Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside General Hospital

Inspection report

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Date of inspection visit: 18 and 19 December 2023
Date of publication: 15/03/2024

Ratings

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

Our findings

Overall summary of services at Tameside General Hospital

Good ➔➔

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

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

Tameside General Hospital provides maternity services to the population of Tameside and Glossop.

Maternity services include an outpatient department, midwifery led birthing centre (Acorn Birth Centre), central delivery suite, 1 maternity theatre, maternity ward (ward 27) with induction of labour suite and transitional care and a day assessment unit. Between December 2022 and November 2023, 2,104 babies were born at Tameside General Hospital.

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 stayed the same. We rated it as Good because:

- Our rating of Requires Improvement for maternity services did not change ratings for the hospital overall. We rated safe and well-led as Good.

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited the central delivery suite, main theatres, ward 27 maternity ward and the day assessment unit, which included maternity triage.

We spoke with 12 midwives, 1 support worker, 7 doctors, theatre staff, 4 women and birthing people and 4 birthing partners and or relatives. We received 216 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 10 patient care records, 4 Observation and escalation charts and 10 medicines records.

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

Our findings

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

Maternity

Requires Improvement ↓

Our rating of this service went down. We rated it as requires improvement because:

- Not all relevant staff had completed level 3 adult safeguarding training.
- Some areas of the maternity unit were not visibly clean and not all staff had completed infection prevention and control training.
- The environment was not always suitable, and some areas were not fully secure. The waiting area for day assessment unit, including maternity triage was outside of the triage and day assessment unit and staff did not have sight of it.
- The service was not always able to maintain the privacy and dignity of women and birthing people due to having to transfer from the maternity unit to theatre, either by walking to the main theatre suite ready for theatre in gowns or being transferred back to the maternity unit on beds via public corridors within the hospital.
- Processes to check emergency equipment were not always effective as we found out of date and missing items on emergency trolleys.
- Staff did not always assess, monitor or manage risks to women, birthing people and babies. Staff did not use tools to identify and escalate deterioration in women and birthing people consistently.
- Women and birthing people could not always access the service when they needed it. The service did not operate effective and timely triage processes.
- Though actual midwifery staffing levels met the planned numbers, it was not clear that planned staffing was sufficient to meet the needs of women, birthing people and babies.
- Staff did not always keep good care records, nor store them securely.
- Staff did not always follow systems and processes to prescribe, store and administer medicines safely.

However:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect women and birthing people from abuse.
- The service mostly managed infection risk well, it provided suitable facilities to meet the needs of women and birthing people's families.
- The service managed safety incidents well and learned lessons from them.
- Leaders had the skills and abilities to run services and were visible in the service for women, birthing people and staff.
- Staff understood the service's vision and values, and how to apply them in their work.

Maternity

- Staff were proud to work for the service and mostly felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- Managers monitored the effectiveness of the service and made sure staff were competent. They supported staff to develop their skills.
- The service engaged well with women and birthing people and the community to plan and manage services.
- Staff were clear about their roles and accountabilities.

Is the service safe?

Requires Improvement 

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The service had a Core Competency Framework Training Needs Assessment 3-year plan, which was based on the National Training Needs Assessment, and incorporated the Great Manchester and East Cheshire (GMEC) training packages. The service submitted compliance rates to the Local Maternity and Neonatal System 3 times a year. The service made sure staff received multiprofessional simulated obstetric emergency training.

The service acknowledged there had been issues previously with maintaining the 90% compliance rate with training. The service had appointed a practice development lead in February 2023, whose role initially was to improve training compliance rates. The service told us this had been achieved and training was mapped across the service to ensure ongoing compliance.

Most nursing and midwifery staff received and kept up-to-date with their mandatory training. The service had achieved between 72% and 100% for mandatory training. Compliance rates for established midwives and theatre nurses were below target for fire safety, information governance and moving and handling. Most medical staff received and kept up to date with their mandatory training. Consultants were below target for infection prevention training, and speciality and specialist doctors (SAS) were below target for fire safety and moving and handling. The practice development lead told us the new training database monitored training in real time enabling staff to see when training was going out of date, making it easier from them to remain up to date.

New staff attended the trust induction week which included the mandatory training and were then booked on midwifery specific training at the earliest opportunity. The service had also developed a 3 day training course for new midwives to assist with completion of the required training in a timely manner.

The service achieved over 90% compliance for most of the training requirements for Clinical Negligence Scheme for Trusts (CNST) for established nursing, midwifery and medical staff. The practice development lead told us the medical

staff had faced challenges attending training due to industrial action and staff shortages. Compliance rates for consultants was below target for practical obstetric multiprofessional training (PROMPT). The service had reviewed the training figures and reported to the board in November 2023 they were on target for CNST declaration sign off in February 2024.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. Training was generally up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. Cardiotocography is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour.

There were dedicated staff responsible for training and development who monitored mandatory training and alerted staff when they needed to update their training. There was a standard operating procedure (SOP) in place for mandatory and essential training for staff. These staff team identified and booked staff onto training a month prior to the training expiring. Staff told us they were usually able to attend training when rostered, especially now staffing had improved.

Safeguarding

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

Though, staff received training specific for their role on how to recognise and report abuse, this was not always at the level recommended in national guidance. Training records showed staff had completed both Level 2 and 3 safeguarding children's training as set out in the trust's policy and in the intercollegiate guidelines. The service had achieved 94% compliance for level 2 and 99% compliance for Level 3 safeguarding children's training in all staff groups. However, there had been recent changes to safeguarding adult partnership policies and procedures. The trust had recognised to meet the intercollegiate guidance they needed to strengthen the adult safeguarding approach and increase confidence, knowledge and competence of the workforce. To this end, level 3 safeguarding adults training was due to be given to relevant staff from April 2024. The service had achieved 99% compliance in all staff groups for safeguarding adults Level 2 training.

Staff were supported by the named midwife for safeguarding who was part of the integrated safeguarding team for the trust. The named midwife was also the lead midwife for domestic abuse and supported staff with complex cases. Tameside had been identified as an outlier for babies discharged into foster care. The service worked closely with The Strengthening Families in Tameside to try and promote positive outcomes for pregnant women, birthing people (and their unborn babies) and fathers who have had at least one child separated from them previously. The enhanced care team supported families and staff when separation needed to take place, and memory boxes created with items such as the cot card and photographs bathing the baby. Staff told us the local authority implemented a very good separation pathway, which enabled families to be involved with the baby and attend appointments whenever possible.

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

Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us they asked women and birthing people about domestic abuse, although we did not see this recorded in the notes. Where safeguarding concerns were identified, women and birthing people had birth plans with input from the safeguarding team.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

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

Maternity service areas were mostly visibly clean and had suitable furnishings which were generally clean and well-maintained. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly.

The service generally performed well for cleanliness. The service carried out a weekly cleaning audit collated over a 13-week period. All areas audited achieved a rolling percentage average above the minimum score 95% or 98% depending on area. The audit highlighted the top 10 failed elements within the specified period. However, we did not see any figures for the day assessment / triage area. We observed some items of equipment in the assessment rooms were dusty, for example suction tubing and portable fans.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed for the central delivery ward, antenatal clinic and ward 27 and demonstrated 100% compliance. Infection prevention audits were completed for the same areas and demonstrated compliance between 94.5% and 100%.

Maternity staff completed infection prevention training annually. Compliance rates were above 90% for established midwives, maternity support workers and medical staff with the expectation of obstetrics and gynaecology (O&G) consultants, where compliance was 78% (2 out of 9 available consultants had not completed this training).

The trust had introduced the Tameside and Glossop Service and Team Accreditation & Recognition Scheme (TaGSTARS). This was designed to support clinical staff in practice to understand how they delivered care, to identify what worked well and where further developments were needed. Each section was rated using the Red Amber Green (RAG) risk rating system, and reassessment intervals were dependant on the rating. Action plans were formulated following each assessment. The scheme had a section covering infection control, divided into three areas: environment, care and leadership. Both Central Delivery Suite / Acorn Birth Centre and Ward 27 were awarded a red rating for the section covering infection control, in accreditations carried out during September / October 2023.

Staff cleaned equipment after contact with women and birthing people. It was clear equipment was clean and ready for use, and staff used ‘I am clean’ stickers.

Environment and equipment

Staff had access to enough equipment to keep women, birthing people and babies safe. The design, maintenance and use of facilities and premises kept people safe in most areas. Staff managed clinical waste well.

Maternity

The design of the environment mostly followed national guidance. Leaders recognised the maternity unit was in need of refurbishment and had commissioned a range of artwork throughout the maternity unit.

The maternity unit was located over 2 floors and fully secure with a monitored entry and exit system. However, we had concerns regarding maintaining the security of the unit. Access on the ground floor (the entrance for the Neonatal Intensive Care Unit (NICU) was via a locked door with camera and buzzer, and was overseen by staff on NICU, via the use of a tow-way intercom and camera. Access was granted by staff who did not ask the identity of the person. Access to ward 27 was reached via a staircase or lift to the first floor. The separate (but co located) NICU was within the maternity unit footprint and access between ward 27 and NICU was unrestricted via a link corridor, although access to the neonatal unit was monitored via a further 2-way link intercom with camera and staff swipe access. This was raised as a potential risk during the inspection, as once a person had entered the maternity unit, via the NICU entrance monitored via 2-way intercom and camera, they could access ward 27 via this link corridor. Following the inspection the service told us the access from Ward 27 to the NICU corridor had been made secure and any person needed to leave via this door would be escorted to the door and the door opened via staff swipe access. In addition, the trust told us there had been no incidents of a near miss or actual child abduction in the last 2 years.

The maternity triage waiting area was outside of the triage and day assessment unit in a corridor. Women and birthing people rang the intercom to request access through the secure door or to speak to staff as there were no staff in direct site of the triage waiting area. Staff told us they carried out hourly safety checks of the waiting area. The service told us there were plans to relocate triage and day assessment in the near future.

There was only 1 theatre located on the Central Delivery Suite (CDS), which was used for emergencies. Elective caesarean sections were carried out in the main theatre suite, located approximately 5 minutes' walk from the maternity unit. This meant that women and their partners had to walk through corridors and past the busy hospital restaurant ready for theatre in gowns, and transfer back to the maternity unit on their bed, which meant privacy and dignity may be compromised. A dedicated theatre team were based on CDS to deal with any emergencies in a timely manner. We discussed the processes in place if the need for a second emergency theatre arose and were told where possible the elective caesarean section list would be temporarily halted or the elective list for another surgical discipline halted, to free up theatre space. The service told us about a Standard Operating Procedure for the use of a third theatre was in place, and there had been 1 occasion during the previous 12 months when a third theatre was required. The service had plans to build a second theatre on the maternity unit and had successfully secured capital funds to complete this project. The service was hopeful the new build would be completed by April 2025.

Staff had access to 8 resuscitaires across the maternity unit. The service had undertaken a risk assessment, identified additional resuscitaires were required, and included this on the maternity risk register. The service told us 2 additional resuscitaires were on order and there had been no incidents reported relating to the availability of resuscitaire.

Processes were in place for staff to carry out daily safety checks of specialist equipment. However, we found that although the records indicated equipment / medicines was present and in date, this was not the case. We found out of date medicines and single use items as well as missing items in the emergency trolleys. This was raised with leaders who took immediate action. We observed senior staff carrying out checks of the emergency trolleys and replacing out of date and missing items.

Maternity

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. There was a dedicated room on CDS for bereaved parents. Although the room wasn't soundproof, it was away from rooms used for labouring women and babies. The room had access to private outside garden. The service acknowledged the room was clinical in appearance and told us plans had been approved for refurbishment of this area.

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

Ligature point risk assessments had been completed for maternity services and each item of risk was identified, a risk rating agreed, and control measures put in place, wherever possible.

Assessing and responding to risk

Staff did not always assess, monitor or manage risks to women, birthing people and babies. Staff did not always complete and update risk assessments, take action to remove or minimise risks, or identify when women and birthing people were at risk of deterioration.

The service did not operate effective and timely triage processes. Though leaders monitored waiting times, they did not always make sure women and birthing people could access emergency services when needed.

We found delays in initial assessment of women and birthing people presenting to maternity triage. During the inspection, we saw a triage audit for September 2023, which showed 17% of women and birthing people were not seen within 30 minutes of arrival. In October and November 2023, 15% of women and birthing people had not been seen within 30 minutes. However, out of 996 women and birthing people who attended triage during the 3-month period, 328 had to be excluded from the audit as the relevant times had not been recorded. Therefore, we could not be assured leaders had effective oversight of waiting times in maternity triage.

Staff did not use an evidence-based, standardised risk assessment tool for maternity triage. The service followed the Maternity Triage Standard Operating Procedure based on national guidance published in 2015, which stated women and birthing people should be assessed within 30 minutes of arrival at triage. More up to date guidance had been published by The Royal College of Obstetricians and Gynaecologists (RCOG) in December 2023: Maternity Triage Good Practice Paper No 17. Therefore, women and birthing people were not assessed in line with local policy and guidance, or current best practice guidelines.

Women and birthing people may not always be able to access timely telephone advice, as we were not assured the dedicated triage telephone was always answered by a trained member of staff. A trained member of staff was not allocated to answer the triage telephone and staff told us the telephone may be answered by the maternity support worker. In addition, staff did not follow a risk-based process to assess and prioritise women and birthing people who contacted the triage telephone. Therefore, the service could not be assured women and birthing people's needs were met in a timely manner.

The service did not have dedicated medical staff allocated to triage and day assessment. Both medical and midwifery staff told us women and birthing people may face long waits for a medical review, especially those from antenatal clinic waiting for a scan review. There was no audit of time to medical review for women and birthing people who attended triage, and therefore, there was no insight into the performance of this part of the service.

Maternity

Following our inspection, we received 'feedback about care' from women and birthing people who told us about issues accessing triage and the treatment they received.

Following our inspection, we sent a letter outlining our concerns and asked the trust how they would mitigate the risks around triage. The service submitted an action plan, and we will continue to monitor progress in relation to this.

Staff used the Maternity Early Warning Score (MEWS) to identify women and birthing people at risk of deterioration and escalate them appropriately. Audits of records completed between January and September 2023 identified the use of MEWS charts ranged from 40% to 100%, and none of the charts had all of the sections completed in full. There was low compliance on central delivery suite (CDS) for commencing MEWS charts for both labour and out of hours triage. In addition, charts were not used alongside epidural or opioid observations when in use or commenced at the beginning of elective caesarean sections. The audit, recommendations and action plan had not yet been presented.

Cardiotocography (CTG) is used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a 'fresh eyes' or buddy approach to regular review of CTGs during labour. Staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. The month-to-month audits for July to October 2023 showed appropriate classification in 100% of cases and staff did 'fresh eyes' at each hourly assessment in 100% of cases.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists and we saw the correct checklist had been used and filed in 100% of the records. However, only 4 out of 19 (21%) checklists had the procedure section completed, and 17 out of 19 (89%) had the patient details completed. Several recommendations had been made and an action plan developed to address the issues.

Staff completed newborn risk assessments when babies were born using an internal Neonatal Early Warning Score (NEWS) tool. An audit of records between January and September 2023 highlighted that NEWS were not completed for all babies, or completed in full when they were used. However, staff had escalated concerns appropriately and plans put in place. Following the audit, several recommendations had been made and an action plan developed to address the issues.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff, women and birthing people were also supported by a specialist midwife for mental health. Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Shift changes and handovers generally included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found generally all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people. The handover generally shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person, although this format was not used during the handover in triage. We saw staff were disturbed during handover on CDS due to this taking place at the main desk.

The service provided transitional care for babies who required additional care. Staff told us midwives who delivered transitional care had received additional training so they could administer intravenous medicines to babies. These staff were also supported by staff who worked on the neonatal intensive care unit.

We observed medical staff responded well to 2 potential emergency situations which occurred at the same time during the medical handover. Medical staff were aware of what action was required on them and responded promptly to the emergency calls.

Midwifery Staffing

Staffing levels matched the planned numbers although they were not always sufficient to meet the needs of women and birthing people and babies, potentially placing them at risk of harm.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support staff needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in January 2023 and staffing at that time was generally in line with the workforce review. The service told us they had one midwife vacancy based on the January 2023 staffing review.

Since the January 2023 review, additional funding had been made available to support specialist roles. The revised position recommended 119.16 whole time equivalent (wte) funded posts, 101.68 registered midwives and 17.48 maternity support workers. The revised staffing position highlighted a shortfall of 10.65 wte registered midwives and 7.92 wte maternity support workers. The leaders told us a paper on the revised staffing figures would be presented to the trust board for sign off.

The service mostly 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. However, this tool was not used effectively, and leaders could not be assured they were aware of all potential staffing issues across the service as staff were not consistently reporting 'red flag' events.

Between July and November 2023 there were 44 red flag events. These suggested that although staffing was at the agreed levels, staff were challenged for time and not always able to provide in care in a timely manner. We saw 6 events related to delay in more than 30 minutes in providing pain relief and 21 events related to missed breaks (midwifery staff). We also saw during this period there were 7 reported events of a delay of 30 minutes or more between presentation and triage. The triage audit shared by the service identified at least 100 known occasions in the period between September and November 2023 where women and birthing people presenting at triage had not been seen within 30 minutes. Therefore, we could not be sure all red flags were reported.

We were told the service used of bank / agency staff familiar with the service to maintain agreed staffing levels. However, it was not clear if the planned staffing levels were sufficient to meet the needs of women and birthing people. Minutes for the Obstetric and Neonatal Governance Assurance Group meeting held on 1 December 2023 identified women and birthing people not receiving one to one care in labour as a theme when incidents were reviewed. Only one 'red' flag had been reported for any occasion when 1 midwife was not able to provide 1:1 care during established labour in October 2023, and no 'red' flags were reported for November 2023.

We saw staff had not reported any 'red flag' incidents relating to supernumerary status. The labour ward co-ordinator told us it could be challenging to maintain the supernumerary status at night, due to their role in overseeing the whole of the maternity service which would include triage 24 hours a day as a co-ordinator. After 1am the triage service

relocated on to the central delivery suite (CDS). The co-ordinator was responsible for ensuring staff staffing across the hospital and home birth service. The home birth service was supported by the on-call community midwife following discussion with the labour ward co-ordinator. They acknowledged they didn't always report when they were unable to maintain their supernumerary status.

The service had reported 10 incidents relating to temporary closure of the unit due to high acuity, shortage of staff or no cots available between 1 March and 1 November 2023. A number of these diverts had 'red' flags attached to them.

The service monitored and reported on staff turnover, sickness and roster fill rates. Data for June through to September 2023 demonstrated average roster fill rates for nurses/ midwives and support staff was 100% or over. Staff told us staffing levels had improved greatly over the past 18 months. The service had undertaken a recruitment drive in January 2022 and had maintained a consistent approach to recruitment and recruited to turnover. The service had taken steps to improve the support and pastoral care given to staff new to the trust, in particular newly qualified and early career midwives.

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 yearly, constructive appraisals of their work. Appraisal rates varied from 62.5% for staff working on Acorn Birth Centre through to 100% for enhanced midwifery staff. Sixty-seven percent of staff on central delivery suite had been appraised, and 76% of staff on maternity ward 27.

The practice development lead midwife had been in post since February 2023. Their role initially had been to ensure the service was safe and compliant with mandatory and national training. They were also the lead preceptor for preceptee midwives. They were supported in their role by a clinical skills educator co-ordinator, who worked alongside new staff and a maternity educator support worker who worked with maternity support workers.

Managers made sure staff received any specialist training for their role. The service had successfully secured funding for external courses in critical care, non-medical prescribing, sexual health (including fitting implants), professional maternity advocacy and advanced neonatal life support.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training, and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment.

The service acknowledged the challenges around medical staffing in part due to sickness, part time and flexible working / reduced duties arrangements. Medical cover was provided by a combined obstetrics and gynaecology team, although not all consultants specialised in both disciplines. The service had reviewed the consultant establishment and concluded it did not meet the demand of the department to meet the need of implementing a separate obstetrics on call rota and allow time in job plans to attend maternity training. As a result, additional staff had been recruited, with 18 whole time equivalent (wte) consultants in post as of November 2023.

There were also challenges with middle grade and junior trainee doctors. The trust had worked with the local medical deanery who had partially filled more junior doctor posts, but there remained a shortfall of 4 wte due to less than full time contracts. The trust used both long and short-term locums to cover any shortfalls in medical staffing.

Maternity

The service had reported 3 incidents relating to temporary closure of the unit in October 2023. One of these occasions was due to the lack of a junior doctor.

