT was an outlier for PPH and PPH is a high-risk emergency for women. Incidents analysed after the inspection showed PPH incidents involving blood loss of 1500mls or greater were consistently reported as low or no harm. Therefore, leaders and teams lost the opportunity to review and learn from the incidents and to enable appropriate follow up to ensure a full recovery. We were not assured that the dashboard was reflecting how the incidents were being graded individually.

Maternity

Staff did not have regular cross-site multi-disciplinary meetings or interactions with colleagues at Colchester General Hospital maternity unit around managing women's care. Staff from each site used different policies and guidance documents despite being the same trust and sometimes providing care for the same women. This meant that staff had different ways of working that were not consistent and cohesive to help facilitate effective care for women across the two sites. Whilst each location continued to work in silo, with different processes and policies, such as the post-partum haemorrhage policy, there was the potential for fragmented leadership and a lack of cohesive oversight of quality and risk.

The maternity dashboard was not displayed in clinical areas; this meant that staff and the public were not informed of the outcomes and risks of the maternity service. This was an outstanding action from our previous inspection from 11 June to 18 July 2019.

The service's dashboard was reviewed as part of the Women's Services risk and governance maternity group meeting. We requested the meeting minutes for these and reviewed three sets from January, February and March 2021. The meetings also discussed incidents, complaints, guidelines, the risk register and audits, however not all actions were clearly assigned to a member of staff with a deadline for completion. Agenda items were on hold without an explanation, were difficult to follow or had been rolled forward across several meetings. This was important as approximately half of all attendees invited were unable to attend the meetings in person or online. Therefore, we were not assured that systems of accountability were effective, and we had concerns that the gaps in leadership had a detrimental effect on the level of governance oversight in place.

We reviewed the Ipswich Hospital maternity risk register and saw risks were RAG-rated with mitigating actions. However, there was insufficient oversight of the risk register as not all risk information had been updated and it was difficult to follow. Actions were not nominated to individuals with clear timescales for review. Some entries were brief and contained a long review date with no progress updates other than the risk was on the trust long term plan. Some risks contained information which was duplicated or contained in other risk entries. For example, the risk associated with the current method of document storage of fetal heart trace monitoring had been on the risk register since June 2018 with a review date of May 2021 with no progress or updates. Although it had a separate risk register entry, it also formed part of another risk register entry for the IT system. We saw the Birthrate Plus acuity tool was to be launched to assist with staff numbers and acuity in September 2020 and February 2021, in two separate entries which was contradictory, and the risk register had not been updated to reflect Birthrate Plus was now in place.

Information provided following our inspection showed environmental risks were included in the trust's long-term strategic plan and the risk register contained actions to mitigate the risks. For example, leaders had assessed the risk related to the obstetric theatre being sited away from the remaining maternity services as high. Other environmental risks on the risk register included paediatricians not being able to attend an emergency in a timely manner and the risk to women's privacy and dignity being transferred through public areas at a vulnerable time. Mitigations for these risks had been put in place to reduce risk levels. However, not all the actions put in place to mitigate the risk were being carried out regularly in line with the information on the risk register. For example, information provided following the inspection showed simulations of evacuation drills were last performed in March 2020 even though the risk register stated simulation of emergency transfer to theatre should be carried out monthly. The risk register showed current risk levels had not been re-assessed to take into account the absence of some mitigations and the trust was not monitoring its risks with full oversight. This meant there was a potential risk to women's and staff safety.

There was an alignment between recorded risks and what staff said was on their worry list. All staff we spoke with told us staffing was their main concern. Other risks consistently identified by staff were the unsuitable environment over several floors of a tower block and the lack of an effective electronic IT system.

Maternity

We requested records of the dates baby abduction drills had been carried out and a copy of the baby abduction plan. We received the baby abduction plan, but information received from the trust showed baby abduction drills had not been implemented. The baby abduction plan did not refer to the frequency of the requirement to carry out drills to better prepare staff should this occur. We were not assured that staff would know what to do in the event of a baby abduction and carry out the plan effectively which could increase the risk of harm to babies in the unit.

The trust had insufficient oversight of risk management issues and performance. We saw examples of information governance incidents, patient safety incidents, complaints and audits which all related to the paper-based system. For example, paper audit sheets were lost from the Orwell ward hand washing audits carried out in March 2021. There were information governance incidents reported which referred to documents containing personal data which had been given to the wrong woman. Therefore, leaders were unaware of the full impact of the risk of the current system. It was difficult for the maternity service to collect reliable data and analyse it as paper-based systems were predominantly used. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Although there was a programme of clinical and internal audit, the programme was not systematic. Audit processes were inconsistent; where actions had been identified there was a lack of oversight to ensure these had been completed to measure improvement or to ensure audits were repeated to measure progress. Staff reported data protection incidents and audits demonstrated paper records had been misplaced or given to the wrong woman. The trust was unable to use missing audit data constructively to drive improvement or recognise where performance was positive.

A number of the issues identified during our inspection, were pre-existing issues that had already been highlighted at the previous inspection from 11 June to 18 July 2019. These included ensuring the environment met national standards, outcomes and safety information was displayed for staff, women and visitors, staff documented times in the entries to records and the service had a strategy, vision and values. Whilst these were detailed on the risk register and mitigations identified but not always actioned, there were no long-term resolution plans or formalised strategy or vision to support improvements.

Areas for improvement

MUSTS

- The service must ensure staff complete mandatory and safeguarding training in line with the trust target. (Regulation 12) (1)(2)(a)(c)
- The service must carry out and record regular baby abduction drills and evacuation drills. (Regulation 12) (1)(2) (a) (b) (d)
- The service must ensure robust review of incidents to ensure they are appropriately graded and managed to keep women and babies safe and ensure appropriate follow up care is provided. (Regulation 17 (1)(2)(a)(b)
- The service must ensure leaders have sufficient oversight of the risk register, and that risks are managed, and mitigations are in place. (Regulation 17(1)(2)(a)(b)
- The service must ensure a robust strategy and vision to set out clear objectives and direction for the service and staff. Regulation 17(1)
- The service must ensure that women's records are completed in line with trust policy. (Regulation 17(1)(2)(c)

Maternity

- The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit. (Regulation 18)(1)
- The service must ensure the delivery suite coordinator is always supernumerary. (Regulation 18)(1)

SHOULDS

- The service should ensure that safety champion roles and responsibilities are clear to maternity staff and they are involved in the process.
- The trust should ensure cross site working and consistency to improve relationships and share good governance including policies and procedures.
- The service should ensure multidisciplinary team working is improved.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, CQC team inspector and two specialist advisors. The inspection team was overseen by Philippa Styles, Interim 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
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing