East Sussex Healthcare NHS Trust

Eastbourne District General Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Eastbourne District General Hospital

Good 

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

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

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

Eastbourne Midwife Unit (EMU) is in Eastbourne Sussex and part of the East Sussex Healthcare NHS Trust. The unit is run by a group of core midwives and maternity support workers (MSW's) and is supported by the community midwifery teams. The unit operated 24 hours a day for low risk mothers. Services offered were antenatal care, day assessment unit which ran on Mondays, Wednesdays and Fridays, telephone triage assessment line and low risk childbirth, pregnancy vaccination and postnatal clinics.

The unit has two main birthing rooms, one included a birthing pool, two en-suite postnatal rooms for women to be transferred into after they have given birth. There were clinical side rooms and a community midwifery hub. EMU accepted women from the main acute site once they had given birth and were able to be transferred to receive extra support if required.

EMU accepted 'low risk' women and pregnant people over 37 weeks for childbirth. Any women that developed complications during labour were transferred to the acute unit at Conquest Hospital.

The midwifery led unit was closed from the 10 December 2021 until the 21 April 2022 due to staffing challenges. This meant there were 107 babies born at the midwifery led unit from October 2021 to September 2022 this was lower than previous years.

Our rating of the Eastbourne Midwife Unit was requires improvement. We rated it as requires improvement because:

This was the first time we inspected the Eastbourne maternity services without gynaecology, and the first visit since it changed to the Eastbourne Midwifery Unit. We rated safe as requires improvement and well-led as good and the Eastbourne Midwife Unit as requires improvement overall.

We also inspected one other Maternity service run by East Sussex Healthcare NHS Trust. Our reports are here:

Conquest Hospital Maternity Unit: https://www.cqc.org.uk/location/RXC01

How we carried out the inspection

Our findings

This maternity thematic review was a focused inspection; we inspected the domains of safe and well led using the CQC's established key lines of enquiries (KLOES).

This was our first inspection of the Eastbourne midwife unit. We visited the telephone triage area and the community midwives office. We spoke with 6 staff members to understand what is was like working for the service, including midwives, maternity care assistants and housekeepers.

We interviewed leaders to gain insight into the trusts leadership and governance model of the service.

We reviewed 3 sets of patient care records. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments and recently reported incidents.

After the inspection we requested further documentary evidence to support our judgements including policies and procedures, staffing rotas and quality improvement initiatives.

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 location was requires improvement because:

- The service did not always have enough staff to care for women and keep them safe, not all staff had completed their 'trust-wide' mandatory training. Staff were not compliant with level 3 safeguarding. The service did not use a prioritisation score to risk assess women when they arrived unexpectedly for care. Managers did not monitor wait times. The service did not always review incidents within national targets.
- Some policies were out of date and staff found it difficult to access policies online, resuscitaires displayed out of date resuscitation council guidelines. Staff appraisal rates were much lower than targets set by the trust.

However:

- Staff received multidisciplinary emergency life support training. Staff worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. They managed medicines well. Services were tailored to meet the needs of the local population.
- Leaders ran services well using reliable information systems most of the time and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment. and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement

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

Staff received and kept up-to-date with their mandatory training. Records showed that the quality improvement and assurance lead was responsible for producing an annual training needs analysis which was based on the most recent evidence and considered themes from previous incidents. Training included but was not limited to, fetal monitoring in labour, SBAR (situation background assessment and recommendation) handovers, neonatal and maternal resuscitation and human factors training.

The trust-wide mandatory training was comprehensive and met the needs of women and staff. The trust had standard mandatory training for all staff. Records showed that Eastbourne Midwifery Unit (EMU) and community midwives met the trust target of 90% for e-learning training like infection control, fire safety and conflict resolution. However, records showed that compliance for basic life adult and newborn life support, blood transfusion and moving and handling did not meet trust targets with compliance figures of between 62% for community midwives and 75% for EMU midwives.