Due to individual working patterns, the service made use of locum staff to cover shortfalls in rotas, including for on call duties. There was always a consultant on call during evenings and weekends. There was a process to follow for booking locum staff and an information pack for locum staff. The service was reviewing job plans and on call cover for consultants. Four recently recruited consultants had been appointed as resident consultants, rather than providing on call cover from home. Each consultant had an individual job plan. The service was carrying out team job planning for 2024.

The sickness absence rate for September 2022 to September 2023 for medical staff was low at 5.27%.

Medical staff told us there were not enough staff to cover the rotas and shortfalls were covered internally or by agency locums. They told us rotas were often provided late, and there was little collaborative working to agree rotas within the team. They told us this also impacted when they were able to take annual leave. The shortfalls in consultant cover impacted on training opportunities and supervision although staff told us consultants tried hard to provide opportunities. Despite the challenges staff told us they enjoyed working at the service, they felt supported and would recommend it as a place to work to other colleagues.

Records

Staff kept records of women and birthing people's care and treatment. However, records were not always clear or stored securely.

The service used a combination of paper and electronic records. The service used 2 different electronic systems in addition to the paper records. We reviewed 10 paper records and found they were not always well organised, and information could be recorded in multiple places. We did not always see information relating to health inequalities, vitamin D, mental health assessments or universal enquiry recorded in the notes reviewed.

Records were not always stored securely. Records were in an open office on the triage and day assessment unit, and patient identifiable information was seen on the electronic notice board on central delivery suite. We raised these concerns with the service, who provided additional information following the inspection. They provided evidence that records were stored in a lockable trolley on the triage and day assessment unit. They also provided assurance that the information displayed on the electronic boards did not breach information governance or other relevant guidance.

The serviced audited a sample of patient handheld notes and hospital records of women and birthing people who delivered between September and November 2023 and identified a number of areas for improvement, including dating and timing all entries, recording staff name and registration personal identification number, as well as the patient identification. The audit did not look at the quality of entries within the records. A second audit looked at whether the SBAR (Situation, Background, Assessment, Recommendation) tool had been used within the notes, and the results ranged from 60% to 90% usage.

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

Medicines

Maternity

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

We were told medicines training and competency was included as part of the Midwifery Preceptorship Programme, and there was a Medicines Administration Competency Assessment for all Registrants. No information was provided regarding compliance with medicine management training for midwives or medical staff, and it was not clear if training or competency assessments were completed periodically post preceptorship.

Staff did not always follow systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We found issues with opiate prescribing on 1 prescription chart. On 1 occasion, we saw the prescriber had not specified which opiate compound to administer, therefore staff had given the patient 2 different medicines. On another occasion, staff was not able to tell us what was administered to the patient as they were unsure. We raised this at the time of inspection and the service reported that the incidents would be investigated.

We reviewed a further 10 prescription charts and found staff had correctly completed them.

Staff checked controlled drug stocks daily. However, we found in the controlled drug register on Ward 27 on 1 occasion staff initials had recorded in the column used to record the amount of medicine in stock, and for another medicine, the register had been signed but the remaining stock level had not been recorded.

Staff did not always store and manage all medicines and prescribing documents safely. The rooms where the medicines were stored were locked and could only be accessed by authorised staff. We noted that the ambient temperature of these rooms was not monitored. We found out of date medicine on central delivery suite, in addition to the out of date medicines we found in the emergency trolleys. The meant the service could not be assured that medicines were safe to use.

Staff monitored and recorded fridge temperatures and knew to act if there was variation. However, the fridge on Ward 27 was broken, resulting in emergency medicines requiring refrigeration being stored in the fridge on the neonatal unit. This created a potential risk of a delay in the administration of emergency medicines. This was raised with leaders and a replacement fridge was installed during the inspection.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. The trust was moving towards using the Patient Safety Incident Response Framework (PSIRF) for management of incidents.

Maternity

Incidents were investigated and responded to in a timely manner; there were 10 incidents open over 60 days. Staff reported serious incidents in line with trust policy. Incidents were reviewed at the weekly multidisciplinary incident review meeting to ensure 72 hour reviews have been carried out and investigation reports completely in a timely manner. Incidents were uploaded onto the weekly incident tracker and shared with staff. We saw that incidents and risks were discussed a variety of meetings.

The service shared learning from incidents with staff. Examples of learning and changes made included the introduction of a single contact number for maternity with a call divert if not answered, electronic diary for booking elective caesarean sections, resuscitaire permanently located on Acorn Birth Centre and stickers used in notes for specific examinations.

We saw incident themes were discussed at the monthly Obstetric and Neonatal Governance Assurance Group. Themes identified in the minutes for the last 3 months included missed antenatal (twice) and postnatal care; results governance (twice); post-partum haemorrhage (twice); diverts (twice); lack of 1:1 care in labour, documentation; specimen issues and issues following spinal anaesthesia in theatre. As a result, several thematic reviews and audits were to be completed.

Staff understood the duty of candour. Governance reports included monitoring of how duty of candour had been completed.

It was not clear how managers reviewed incidents potentially related to health inequalities.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

The maternity service was part of the Division of Surgery / Women and Children and had a clearly defined management and leadership structure. The service was led by a triumvirate made up of the divisional director, divisional midwifery and nursing director, obstetric governance lead and clinical director. The divisional midwifery and nursing director's role was supported by the deputy head of midwifery and the maternity matrons.

