Basildon University Hospital

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Ratings

Overall rating for this hospital

Are services safe?	
Are services effective?	
Are services caring?	
Are services well-led?	

Summary of findings

Overall summary of services at Basildon University Hospital

Basildon University Hospital is operated by Mid and South Essex NHS Foundation trust. The maternity unit at Basildon University Hospital provides a comprehensive range of services including; ambulatory care assessment, prenatal diagnostic screening, antenatal care services, perinatal mental health and counselling service, midwife led birthing unit, delivery suite and home birth service.

The maternity unit offers women the following birth options:

- Home birth: around 3% of all trust births are home births.
- Midwife-led birthing unit: Located on the Willow suite, consists of five delivery rooms (including two pool rooms) and four postnatal beds.
- Delivery suite: eight birthing beds and four enhanced care beds. There are two dedicated maternity theatres.

The maternity unit also includes Cedar Ward, a 33-bedded postnatal ward that also provides antenatal care and the Mulberry Suite, which is a seven-bedded ambulatory care assessment unit for all women from 14 weeks gestation.

From April 2019 to March 2020 there were 4,304 deliveries at Basildon University Hospital.

At our inspection of the maternity service at Basildon Hospital in February 2019. The service was rated requires improvement overall; safe and well led were rated requires improvement, effective, caring and responsive were rated good.

During the 2019 inspection, we identified a number of concerns in the maternity service. As a result, requirement notices for breaches of regulation 12 and 17 of the health and social care act (2014), were issued against the trust. The requirement notices informed the action the trust must take to comply with its legal obligation, and we requested an action plan from the trust, outlining steps that had been taken to address the concerns we raised. The trust submitted an action plan following publication of the inspection report in July 2019. The trust submitted regular updates on the progress of the action plan and in February 2020, the actions relating to the maternity service were all signed off as completed by the trust.

We last inspected the maternity service in June 2020 following concerns raised to the Care Quality Commission (CQC) from an anonymous whistle-blower, raising safety concerns at Basildon Hospital maternity services. The information received and a review of the trust's incident reporting data highlighted a cluster of six serious incidents where babies were poorly at birth and subsequently transferred out for cooling therapy from March and April 2020. Cooling therapy is a procedure which can be offered as a treatment option for newborn babies with brain injury caused by oxygen shortage during birth. It involves bringing baby's temperature from the normal body temperature of 37°C to a temperature between 33°C and 35°C soon after birth and for a few days afterwards.

In response to the concerns we found during our inspection in June 2020 we issued the trust with a Section 29A warning notice. We carried out a further focused inspection on 18 September 2020 to follow up on the concerns raised during our engagement with the trust to monitor their compliance to the warning notice. This focused inspection did not include all of our key lines of enquiry (KLOEs).

Following our inspection in September 2020 we issued an urgent notice of decision, under Section 31 of the Health and Social Care Act 2008, on the 7 October 2020, to impose conditions on the trust's registration as a service provider in respect of the regulated activity: maternity and midwifery services. The conditions set out specific actions to enable the improvement of safety within the service.

Summary of findings

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. As a result of this inspection the ratings remained the same, we rated safe, effective and well-led as inadequate, and overall the service was rated inadequate.

The link below is our report published following our last inspection:

https://api.cqc.org.uk/public/v1/reports/f81a77ed-feb1-424b-a266-99b75bb4102a

During this inspection we:

- Spoke with 20 staff members; including service leads, matrons, midwives, doctors, midwifery care assistants and administrative staff.
- Checked six pieces of equipment.
- Reviewed 12 medical records.
- Reviewed five prescription charts.

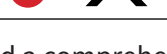
Maternity

Inadequate 

Summary of this service

- Staff did not always complete training in key skills, they did not identify and escalate safety concerns appropriately. The service did not always have enough staff to keep women safe and to provide the right care and treatment. Multidisciplinary team working continued to be dysfunctional which had impacted on further safety incidents reported. The service did not always use systems and processes to safely prescribe, administer and record medicines. Incidents were not always graded correctly according to the level of harm and lessons learnt were not being implemented fully. Staff collected safety information, but it was not routinely shared with women and visitors. However, staff kept detailed records of women's care and treatment in line with good practice and records were stored securely.
- Staff did not always work well together. Some staff did not feel able to approach some colleagues which was not to the benefit of women and babies. There was poor structure to the safety handover on the delivery suite and confusion to what constituted a safety huddle.
- Leaders did not have the skills and abilities to effectively lead the service. The pace of change was ineffective, and the service did not operate effective governance processes. The service did not have an open culture where staff could raise concerns without fear of reprisal. Leaders and teams did not always use systems to manage performance effectively.

Is the service safe?

Inadequate 

- The service had a comprehensive training programme to provide staff with the training they required, however the trust target for attendance at training was not met by the service.
- Medical Staff did not always complete training in key skills.
- The service did not always 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.
- Staff used national guidance to assess risks, although risk was not always acted upon appropriately. Safety handovers and briefings were not fully effective to respond timely to safety concerns.
- The service did not always manage safety incidents well. Staff recognised incidents and near misses but did not always report them appropriately according to grading and level of harm. Lessons learnt from past incidents were not being implemented by the whole team and the wider service
- The service did not always use systems and processes to safely prescribe, administer and record medicines. The service store medicines safely.
- Staff did not always use equipment and control measures to protect women, themselves and others from infection.

However, we also found:

- Staff kept detailed records of women's care and treatment in line with good practice. Information that was recorded in records was clear, up-to-date and easily available to all staff providing care. Records were stored securely
- The service mostly had suitable premises to care for women. Staff managed clinical waste well.

Maternity

Is the service effective?

Inadequate 

- Doctors, midwives and other healthcare professionals did not always work well together to benefit women and babies. They did not support each other to provide good care.
- Multidisciplinary team working was dysfunctional. The longstanding poor staff culture had created an ineffective multidisciplinary team.

Is the service caring?

- Staff did not always treat women with compassion and kindness, although they respected their privacy and dignity, and took account of their individual needs.