Maternity

Managers on EMU were unable to provide us with a formal list of staff compliance to all aspects of mandatory training for staff working at the midwifery led unit. There was no evidence of recent skills and drills training for evacuation of the pool and baby pod transfer, although staff had completed an online scenario. Training records for May 2022 did not show which staff attended or whether the training was delivered online or face to face.

Managers made sure staff received any specialist training for their role. The service provided multidisciplinary emergency simulated obstetric mandatory training. Records confirmed that the trust kept data of cross-site training compliance for Practical Obstetric Multi-Professional Training (PROMPT) emergency multi-disciplinary skills and drills training. The training ensured compliance with the following national maternity standards

- Saving Babies Lives Care Bundle
- Fetal Surveillance in Labour
- Maternity Emergencies and multi-professional training
- Personalised Care
- Care During Labour and the Immediate Postnatal Period
- Neonatal Life Support
- Covid-19
- Local Learning from incidents, complaints, and claims.

Records showed that 92% of staff had completed the emergency training.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism. The training provided staff updates about caring for women identified as suffering from perinatal mental health problems. Staff were 83% compliant, which did not meet the trust target.

Safeguarding

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

Midwifery staff received training specific for their role on how to recognise and report abuse most of the time. The service had a named midwife for safeguarding who was responsible for implementing safeguarding training. The named lead for safeguarding was trained at level 4 safeguarding children and adults. Safeguarding at the trust was multi-professional and focused on the family. Online training reflected evidence based practice and became a hybrid module during the COVID-19 pandemic. Pre learning modules were provided to staff before the training sessions.

Safeguarding training for children and adults was inclusive and called ‘Think Family’; the training was provided at level 3 for registered practitioners. Records showed that 79% of Eastbourne Midwife Led (EMU) midwives and only 68% of community midwives had completed the training. These figures were not aligned to the trust target of 90%. The impact of low safeguarding compliance is midwives do not act in line with current guidance.

Non-clinical staff receive level 2 safeguarding training which is completed via an electronic learning data base and records showed 80% compliance.

Medical staff received training specific for their role on how to recognise and report abuse however not all were up to date with training. National guidelines state that all healthcare professionals planning care for families should receive level 3 safeguarding training. Records showed that only 74% of consultants were compliant for level 3 safeguarding. However, only 36% of all other medical staff had completed the training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The safeguarding lead delivered a safeguarding masterclass on specific key topics such as domestic abuse and FGM. The training combined both adult and children safeguarding within the 'Think Family' ethos. The training was updated annually or as required to ensure that it was evidence based.

A team of senior Band 7 and 8 midwives facilitated the virtual training online in pairs. This was initially a weekly rolling programme but due to staffing pressures within the team it was changed to monthly. Staff also received domestic abuse training.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with, knew how to protect vulnerable groups of women and pregnant people.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew who the safeguarding lead was and how to contact them. Staff had access to assessment documents and new who to inform if they had concerns. The electronic patient care records included a safeguarding alert for families who required social care support.

Staff followed safe procedures for children visiting the ward. The midwifery led unit was accessed by swipe cards. People attending the unit used a buzzer to gain access.

Staff followed the baby abduction policy and undertook baby abduction drills. All areas were password protected and accessed by swipe cards.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Housekeepers provided regular cleaning of toilets, corridors, and floors. Privacy curtains were made of material and changed every 3 months unless soiled.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. Maternity support workers and midwives made sure childbirth rooms and postnatal side rooms were cleaned after use. All areas were well maintained. However, the trust did not use system to notify staff once equipment was cleaned and ready for use like the nationally recognised 'I am clean' stickers.

The service performed well for cleanliness. Records showed that the midwifery unit did not submit data for July 2022, but for August and September 2022 performed well with 99% compliance.