There was clear oversight of the service with appropriate lines of reporting to various meetings, to ensure a line of communication between the ward and the trust board. Due to previous challenges within the service, weekly dedicated maternity assurance meetings had been held to ensure the service was fully sighted on issues and assurance. This had been achieved and maternity was going back to being discussed within the diversional oversight and assurance groups in 2024.

Maternity

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They did not have a clear understanding of the challenges to quality and sustainability within the service as they weren't always supported to have clear oversight of triage as the audits did not give sufficient robust data, and the under reporting of 'red flag' incidents. They described ongoing work to improve the facilities, including the proposed relocation of triage and day assessment, additional theatre facilities and managing workforce gaps in the medical team.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service was supported by maternity safety champions and non-executive director (NED). They completed a walk around on a monthly basis and spoke with staff and women, birthing people and families using the service. Maternity safety champions meetings were held monthly, and the NED also had monthly 1:1 meetings with the division director of midwifery and nursing. The NED also presented the maternity safety champions report to the Quality and Governance Committee.

They supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. Newly qualified midwives were supported through the preceptorship programme and the support continued as staff moved to more senior positions.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision for maternity was to help deliver care that is safe and of a high quality for patients. The maternity strategy was framed in 5 strategic ambitions, each led by a senior leader. These ambitions were equality in access and outcomes; learning; staffing and retention; culture of development and support and effective listening and communication. The commitments attached to each ambition had been developed, defined and prioritised by the team. The maternity vision further focused on clinical outcomes; improvement initiatives; mandatory training; effective learning and working environment.

The commitments in the strategy were interlinked with other trust strategies and fed into and from the following: equality, diversity and inclusion; people and workforce; research and development; quality strategy and continuous improvement strategy.

Leaders and staff understood and knew how to apply them and monitor progress. Delivery was through working groups attached to the Maternity Improvement Plan, and progress reviewed through the Safety, Quality and Governance Group and Service Improvement Group.

Culture

Maternity

Staff felt respected, supported, and valued. The majority of staff 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 woman and birthing people, their families and staff could raise concerns without fear.

Staff were proud to work for the trust and felt respected, supported, and valued. Staff were generally positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

Staff were generally focused on the needs of women and birthing people receiving care. Most staff worked within and promoted a culture which placed peoples' care at the heart of the service and recognised the power of caring relationships between people. However, comments received suggested that not all women and birthing people felt listened to in their dealings with medical staff. They had not been given sufficient information to make an informed choice, they felt coerced into making decisions, they were not listened to, and their birth choice was not respected.

Following sight of the draft report, the service informed us at the time of the inspection the trust's Medical Director was actively supporting the service in promoting values and behaviours within the medical workforce which included a specific workshop. The workshop was titled "Professional Behaviour, Patient Safety Training Workshop". In addition to this the service had an ongoing maternity Improvement Board which was in place at the time of the inspection. One of the key workstreams for the improvement board was "Listening to our service users". This group, which included the independent Maternity Voices Partnership Chair had been triangulating user feedback to support ongoing improvement work and co-production. Though dignity and respect were intrinsic elements of the culture we observed some behaviours which did not always demonstrate this. For example: transfers to and from main theatre and lack of interaction following introductions by medical staff with mother and birthing partner during elective procedures.

Leaders were aware of how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. For example, the service had provided enhanced continuity of care support to areas where smoking at the time of delivery was high. The service told us this had significantly reduced the percentage of women and birthing people who were smokers at the time of delivery. Following sight of the draft report, the service informed us this data was collated on the Regional Smoke Free Digital Platform and reviewed centrally by the Greater Manchester network. Data of this kind was monitored as part of the usual pregnancy pathway in terms of ethnicity or disadvantage and was aligned with intelligence work which identified areas in the lower deprivation deciles in the locality. This enabled the service to provide targeted, enhanced support to specific communities with the locality.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment. The maternity vision and strategy interlinked with the trust strategic aims, which included equality, diversity and inclusion (EDI). Staff had been involved developing the maternity and neonatal EDI strategy 2024/2025 and had identify 4 strands: career progression for all; staff experience; inclusive recruitment and embedding EDI.

The results of the Maternity Survey 2022 when compared to other trusts showed, the results were about the same with 2 questions somewhat better than expected, and 1 question showed a statistically significant decrease when compared to 2021. Comments from women and birthing people detailed positive staff interactions, describing staff teams as

supportive and helpful. However, not everyone using the service felt staff listened to them and some reported they had received negative comments from staff. There were also issues with clinical care, such as not being checked enough, and mistakes made by staff which led to further complications. Some women and birthing people felt the service did not provide enough physical or psychological support following the birth of their babies.

We reviewed the trust's NHS Staff survey for 2022. The results of the survey were measured against the 7 People Promise elements and against 2 of the themes reported in previous years (staff engagement and morale). In all areas the trust was above or slightly above the average of comparable trusts. However, scores for staff engagement, morale and all elements with 'People Promises' had improved significantly compared to 2021.

The maternity service had undertaken a local staff survey in Spring 2023. The survey demonstrated an improvement in how staff viewed working at the service when compared to 2022. The service planned to carry out 'deep dives' into area of least satisfaction and incorporate these into the Spring 2024 survey. An action plan had been developed, which included establishing curiosity cafes (now implemented) and monitoring trends versus local and national staff survey results.