Is the service well-led?

Inadequate 

- The service leaders did not have the skills and abilities to run the service. Leaders within the service were not effective at implementing meaningful changes that improved safety culture within the organisation.
- Leaders did not operate effective governance processes to continually improve the quality of its service and safeguarding standards of care. Whilst governance processes were in place these were not fully effective, there remained a lack of oversight and acknowledgment of risk and cultural concerns from the maternity senior leadership team.
- The service did not have an open culture where staff could raise concerns without fear. Staff were very aware of the long-standing poor culture and safety concerns.

However, we also found:

- 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.

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service had a comprehensive training programme to provide staff with the training they required however the trust target for attendance at training was not met by medical staff.

The trust set a target of 85% for completion of mandatory training, with the exception of information governance, safeguarding and preventing radicalisation training for which the target was 95%.

Maternity

For the reporting period March 2020 to September 2020, the training target was met for 13 out of the 14 mandatory training modules for which qualified midwifery staff were eligible. This was an improvement from the June 2020 focused inspection where mandatory training for midwifery staff did not always meet the trust targets.

For the reporting period March 2020 to September 2020, the training target was met for four out of the 14 mandatory training modules for which medical staff in maternity were eligible.

Mandatory training for medical staff in the maternity unit did not always meet the trust targets. Information from the trust showed that the low compliance rates for medical staff was due to the small number of staff who were required to complete the training. For example, 24 members of the medical team needed to complete information governance training. Out of these, 16 had completed with eight remaining. Similarly, four medical staff had to complete the training in record keeping, of which two completed the training.

Following the inspection, information provided by the trust stated that the majority of training compliance has improved since June 2020 with a concentrated effort on key areas of training such as safeguarding and basic life support for adults and neonates.

The mandatory training programme was comprehensive and met the needs of the maternity service. Training was provided online learning and at face to face sessions.

The service used nationally recommended 'Practical Obstetric Multi-Professional Training' (PROMPT) to deliver some of the maternity mandatory training. The topics covered by the PROMPT training included: fetal monitoring, inverted uterus, human factors, sepsis, Modified Early Obstetrics Warning Score (MEOWS) use to identify deterioration in a woman's condition, obstetric haemorrhage (excessive bleeding), shoulder dystocia (an emergency where the baby's shoulders are difficult to birth), breech (baby is birthed bottom presenting), eclampsia (seizures during pregnancy), twin birth and cord prolapse (the baby's cord slips down in front of the baby after the waters have broken). The training was delivered by a multidisciplinary team and involved a mixture of skills and live drills interactive sessions and presentations.

As of 1 September 2020, 85% of midwives and 87% of medical staff including obstetric and anaesthetic medical staff completed the PROMPT training. Due to the Covid-19 pandemic a number of restrictions were placed on the ability to complete the training, therefore the service amended the compliance target to 75% with the aim to achieve 90% by December 2020.

The trust employed three practice development midwives (PDMs) who were responsible for developing and delivering the mandatory training programme and recording midwifery attendance.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training attendance was monitored electronically, and staff received reminders to complete training. Training compliance for midwives had improved since the June 2020 focused inspection however it remained poor for the medical staff.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Medical staff training compliance rate on how to recognise and report abuse did not meet the trust target, however they knew how to apply it.

The trust set a target of 95% for completion of safeguarding training. The trust compliance target was met for five of the six safeguarding training modules for which qualified midwifery staff were eligible.

The trust compliance target was not met for four out of the six safeguarding modules for which medical staff were eligible. For the modules that medical staff did not meet trust target compliance rate ranged from 80% to 92% against the trust target of 95%.

Maternity

Midwifery and medical staff received safeguarding training specific for their role on how to recognise and report abuse. The safeguarding training staff received included child sexual exploitation (CSE) and female genital mutilation (FGM).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The staff we spoke with could confidently inform us of what a safeguarding concern would be and their process for reporting this. For example, domestic violence cases were some of the issues that had been identified and reported by maternity staff. Staff used the trust intranet safeguarding page to access contact details for further advice or support with safeguarding referrals.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were familiar with the process of escalation and referral to the safeguarding specialist midwife for extra support and understood the reporting system for women who presented with FGM. Staff told us they were always able to get support from the lead safeguarding midwife if they needed advice.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect women, themselves and others from infection. However, the service kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well maintained.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. The service had housekeeping staff who were responsible for cleaning wards and public areas, in accordance with daily and weekly checklists.

Staff cleaned equipment after each contact and labelled equipment to show when it was last cleaned. We saw that there was a system in use throughout the service to identify clean equipment by using 'I am clean' stickers.

The service audited hand hygiene and displayed the results in the entrance to the ward area. Data from March 2020 to August 2020 showed that all areas of the service scored 100% in the monthly hand hygiene audit.

The service followed current guidance for infection prevention and control when assessing and caring for women with possible or confirmed cases of COVID-19. Women with possible or confirmed COVID-19 were cared for in a side room away from other women.

Most staff followed infection control principles including the use of appropriate personal protective equipment (PPE). PPE was readily available, such as disposable gloves, masks and aprons. However, we observed three members of the midwifery staff not wearing their face mask correctly. We escalated our concerns to the trust leadership team who took immediate actions, an email communication was sent to all staff from the Chief executive officer (CEO) reminding them of the national directive to wear a face mask. In addition, local communication was carried out within maternity unit by the clinical director and head of midwifery.

We observed staff adhered to the trust's 'bare below the elbows' policy to enable effective hand washing and reduce the risk of spreading infections. We observed staff performed hand washing before and after episodes of direct care. Hand sanitising units and handwashing facilities were available throughout the unit and handwashing prompts were visible for staff, women and the public.

Women were screened for Methicillin resistant Staphylococcus aureus (MRSA) at booking. Where inpatient women had a known or suspected infection, they were cared for in single side rooms. For the reporting period March 2020 to August 2020, there had been two case of Clostridium difficile (C Diff). There was no cases of MRSA bloodstream infections in the maternity service for the same period.