Managers completed monthly hand hygiene audits records confirmed that the average score for the midwifery unit was 100%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff completed daily cleaning checks and the records available in the staff office and confirmed compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff on the midwifery unit always wore face masks unless a mother or pregnant person struggled to understand then face masks were removed to ensure effective communication. Staff had access to single use gloves and aprons when required.

Antibacterial hand gel and surface wipes were available in all rooms on the Eastbourne midwifery unit.

There were no reported nosocomial outbreaks during the reporting period November 2021 to October 2022.

Environment and equipment

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

The design of the environment followed national guidance. The self-contained midwifery led unit was on the second floor. The area was spacious well maintained and easy to access in an emergency. However, although it was fit for childbirth, the environment did not meet Midwifery Unit Standards (2018) because of the limited amount of community hubs and lack of available space for clinics within the EMU. This was because since COVID-19 GP surgeries had stopped maternity services hosting community clinics. This meant that community clinics had been relocated to the EMU. The risk was identified on the internal risk register.

The service had suitable facilities to meet the needs of women's families. The unit included 2 birthing rooms, one with a built on pool. There was an assessment room which included a corner bath which was used as a backup bath for women in early labour. There were two postnatal side rooms with bathrooms. Parents had access to a family room, which contained a kitchen area and the service provided tea and coffee making facilities.

The staff room was large and was where staff met to discuss patient care, record notes and complete administrative duties. Community midwives had an office and clinic rooms within the midwifery led unit.

Staff carried out daily safety checks of specialist equipment and the service had enough suitable equipment to help them to safely care for women and babies. Staff were allocated to daily checks of the emergency safety equipment which included a neonatal and adult resuscitation trolley which were sealed so staff knew they had been checked and were ready to use. Midwives had access to one resuscitaire and records showed that daily checks were completed, and managers monitored compliance.

Staff disposed of clinical waste safely. Clinical bins were colour coded and sharps bins were dated and signed for. When full they were sealed and removed from the unit.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration most of the time. However, staff found it difficult to access to standard operating procedures on the trusts intranet system.

Maternity

Staff working in the Eastbourne Midwife Unit (EMU) followed the trusts 'Clinical Guidance for Birth within the Home Environment or Eastbourne Midwifery Unit'. The guidance was reviewed in March 2021 and included a birthplace assessment tool, to be used in conjunction with the 'choosing where to give birth to your baby' leaflet. Midwives gave women information about place of birth options during the first midwives 'booking' risk assessment.

Staff completed risk assessments for each woman during the antenatal period, on admission during labour and during the post-natal period. Staff used nationally recognised care bundles to assess and plan care throughout pregnancy, childbirth and during the postnatal period and reviewed care at each appointment.

The trust provided a 'Personalised Care' clinical guideline which included referral pathways for all women. However, the guidance review date expired in May 2021, this meant staff may not be clear about current practice.

Community midwives completed booking risk assessments in clinics to identify women suitable for the birth centre. Staff used nationally recognised care bundles to assess women during pregnancy. For example, the 'Saving Babies' Lives Version Two (2019), which is an evidence-based bundle of care designed to reduce the numbers of stillbirth and early neonatal deaths bringing together five elements of practice which are identified as best practice:

- Reducing smoking in pregnancy
- Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction (FGR)
- Raising awareness of reduced fetal movement (RFM)
- Effective fetal monitoring during labour
- Reducing preterm birth

Community midwives completed a birthplace risk assessment at 36 weeks of pregnancy. The information required included details or previous medical and obstetric history as well as any pre-existing medical conditions that may increase risks during childbirth.