Trainees in an approved training post in the UK completed the General Medical Council National Trainee Survey (GMC NTS) regarding the quality of training received support and wellbeing. In the 2023 survey, the scores were significantly lower (i.e. worse) than the national average for 7 indicators. These indicators were overall satisfaction, clinical supervision, clinical supervision out of hours, teamwork, handover, adequate experience and rota decision. Comparing 2023 to 2022, the score for teamwork had improved for 2023 whereas the score for handover had dropped, and both were still lower (i.e. worse) than the national average. These results echoed the comments made by medical staff. Following sight of the draft report, the service informed us that at the time of the inspection the service had a detailed General Medical Council (GMC) survey action plan which included the redesigned and recruitment to new junior rotas. The action plan was co-produced by junior and senior medical colleagues together with the operational team.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. The service had received 4 complaints in the 3 months prior to the inspection. We reviewed the complaints and found the themes included attitude of staff across the service, poor communication and missed appointments and lack of skills and knowledge exhibited by some clinical staff, including those at a senior level. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in woman and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them. Complaints were reported monthly to the Obstetric and Neonatal Governance Assurance Group.

Governance

Leaders did not always operate effective governance processes due to a lack of monitoring and oversight in some areas. However, 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.

Although governance processes were in use, these were not always effective. The service had a governance structure which supported the flow of information from frontline staff to senior managers. There was a comprehensive series of well-structured governance meetings, but leaders were not always made aware of key safety or performance metrics due to the lack of monitoring and oversight in some areas. For example, we found several safety concerns with out-of-date emergency equipment and medicines.

Maternity

Oversight of safety in maternity services was reported through a range of meetings. These included the monthly Obstetric and Neonatal Governance Assurance Group, Maternity Safety Champions meetings, Finance Divisional Management Team Meetings and HR Divisional Management Team Meetings. We reviewed minutes of these meetings and found the service reported on their challenges and successes. Information discussed included Ockenden, CNST, risk register, policy updates, maternity dashboard reports, incidents, training targets, complaints and safety updates. Information from these groups fed into the Governance/Risk Divisional Management meetings.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates and reviewed policies every 2 or 3 years to make sure they were up to date.

Management of risk, issues, and performance

Systems to manage performance were not always used effectively. Relevant risks and issues were not always identified so that action could be taken to reduce their impact.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

The service used a maternity quality dashboard to benchmark against national indicators and provide target figures to achieved. Data from the dashboard had identified an increase in postpartum haemorrhage and as a consequence the service had implemented 1000 lives quality improvement work.

The service complied with all 5 elements of the saving babies lives care bundle V2. The service told us they were working towards compliance with version 3 of the saving babies lives care bundle, including the additional element of management of pre-existing diabetes in pregnancy. The service aimed to reach 70% compliance by December 2023. The checkpoint submission completed in October 2023 demonstrated compliance in elements 1 to 3, with elements 4 to 6 on track to deliver the target.

The service provided up to date data to the national Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBBRACE) survey. We looked at the actions from the survey which were around updating cases and ensuring accuracy of data. The report also highlighted what was going well within the service. The service had bench marked against the detail from the report and a report compiled for the Mortality Group.

The Maternity Incentive Scheme is a national programme which rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service declared compliance with 6 out of 10 safety initiatives for Year 4. The service had received funding to support completion of the action plan. Following sight of the draft report, the service informed us compliance with 7 out of the 10 safety initiatives for Year 4 had been declared, following review of the information submitted. The service had received an assurance visit in October 2023 to review compliance towards the safety initiatives for Year 5. The visit indicated there was no reason the service would not be compliant with the 10 safety initiatives at the time of submission in 2024.

Maternity

The service continued to work towards meeting the recommendations outlined in the Ockenden report. The Quality Oversight report in November 2023 reported work continued towards meeting the 15 recommendations from the Ockenden final report. The first 7 initial immediate actions from the initial report had been completed with the exception of the microsite for maternity on the trust website. Progress towards the Ockenden Action Assurance Plan was also reported to the monthly Obstetric and Neonatal Governance Assurance Group.

We reviewed the service's risk register and saw the service had recorded relevant risks rated as high risk. Against these was the mitigation actions and actions to address the risks. The register stated clear ownership of the risks, timescales for review or completion.

There was a system in place to review and monitor actions from HSIB (Healthcare Safety Investigation Branch), now known as Maternity and Neonatal Safety Investigations (MNSI). There had been no new HSIB cases in the last 6 months.

The service reviewed neonatal deaths using the national Perinatal Mortality Review Tool (PMRT). We were shown the PMRT presentation shared with the Local Maternity and Neonatal System (LMNS) May 2023. There had been 6 cases during 2022/2023. Several concerns had been identified at the antenatal stage and subsequent learning and actions included a new centralised telephone contact number and a new booking in system for appointments. Identified learning following completion of investigations included ensuring stillbirth pathways were always completed (included in bereavement training on the maternity update day) and a delay due to documentation error, resulting in the introduction of new bereavement packs.

Managers and staff carried out a programme of audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

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 meeting minutes for the weekly incident or serious incident group meetings. The leadership team took action to make change where risks were identified.

The service had an escalation policy in place to proactively manage activity and acuity across the trust. They followed a standard escalation policy across the local area. All diverts were incident reported and recorded on a tracker sheet. In the last 12 months, the service had been on divert 16 times, affecting a total of 19 women and birthing people.