Environment and equipment

The service mostly had suitable premises to care for women. Staff managed clinical waste well.

Maternity

During our focused inspection the Midwife Lead Birthing unit (MLBU) was closed following an assessment due to escalation of staffing issues, this was in line with the trust policy, therefore we did not visit this area.

The birthing rooms on the delivery suite did not have en suite facilities, which meant women in the delivery suite had to walk past other women, visitors and staff to use any toilet or shower facilities. This was not in line with national guidance (Department of Health (DH), Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities (2013)). The service had plans for the future to improve services however this work was in its infancy.

The service had two dedicated obstetric theatres and recovery area. The neonatal unit was close by if a baby's condition deteriorated and they required an urgent transfer.

All areas of the maternity service had card swipe in access for staff and visitors had to use a buzzer to gain entry or exit. The entrance to each ward was manned by a ward clerk between 9am and 5pm each day and after hours ward staff were responsible for ensuring the correct entry and exit procedure was adhered too. A camera monitor was positioned at the midwifery station which showed who was at the door awaiting entry or exit.

The service had enough suitable equipment to help them to safely care for women and babies. We checked six items of equipment and saw that they had up to date safety testing including resuscitaires, weighting scales and sonicaids (sonicaids are used to monitor the fetal heartbeat).

Staff carried out daily safety checks of specialist equipment. Staff checked adult and neonatal emergency equipment daily. We reviewed daily checklists for the emergency equipment from 1 July to 18 September 2020 which were all fully completed.

Staff disposed clinical waste safely. Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed in sharps containers which were dated and labelled with the hospital's details for traceability purposes. This was in line with national guidance (Health and Safety Executive Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for employers and employees (March 2013)).

Arrangements for the control of substances hazardous to health (COSHH) were adhered to. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials.

Assessing and responding to risk

Staff used national guidance to assess risks, although risk was not always acted upon appropriately. Safety handovers and briefings were not fully effective to respond timely to safety concerns.

The Mulberry assessment unit had a designated four-bedded bed and three triage rooms. This provided 24-hour assessment, review and care planning for pregnant women from 16 weeks gestation. Women who visited the assessment unit were triaged by midwives using a traffic light RAG (red, amber, green) rating to see a midwife and/or doctor based on the symptoms they had. We reviewed the notes of six women who visited the assessment unit, and all were seen within the appropriate time for their RAG rating. This was in line with national guidance (National Institute for Health and Care Excellence (NICE), Safe midwifery staffing for maternity settings overview (September 2019)).

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff took all observations required and scored correctly on the 'Modified Early Obstetric Warning Score' (MEOWS) charts. We reviewed 16 MEOWS charts in women's records on the day assessment unit, delivery suite and postnatal ward, we found all observations were completed and scored correctly.

Staff used a nationally recognised tool the 'Newborn Early Warning Score' (NEWS) to identify new born babies at risk of deterioration. At the time of our inspection we reviewed the two available NEWS charts, which were both completed and scored correctly.

Maternity

Managers audited compliance with the MEOWS guideline. We reviewed the audit results and action plans for August 2020. The results showed out of 41 sets of healthcare records which were randomly selected from women who delivered in August 2020; 100% had a MEOWS assessment undertaken on maternity triage and 80% on antenatal admission. The audit also showed that MEOWS assessment was undertaken 12 hourly in 91% of antenatal admissions and in 73% following birth. However, in postnatal ward, 12 hourly MEOWS assessments were undertaken in 94% of cases. The audit also showed that, 30% of cases were not actioned in accordance with guidance when a MEOWS triggered a score of one or two, the observations were not repeated for a range of between two to nine hours when they should be reassessed every hour. The action plan that was submitted consisted 11 actions for the service to complete. The action plan had actions assigned to individual staff members and was reviewed regularly to ensure the actions have been implemented.

Staff used a buddy system to review cardiotocography (CTG) interpretation. This was in line with national recommendations (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)). The service used the 'fresh eyes' approach. This meant a second midwife was required to review the CTG recording hourly during the woman's labour, to ensure it had been interpreted and classified correctly and escalated when needed. We reviewed 12 maternity records which showed CTG peer reviews were performed hourly and were escalated appropriately.

In May 2020 the review of six serious incidents showed that misinterpretation of CTGs and where abnormalities had been identified had not been appropriately escalated. During our focused inspection in June 2020 the service was taking immediate actions to provide all medical and midwifery staff with CTG interpretation masterclass. During this inspection we found that all midwives in high risk areas and 90% of staff in other areas have attended the masterclass and completed their competencies. Compliance for doctors at the time of our inspection in September was at 97%.

Staff completed booking risk assessments for each woman at their initial booking appointment which included social, medical, obstetric and mental health assessments. This enabled staff to decide if the woman was a high or low risk pregnancy, staff updated them throughout pregnancy, labour and the postnatal period as needed. We reviewed 12 maternity care records which confirmed these details.

Women who were assessed as high-risk and unsuitable for the midwife led birthing unit (MLBU) were referred to an obstetrician for review and management. Following our inspection, we reviewed the midwifery led birthing unit births report from June 2020 to August 2020. During this period 55 women birthed on the MLBU and they all met the criteria within the operational MLBU policy for admission to the MLBU. This was an improvement from the June 2020 focused inspection where high risk women had given birth in the MLBU.

Staff completed venous thromboembolism (VTE) assessments of in line with the service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein.

During our inspection in June 2020 we found the delivery suite handover was not multi-disciplinary (MDT) attended, there was no representation from the neonatal unit (NICU) or theatres. The format of the handover was not effective and handover from the postnatal ward did not follow situation, background, assessment, recommendation (SBAR) format. SBAR is a tool used to facilitate prompt and appropriate communication between wards/services.

During our September 2020 inspection we found handovers and safety huddles remained confusing and not fully compliant. We reviewed the daily handover sheet; on five occasions out of twelve days, the 18:00 handover was blank. We also attended the 11am safety huddle which did not happen. The maternity senior leadership team told us it had been moved to 12:30. We asked staff on delivery suite if they were aware of the 12:30 safety huddle and staff told us they were not aware. Instead staff informed us of a handover at 20:00 which was not recorded. This meant that the maternity leadership team could not be sure that the right staff would be attending the correct handover to receive important safety information.

Maternity

Following the inspection, the senior leadership team said they took immediate actions by communicating to all staff highlighting the difference between handover and safety huddle and the daily routine for handovers. The service also introduced handover sign in sheet for 20:00. Compliance was also monitored by the clinical director on a daily basis.

There was a pathway for the management of sepsis. Staff we spoke with described what actions they would take if a woman was admitted with suspected or known sepsis including the prompt use of the sepsis six tool, administration of fluids and antibiotics.

Swabs used for vaginal birth and perineal suturing were counted for completeness by two members of staff. This was in line with national recommendations (NSPA, Reducing the risk of retained swabs after vaginal birth and perineal suturing: 1229 (May 2010). We reviewed 12 records and saw two members of staff had verified the swab count.

The World Health Organisation (WHO) surgical safety checklist 'Five Steps to Safer Surgery' was used in maternity theatres. The service carried out observational audit to demonstrate compliance in all sections of the checklist utilised in maternity theatre. The audit measures whether all sections of the checklist are verbalised, exceptions noted and that all relevant staff are fully involved in the process. Since our inspection in June 2020 the service has been conducting monthly WHO surgical checklist observational audit. The reports from July and August 2020 showed 100% compliance with all aspects of the checklist. This was an improvement since the last inspection in June 2020. During this focused inspection we reviewed 12 WHO checklists and found they were fully completed.

Midwifery and nurse staffing

The service did not always 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. However, to mitigate the risk of harm managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough midwifery staff to keep women and babies safe. Staff told us the delivery suite coordinator was not always supernumerary which meant that in the event that a high number of women attended the delivery suite then they would be providing one to one care for a woman and not facilitating the communication between professionals and overseeing the risk and appropriate use of resources. This was not in line with the '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.' This was an area of concern highlighted in the June 2020 focused inspection and requirement notice was issued.

The service used an acuity tool to identify if it had the correct number of midwives employed to match the acuity of women accessing the service. Acuity is the measurement used to decide the level of care needed by a woman when in labour and giving birth. The service had conducted a staffing review in 2019 which indicated there was a shortfall of 15.39 whole time equivalent (WTE) registered midwives and 10.98 WTE for maternity support staff. The maternity senior leadership team told us the service continues to recruit midwives and had recruited 20 midwives since the June 2020 focused inspection.

The managers told us they adjusted staffing levels daily according to the needs of women. The service had an escalation policy which all staff we spoke with were aware of. The policy included calling in community midwives or closing the MLBU in the event of high levels of activity or staff shortages. Staffing was reviewed by managers within the service four times a day.

We saw staffing levels were displayed publicly in all clinical areas for midwives and maternity care assistants. On the day of our focused inspection we found planned staffing levels were mostly met. Although there were staffing shortages managers filled vacancy with bank or agency midwives and also closed MLBU. The service tried to use midwives familiar to the service all bank or agency midwives had received an induction.

Planned vs actual

Maternity

The trust reported in August 2020 it planned for 193.78 whole time equivalent (WTE) qualified nursing and midwifery staff for the service however the actual number of staff available was 171.17 WTE.

Vacancy rates

As of August 2020, the trust reported an overall vacancy of 29.59 WTE which equated to 14.6% of qualified midwifery staff in maternity. Vacancy rate has continued to increase despite the trust recruiting 20 WTE midwives since the focused inspection in June 2020.

Turnover rates

From June 2020 to August 2020 the trust reported an overall turnover of 3.9 WTE qualified midwifery staff in maternity.

Bank staff usage

The service used bank staff to fill gaps in midwifery staff. Bank staff completed an induction programme before working in the service. Ward managers told us they tried to use the same staff to promote continuity of care for women.

From June to August 2020 the service reported 16013 hours were covered by bank midwives and 2990 hours were covered by agency midwives.

Medical staffing

The service did not have enough middle grade medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The trust informed us that medical staff worked across maternity and gynaecology. For this reason, the data submitted includes medical staff that work in both core services. The trust reported in August 2020 that it planned for 42.9 whole time equivalent (WTE) medical staff for maternity and gynaecology services however the actual number of staff available was 29.58 WTE. The senior maternity leadership team told us that they were recruiting into these vacant roles.

The service had sufficient consultants to cover presence on the delivery suite in line with national guidance 'Labour Ward Solutions (Good Practice No. 10) 2010'. Monday to Friday, consultants were rostered from 8am to 8pm and from 8pm to next day 8am on call off site. At weekends the consultants were rostered for five hours each day and when required to provide offsite on call cover.

At the June 2020 inspection concerns were raised by staff that there was a lack of response by consultants to emergencies which meant delays in treating women. During this inspection staff told us that all elective caesarean sections were performed by a consultant dedicated to an all-day list and not on call for emergencies. This meant that there was a dedicated consultant that covered delivery suite. In addition, gynaecology and antenatal triage emergencies were going being managed by a separate consultant from 9am to 6pm Monday to Friday.

Vacancy rates

As of August 2020, the trust reported an overall vacancy of 7.75 WTE medical staff working across maternity and gynaecology. These vacancies were in middle grade medical staff posts.

During this inspection we spoke to a number of junior doctors who told us they were tired, short staffed and training was not taking place as they were working extra hours to cover any gaps in the rota. We escalated our concerns to the senior leaders for the service who told us that they had recently been successful in recruiting to the vacant posts, once in post this would help reduce the additional hours that the doctors were working. Following the number of serious incidents in May 2020 a number of registrar level doctors were working under supervision, the senior maternity leadership team told us that they have now been signed off as competent and are now fully contributing to the rota.

There were no vacancies in consultant roles.