Information Management

The service could not be assured they were collecting and analysing all relevant data, as not all incidents were being reported consistently. Paper records were not always stored securely. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

The service collected data and analysed it. They had a live dashboard of performance which was accessible to senior managers. However, the dashboard did not provide leaders with information to monitor trends over time or compare performance with peers. Following sight of the draft report, the service informed us performance against peers was undertaken regionally and supported by the Local Maternity and Neonatal System (LMNS). The data was discussed at the monthly 1:1 meetings between the Head of Midwifery and the LMNS.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, the service could not be assured they were collecting all relevant data across the service as staff were not consistently reporting 'red flag' incidents, for example in triage.

The service used 2 electronic patient records systems as well as paper records. The electronic systems were secure, but staff did not always keep paper records securely.

Data or notifications were consistently submitted to external organisations as required.

Engagement

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

Tameside Maternity Voices Partnership (MVP) held quarterly engagement meetings with leaders and we saw the most recent set of minutes. Discussion included potential changes to the MVP, plans to increase levels of feedback, including planning future listening events. Discussion included themes from previous outreach work and feedback from surveys. Weekly visits to the antenatal clinic had been agreed to raise the profile of the MVP and to access a wide demographic of people using the service. Leaflets were available with a QR code, which linked to social media and email enabling people to give feedback. The MVP had previously completed a 15 steps review of the service and improvements based on the results including making the central delivery suite more welcoming with bespoke artwork and the introduction of signage in a range of languages.

The MVP told us they were trying to raise the profile of the MVP in the locality and attended baby fayres and used social media to request feedback. They told us they had set up an alliance with local health visiting and family hubs in Tameside to co-ordinate how to reach seldom heard groups.

The service made available interpreting services for women and birthing people and pregnant women. However, we were told the majority of written information available on the maternity unit was still in English. Following sight of the draft report, the service informed us patient information in different languages was available for women and birthing people via the trust website, where the information could be accessed to meet specific needs. Work was also ongoing to improve the maternity microsite on the trust website.

We received approximately 216 responses to our give feedback on care campaign. Of these responses just over half were positive, just under a third were mixed and the remainder were negative. Positive comments were about caring, compassionate and friendly staff and good care on labour ward. Themes identified in the mixed and negative feedback included poor staff attitude; lack of pain relief; lack on monitoring and care on ward 27; lack of informed consent, coercion, not being listened to and birth choice not being respected; understaffing impacting on care and treatment; delays in induction of labour; issues in triage and poor antenatal care.

The service held regular engagement sessions with staff, including bi weekly meet the matron and curiosity café with the deputy head of midwifery and practice development midwife, as well as leaders undertaking walk arounds and speaking with staff informally. The service collated feedback from these sessions and posters used to disseminate information and updates.

Learning, continuous improvement and innovation

Maternity

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

All staff were committed to continually learning and improving services. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. The service had developed the Maternity and Neonatal Improvement Board and had a quality improvement programme (IQP). There were a number of ongoing workstreams, and we saw evidence of monitoring the progress towards achieving the various workstreams.

The service had introduced an accreditation tool for maternity (TaGSTARS), designed to support clinical staff to understand how they deliver care, identify what works wells and where further improvements are needed. The service shared the results from the accreditations completed in 2022/2023 on central delivery suite and ward 27.

The service was committed to developing staff. Staff were being supported to complete post graduate courses, non-medical prescribing, high dependency care and advanced neonatal life support training. The practice development midwife told us staff were now asking for development opportunities and external courses and these were being supported by the trust.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Maternity

- The service must ensure the triage operates effective and timely triage processes for women, birthing people and babies to reduce risk. Regulation 12(1)(2)(a)(b)
- The service must ensure risk assessments are fully completed women, birthing people and babies. Regulation 12(1)(2)(a)(b)
- The service must ensure medicines are prescribed correctly, administered safely and are in date. Regulation 12(1)(2)(g)
- The service must ensure checks of emergency equipment and consumables are carried out thoroughly and identify any out of date equipment in order that it can be replaced. Regulation 12(1)(2) (e)
- The service must ensure effective risk and governance systems are implemented and audited to support safe, quality care. Regulation 17(1)(2)
- The service must ensure there are sufficient staff deployed at all times to provide the right care and treatment for women, birthing people and babies. Regulation 18(1)

Maternity

Action the trust SHOULD take to improve:

Maternity

- The service should ensure premises and equipment are kept clean to prevent, detect and control the spread of infection.
- The service should ensure WHO safety checklists are completed in full.
- The service should ensure all patient records are completed to the required standard, including the use of Situation, Background, Assessment, Recommendation (SBAR) and stored securely.
- The service should promote a culture where women and birthing people feel listened to and empowered to make choices about their care.
- The service should prioritise the completion of level 3 safeguarding adults training for staff as identified in the intercollegiate guidelines.
- The service should continue to monitor and ensure all mandatory training meets the trust's targets.
- The service should consider the impact on the privacy and dignity of women and birthing people during transfer to and from main theatre, and during elective procedures.
- The service should undertake infection prevention audits in day assessment / triage.
- The service should act on staff surveys to improve the experience of staff working within the service.
- The service should review incidents potentially related to health inequalities.
- The service should review the written information it provides on the maternity unit for women and birthing people so that it meets the needs of those whose first language is not English.

Our inspection team

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