Maternity

Turnover rates

From June 2020 to August 2020 the trust reported an overall turnover of two WTE medical staff working across maternity and gynaecology.

Bank and locum staff usage

Locum staff were employed to complete any rota gaps and staff confirmed these locum doctors were regularly employed within the service. The service had an induction process to ensure locum doctors understood the process and protocols and to familiarise them with the environment.

From January to March 2020 the service reported 2275 hours were covered by bank and 2137 hours covered by locum doctors across maternity and gynaecology.

Records

Staff kept detailed records of women's care and treatment in line with good practice. Information that was recorded in records was clear, up-to-date and easily available to all staff providing care. Records were stored securely.

Staff could access women's records easily. The service mainly used paper-based records, with some information held on the trust's electronic patient record system.

We viewed 12 care records of women who had used the maternity service in the previous 48 hours or whom were still on the ward at time of inspection. The records related to all of the episodes of care during their pregnancy. The records were mostly completed in line with records management code of practice for health and social care. During this inspection 11 out of the 12 records we reviewed include time of the woman's antenatal appointment this was in line with the national Nursing and Midwifery (NMC) record keeping guidance (January 2019) and an improvement from the June 2020 inspection.

During the current Covid-19 pandemic, as a precautionary measure, carbon monoxide monitoring has been paused. We reviewed 12 records, 11 out of 12 records demonstrated the service continued to ask all women about their smoking status at antenatal appointments, and at the time of delivery, and gave appropriate advice and support.

Records were stored securely. Records were kept in lockable mobile storage trolleys when not in use. This was an improvement since the June 2020 focused inspection.

Medicines

The service did not always use systems and processes to safely prescribe, administer and record medicines. The service store medicines safely.

We reviewed the medicine records for five women and found prescriptions were readable, signed, allergies were clearly documented. Staff recorded the time medication was given and route of administration.

Women at risk of developing a blood clot were prescribed an anticoagulant (anti-clotting medicine) to reduce this risk. During the inspection two out of the five prescriptions we reviewed women were required to have anticoagulant prescribed. Anticoagulant administration by a midwife, was not recorded in the correct section on the prescription chart.

We escalated our concerns to the senior leadership team. Following the inspection, we were advised that communication was sent to all staff around safe medicine administration and recording correctly on the prescription chart. In addition, the service was conducting an audit of all women discharged to measure compliance with correct completion of drug chart. We reviewed the results of these audits and the findings confirmed that staff where not

following the correct process of recording on the prescription charts when women were prescribed. In addition, the audits showed staff were not always completing the self-administration form if a woman self-medicated. Therefore, we were not assured that the service was following their own medicine administration policies and procedures and applying best practice.

Staff reviewed women's medicines regularly and provided specific advice to in relation to options of pain relief during and following the birth of their baby. The service had access to pharmacy staff to support the maternity areas.

Medicines were stored securely in all clinical areas we visited. Controlled drugs (medicines subject to additional security measures) were stored correctly in locked cupboards and stock was checked by two qualified members of staff twice a day.

We found medicine storage areas were well organised and tidy, with effective processes in place to ensure stock was regularly rotated. All medicines we checked were within their use by date, including intravenous fluids (fluid given through a vein).

We saw that staff kept records of medicines fridge temperatures and ambient room temperature of their medicine rooms on the delivery suite and postnatal ward.

Secure bedside storage was provided for women's own medicines, which meant women's own medications were stored securely on the wards.

Incidents

The service reported safety incidents, staff recognised incidents and reported them. However, we were not assured that incidents were always graded correctly according to the level of harm and if lessons learnt from past incidents were being shared with the whole team and the wider service.

Staff we spoke with knew what incidents to report and how to report them. The trust used an electronic reporting system which all grades of staff had access to. Staff we spoke with said they were encouraged to report incidents.

Never events

From June 2020 to September 2020 the service had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly. All potential serious incidents were reviewed by the trust's serious incident panel which met three times a week. If an incident was declared as a serious incident the panel appointed an appropriate senior member of staff to lead the investigation and conduct a root cause analysis (RCA).

Incidents which met the reporting criteria were referred to the Healthcare Safety Investigation Branch (HSIB) for independent investigation. The HSIB's maternity investigation programme is part of a national action plan to make maternity care safer. They investigate incidents that meet the 'Each Baby Counts' criteria and maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from June 2020 to September 2020.

At the June 2020 focused inspection, we observed that incidents were not always graded correctly. Following the focused inspection in June 2020 information received to demonstrate compliance with the service maternity

improvement plan showed that incident management processes had been strengthened by the introduction of daily huddles where all incidents were reviewed, and appropriateness of grading and level of investigation discussed. However, we reviewed the July and August 2020 STEIS reported data where a number of incidents have been inappropriately graded. These included:

- A number of postpartum haemorrhage (PPH)greater tan1000ml graded as no harm (not clearly documented within the incident if there were predisposing risk factors).
- Babies transferred to the neonatal intensive care unit for admission were graded as no harm or low harm (however from the incident descriptor not sure if these were term babies).
- Missed venous thromboembolism (VTE) prophylaxis at antenatal (incidents graded as no harm and low harm).
- Women discharged following delivery without correct VTE prophylaxis (incident graded as no harm and low harm).
- There were two incidents reported as missed observation of a baby on antibiotic therapy on the postnatal ward.
- Two incidents with concerns around cardiotocography (CTG) reading and escalation, graded as low harm
- Two incidents where women were discharged without having their anti-D injection (given to women during and after delivery with a negative blood group). Another woman received anti-D when positive blood. All three incidents graded as no harm or low harm.

Therefore, we were not assured that incidents were being graded appropriately. This meant that incidents would not be investigated fully, or duty of candour not be applied correctly. People would be at risk of harm as lessons could not be learnt. This was an area of concern that was identified at the June 2020 focused inspection and a section 29a warning notice was issued against the service.

At the time of our inspection the service had 110 open incidents that were awaiting a review. We were not assured that the service was aware of the safety concerns due to the number of incidents awaiting a review.

Is the service effective?

Competent staff

The service made sure staff were competent for their roles.

We identified concerns regarding incorrect classifications of cardiotocograph recordings, staff competency compliance during our June 2020 inspection. These concerns were also highlighted in findings from the six serious incidents reported from January 2020 to April 2020 which resulted in harm to babies. The service decided that only competent assessed consultants and senior midwives were allowed to sign off classifications, discontinuation and hourly reviews of CTG traces. This was a short-term intervention until all midwives and medical staff attended the CTG masterclass and completed their competencies assessment.

At the time of our inspection in September 2020 all midwives working in high risk areas and 90% of staff in other areas have attended the masterclass and completed their competencies. Compliance for doctors for the CTG master class was at 97%. This was an improvement from our June 2020 inspection.

During the June 2020 inspection junior medical staff told us that they were not comfortable asking the consultants for support as they were made to feel incompetent. The maternity senior leadership team (SLT) said that following a meeting with the consultants in May 2020, the consultants felt it was not their role to support and teach the junior staff.

An action plan to address the lack of junior staff supervision and support had been developed by the SLT and was implemented in June 2020. However, during this inspection junior medical staff told us that there were consultants who did not follow the new CTG guidelines which caused difficulties when approaching the consultants to discuss plans of care

Senior leaders told us that the service training director and trainee medical staff had devised an action plan to improve supervision of the junior medical staff and encouraged the junior medical staff to speak out and raise concerns.

Although an action plan to improve support for junior doctors was being progressed, seven medical staff we spoke with said that they felt over worked and lots of pressure to cover the rota. Junior doctors told us that they did not have protected teaching. Although there had been opportunities to go for teaching for example, the weekly CTG meeting, they were unable attend as they had to cover gaps on the rota.

We escalated our concerns to the senior leadership, and we were told that Health Education England, Royal college of Medicine and General Medical Counsel conducted a recent joint visit of the service. The SLT told us they were satisfied with training conditions for doctors and were complimentary of the support that trust provided the doctors.

Following our inspection, the service organised for the service training director to meet with junior doctors on a weekly basis and also for the clinical director to meet the junior doctors twice monthly. In addition, we were told that the trust director of medical education would meet doctors every three months.

Trainee representative to represent trainees at business unit meeting once a month.

Appraisal rates

The service met the trust's target of 90% for appraisals between June 2020 and August 2020. Appraisal compliance data in maternity for midwifery staff was 92.75% and medical staff was 100%.

Multidisciplinary working

Doctors, midwives and other healthcare professionals did not always work well together to benefit women and babies. Staff were not always supportive of each other to provide good care.

Following the June 2020 inspection, changes were made to the multidisciplinary team (MDT) handover meetings to discuss women and babies and improve their care. However, during this inspection we found the MDT handovers remained confusing and not fully compliant. Staff told us that since the arrival of the new clinical director, daily checks and phone calls were made by the clinical director to check consultant presence on the labour ward. Medical staff were more available and their response to emergencies had improved. Staff told us they were concerned regarding the sustainability of this process if the daily checks were removed.

Junior medical staff told us that some consultants were not onboard with the new physiological CTG interpretation and were not engaging with the CTG teaching, which made the process even more difficult and created uncertainty with decision making. Some junior doctors felt they were being dismissed by consultants which led to some difficult debate in care plans for women they looked after.

We escalated our concern with the senior leadership team (SLT). Following the inspection, the SLT stated that the guidelines were being published on the 22 September. Ahead of the launch on 21 September, the clinical director held a meeting with all the consultants and confirmed that no consultants were refusing to adopt the new CTG guidance following CTG training.

In addition, the SLT told us to empower and engage staff in the safety improvements that needed to be made, each of the key improvement workstreams had a consultant lead and midwife supporting, and the culture workstream had MDT

representation including a middle grade doctor. However, midwife managers told us that they did not feel that there was appropriate involvement of all grades of staff. Staff told us communication with the senior maternity leadership team remain poor, for example the implementation of the post-partum haemorrhage proforma was completed without the knowledge of the midwife managers.

Is the service caring?

Compassionate care

Staff did not always treat women with compassion and kindness, although they respected their privacy and dignity, and took account of their individual needs.

Staff did not always care for women with compassion and kindness. We observed two uncaring face to face interactions with women and their partners and one telephone interaction between a member of staff and a woman. In these incidents we witnessed staff did not interact with women who used the service and those close to them in a respectful and considerate way.

During our inspection we feedback our findings to the executive and senior leadership team. Following our inspection, the trust submitted a daily reassurance audit. Staff asked 10 women each day, two questions face to face 'What was positive or good about your stay?' and 'What can we improve on?'. We reviewed audits from 22 September to 8 October 2020. These demonstrated mainly positive comments. We were concerned that as these were direct questions face to face with women, when not all women may feel able to answer them as they would if they were able to anonymously.

Staff made sure women's privacy and dignity needs were understood and respected. There were curtains in the rooms and ward areas. We observed staff knocking and asking for permission to enter before going into women's rooms.

Is the service well-led?

Leadership

We were not assured that the service leaders had the skills and abilities to run the service. Leaders within the service were not effective at implementing meaningful changes to provide the evidence that demonstrated an improved safety culture within the organisation.

Maternity services were within the women's and children's division in the trust's structure. There was a head of midwifery, clinical director and general manager. Following our inspection June 2020, the trust had recruited support for the head of midwifery two days a week to help implement changes required to improve the service. We did not observe significant changes following this additional resource.

At the time of our focused inspection, the trust's group clinical director for the three hospitals maternity services remained as the interim clinical director (CD), with the interim general manager. The service had also recently recruited an interim director of midwifery and a deputy head of midwifery to strengthen the senior leadership team, both were very new in post.

The head of midwifery (HOM) and the clinical director told us since our June 2020 inspection that they had now presented directly to the board and this was to continue in line with Spotlight for Maternity 2016. The 'Spotlight on Maternity' March 2016 states '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 to present regularly to the board.'

Maternity

During our focused inspection, the HOM told us that since our last inspection the CD and the HOM had presented safety improvement evidence to the board. The chief nurse met weekly with the HOM and clinical director to discuss progress with their maternity improvement plan these meetings were now minuted which was an improvement from our June 2020 inspection. We were concerned with the effectiveness and oversight of the evidence due to the concerns on our inspection, for example but not limited to; poor safety handovers, ineffective governance processes and learning.

Information provided post inspection outlined that as part of the integration of the corporate governance structures across the trust's three maternity services, the principle assurance committees would meet in common only and retain oversight of performance at individual site level. We were not assured that these processes that had been put in place were effective, safety concerns identified at our June 2020 inspection were still evident.

Staff told us that some changes in process had been implemented, however staff continued to report the presence of the longstanding poor culture had not changed since our inspection in June 2020. Staff remained concerned that this would result in a further deterioration of the safety of the service. We did not observe changes being driven by the SLT and support and involvement of local managers or the junior midwives, therefore the governance and oversight for improved progress and change was not owned locally or effective to embed change and improvements.

Staff told us that they had previously raised the safety concerns to the SLT and due to the lack of improvement staff then reported concerns to the executive team in September 2019. Staff were very emotional and upset that there had been no change of direction to improve services following those meetings. Staff told us following the publication of our report in August 2020 they returned to the SLT and executive team to share their frustrations and that they had escalated the concerns we found on our June 2020 inspection to them last year. We were not assured that the SLT or executive team had listened and acted upon the safety concerns that staff from the service had escalated to them.

We raised our concerns to the executive team during our feedback regarding what their staff had reported to us. Following our inspection, the service recruited a director of midwifery and an external improvement director to support and direct the maternity SLT.

Following our inspection, we received nine whistle-blower concerns to the CQC regarding the maternity leadership. We were not assured sufficient steps had been taken to address the culture issues following the warning notice we issued in June 2020. Actions and change of processes to improve culture had been implemented in May 2020, however, we found that this remained in its infancy and yet to be embedded.

At our inspection June 2020 the new maternity SLT told us that there had been a lack of leadership and oversight of the consultant body's support for junior medical staff. The junior medical staff found it difficult to approach and escalate risk to some of the consultants for support as they were made to feel incompetent. Although an action plan to address the lack of junior staff supervision and support was implemented in June 2020, junior medical staff told us that these concerns had not been resolved.

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.

The trust developed a five year strategic plan following the recent merger of Basildon University Hospital with Mid Essex and Southend University Hospitals to form Mid and South Essex NHS foundation Trust. The maternity service strategy was included with the trust's five year strategy.

The maternity service's strategy detailed the service's ambitions for the next five years and was aligned to the local maternity board (LMB) strategy. The strategy spoke of close collaborative working with the LMB throughout. We did not see an action plan in place with actions assigned to individual staff members, to achieve the strategy.

Maternity

The maternity service has its own vision of "working in partnership with women, empowering them to make informed decisions about their care, ensuring that it is personalised to meet their individual needs." Staff did communicate and plan care with the women individually, however, due to the remaining concerns found present throughout our inspection we not assured that this was always achievable with the current standard of multidisciplinary working within the service.

Culture

The service did not have an open culture where staff could raise concerns without fear.

All staff we met during our inspection were welcoming, friendly and helpful. It was evident that staff remained concerned about safety within the service. All staff we spoke with were very aware of the longstanding poor culture and safety concerns. Staff told us that some of the consultants and longer serving midwives poor behaviours continued. Staff told us some colleagues were not welcoming of new staff, judgemental and demeaning in front of women which was demoralising. Staff told us they could approach the SLT to report concerns, however they did not see a response or improvements to their concerns raised.

Following our June 2020 inspection, the new maternity SLT had implemented actions to improve the long-term history of poor culture and ineffective multidisciplinary team working which had impacted on safety within the maternity service. However, staff told us that there were continued poor behaviours, we also received nine whistle-blowers expressing the same concerns including; poor culture within the maternity service from the leadership team, lack of oversight by senior management, poor staffing and inability to access training, incorrect guidance and poor communication. Therefore, we were not assured sufficient steps had been taken to address the culture issues that had been identified in our June 2020 inspection. Following this inspection, the trust provided us with a communications plan which was emailed to all staff.

All NHS trusts are required to nominate a freedom to speak up guardian (FTSUG). The role of the FTSUG supported staff who wished to speak up about a concern or issue and ensured that any issue raised was listened to and the feedback was provided to them on any actions or inactions because of them raising an issue. Most staff we spoke with were aware the trust had a FTSUG service and how to report their concerns if required.

Following the cultural issues we observed and staff shared with us at our June 2020 inspection, the SLT told us to assist staff escalating concerns they had promoted awareness of the FTSUG within the maternity service.

Despite the number of measures the service has implemented to encourage staff to speak up, the pulse maternity staff survey from August 2020 showed that only 59% would feel secure raising concerns about unsafe clinical practice compared to 70% in the 2019 survey. In addition, the August 2020 survey showed only 34% of staff felt confident that the organisation would address their concerns, compared to 62% in 2019. Therefore, we were not assured that the processes that were in place to support staff to raise their concerns were effective.

The SLT told us that the director of nursing and the chief nurse were performing assurances visits. Two non-executive directors had also visited for assurance visits and reported back key messages to the chief nurse for example, 'member of staff emotional', 'unit felt calm and in control' and 'no hand sanitiser on two occasions'. However, staff told us they felt that the SLT were blaming them for the safety concerns within the maternity service.

We received an action plan following our June 2020 inspection to improve the culture which contained the following for example: establishing regular staff forums, the development of a communication strategy to encourage staff to escalate concerns and involving external stakeholders for cultural support. These remained in their infancy and were not yet embedded.

Governance

Maternity

Leaders did not operate effective governance processes to continually improve the quality of its services and safeguarding standards of care.

There were governance processes in place, however, these were still not fully effective, there remained a lack of oversight to review the effectiveness of the processes from the senior leadership and executive team. A number of the issues identified during our inspection, were pre-existing issues that had already been highlighted at the June 2020 and February 2019 inspection. A warning notice was issued in relation to these breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust developed an action plan in response to these breaches, submitted regular updates and closed the actions, however, we found at our inspection the concerns were still present. The actions put in place did not address or remedy the issues and the maternity governance did not identify issues with the quality of care being provided. The systems and processes that were in place to address the concerns from June 2020 had still not been embedded within the service.

The maternity service had six serious incidents reported between January 2020 and April 2020. Five of these serious incidents identified the same failings of care. Following our inspection June 2020 to September 2020 the service had two further serious incidents with elements of the themes from the six incidents earlier in the year. This demonstrated that the actions put in place following our June 2020 inspection were not embedded. Therefore, we were not assured that the governance and oversight of lessons learnt was effective to prevent similar incidents from occurring.

We found continued concerns relating to the governance processes of incident grading and appropriate review. This was an area that was identified at the June 2020 inspection, for which a warning notice was issued. Incident data reported by the trust from July to August 2020, demonstrated that incidents were not always graded correctly in accordance to moderate harm as stated in Regulation 20 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

The service had revised their governance structure which was within the women's and children's division. The clinical maternity governance and risk manager held responsibility for managing risk within the maternity services, including monitoring incident reports, compliance with learning outcomes, and actions resulting from serious incident reviews. At our focused inspection we found a number of areas of concern remained within the structure of the maternity governance and risk management team. The clinical governance lead role was vacant and staff within the department did not know who their line manager was. We escalated our concerns to the SLT during our inspection. Following our inspection, the trust provided us with a further governance proposal to strengthen their governance structure. However, this had yet to be agreed and implemented in practice.

The service had improved since our last inspection June 2020 and now held monthly clinical governance meetings. We requested the last four meeting minutes and we were provided with the minutes from June to September 2020. The minutes showed that the head of midwifery and the clinical director presence had improved. The minutes confirmed governance matters such as incidents, risks, performance, guidance, audits and complaints were discussed, however the actions were not clearly assigned to a member of staff with a deadline for completion.

The service held perinatal mortality and morbidity meetings. Following our focused inspection, the executive team told us that the interim clinical director had reviewed some of the cases discussed by the perinatal review group and had raised concerns about the decisions made by the group and sometimes the group was not quorate and hence the discussions and decisions would not be valid. Senior leaders confirmed that they had taken urgent actions and put new measures in place to address the concerns raised; by reviewing all the cases discussed since January 2020, and a review of the terms of reference of the perinatal mortality and morbidity review group.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively.

There were some processes in place to identify risk. The maternity service had a risk register and we saw that risks within the service were on the risk register. Risks were recorded and managed using the trust's electronic risk reporting

system. All risks on the register were allocated to a member of staff responsible for reviewing and monitoring them. We observed the risk register and risks were in date and had been reviewed. However, there were risks that had remained on there for a significant amount of time for example, 'the risk to consistently maintain a high standard of record keeping' which was added June 2013. We found concerns with the standard of record keeping at our June 2020 inspections.

We reviewed the 'clinical audit & quality improvement programme 2020 to 2021'. The timetable was a comprehensive programme and included a variety of clinical audits allocated to a lead and a junior doctor to complete. The service provided us with three completed audits, for example 'reduced fetal movement audit' and 'preterm birth audit' which demonstrated findings identified from the audits and recommendations to be shared with the service.

Following our inspection, the service commenced a weekly site leadership and maternity meeting we were provided with documents from July 2020 to September 2020. There was no structured agenda, which meant there was no audit trail of improvement or decisions made pertaining to a particular topic. Notes were made, however there were no actions aligned to staff or completion dates.

Daily handovers included a briefing of any issues highlighted by managers. The service had made some improvement since our last inspection in June 2020, we observed that the handovers included safety briefings. However, qualified midwives still did not receive a full detailed handover on the delivery suite. Therefore, not all would be aware of the risks discussed.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The service had made some improvement from our last inspection June 2020, the dashboard was now displayed for staff to see, but not in clinical areas for the public to be aware of the outcomes and risks of the maternity service.

We saw that the services dashboard was reviewed as part of the women's health clinical governance and risk group meeting. We requested the meeting minutes for these and reviewed four sets from June 2020, July 2020, August 2020 and September 2020. We saw that 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 this was the case at our last inspection June 2020.

Following our June 2020 inspection, the service introduced a maternity daily scorecard. We were provided with scorecards from 3 August 2020 to 31 August 2020. Staffing was consistently not achieving the fill rate. At the time of our inspection the maternity SLT told us staffing was not an issue, we were not assured that the oversight of risk of consistent poor staffing escalated on the maternity scorecard had been escalated and actioned appropriately. This has been on the risk register since August 2018.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations.

- The service must ensure medical staff complete mandatory and safeguarding training with the trust target. Regulation 12 (2) (a)
- The service must ensure that the delivery suite daily handover is fully attended and documented. Regulation 12 (2) (b)
- The service must ensure the delivery suite coordinator is always supernumerary. Regulation 12 (2) (b)
- The service must ensure that medicines are administrated and recorded always in line with the trusts medicine administration policies and best practice. Regulation 12 (2) (g)

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- The service must ensure that incident grading is reviewed to ensure it is accurate and reflects the level of harm in line with national guidance. Regulation 12(2)(b)
- The service must ensure that staffing is actively reviewed and escalated appropriately to maintain safe staffing in the maternity unit. Regulation 18 (1)
- The service must ensure multidisciplinary team working is improved. Regulation 12 (2) (b)
- The service must implement an effective governance system. Regulation 17 (1)

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

- The service should ensure all staff are wearing the right personal protective equipment (PPE) at all times.

Our inspection team

The team that inspected the service comprised an of inspection manager, a lead inspector, an inspector and specialist advisor. The inspection team was overseen off site by Mark Heath, 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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Section 31 HSCA Urgent procedure for suspension, variation etc.