Women categorised as moderate or high risk who wanted to give birth at the EMU were referred to a doctor and or consultant midwife for conversations around the risks of childbirth. The reason for referral was to develop a personalised care plan in case of complication and the need for transfer to the obstetric unit at Conquest Hospital.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately for most aspects of care. The maternity telephone triage service was housed within the Eastbourne Midwifery Unit. There was designated experienced midwife and the telephone line was open from 8 am to 8 pm, 7 days a week. Midwives used clinical judgement and trust guidelines to risk assess women to identify those in urgent need of care. However, the trust had not implemented a standardised triage process. The service did not use a prioritisation score to assess women based on need, such as, Red, Amber Green (RAG) risk rating. We heard an example of a woman reporting reduced fetal movements being asked to attend the unit 4 hours after the telephone call.

Eastbourne hospital did not have an obstetric unit, this service was provided at the trusts sister site, the Conquest Hospital in St Leonards which was 17 miles away. The EMU at Eastbourne operated a day assessment unit on Monday, Wednesday, and Friday for women with mild or moderate complications of pregnancy. Midwives followed the 'Clinical Guidance for Birth within the Home Environment or Eastbourne Midwife Unit' which included an inclusion criteria for appropriate referrals.

Maternity

Women could self-refer to the day assessment unit via the triage line, be referred by their community midwife, or general practitioner. The service was manned by midwives with access to the on call obstetric team when necessary. However, if women developed serious complications on arrival, then staff had to send them to the Conquest obstetric unit for a review.

Staff recorded observations via an electronic patient record. If observations were out of normal range, it systematically alerted the midwife to escalate concerns and triggered the electronic Modified Early Obstetric Warning Score (MEOWS) to alert midwife about when to escalate concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Those identified at higher risk were referred to a consultant led perinatal mental health service for additional support.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The service had clear processes for staff to follow which included the contact details of the onsite and out of hours psychiatric liaison teams.

Staff knew about and dealt with any specific risk issues. Midwives working on the Eastbourne Midwife Unit used partograms (childbirth observations charts) to monitor progress and deviations from normal during childbirth and in the immediate postnatal period.

Staff followed guidance on maternal collapse. Staff dialled the nationally recognised internal emergency call out number to request the onsite adult cardiac arrest team once they had dialled 999 for an ambulance to transfer women to the Obstetric unit at Conquest Hospital.

Staff followed the 'emergency evacuation from the birthing pool' guidance and had access to additional equipment so they could evacuate women from the pool safely. However, it was unclear when staff had last completed a live multidisciplinary skills and drills session.

The EMU staff followed Clinical guidelines for birth within the home environment. The guidelines quoted Resuscitation Council (UK) 2015 Guidelines. However, the Resuscitation guidelines were updated in 2021 and included updated advice on airway management.

The standard operating procedure for paediatric resuscitation stated staff call the internal emergency number to request the paediatric cardiac arrest team to support transfers to a consultant led unit. There was no paediatric cover after 8 pm at EMU. After 8 pm emergency calls were redirected to the anaesthetic registrar or the on call paediatric consultant to discuss the safest quickest transfers options. There was no special care baby care unit at Eastbourne, this service was provided at the trust's sister site, Conquest Hospital.

Staff shared key information to keep women safe when handing over their care to others by using SBAR (situation, background, assessment, and recommendation) process. Staff completed a transfer checklist when handing over care to midwives on the labour ward at the Conquest Hospital.

Shift changes and handovers included all necessary key information to keep women and babies safe. Midwives and Maternity care assistants attended handover at the beginning of their shift.

Maternity

Staff completed a newborn rag (traffic light) rating risk assessments at birth. Information included but was not limited to: -

- APGAR (Appearance, Pulse, Grimace, Activity and Respiration) scores,
- type of delivery,
- maternal health
- Maternal medication
- weight
- type of feeding.

The service had implemented the rag rating system alongside colour coded hats on the babies name on the electronic patient record. Babies identified as high risk required extra care and support and if needed were sent to the Conquest hospital for transitional care.

Staff supported women in the post-natal period. Women and pregnant people and their partners could stay in one of the two allocated side rooms for up to 48 hours after birth for breastfeeding and emotional support.

Staff followed guidance to transfer women and babies during emergency situations. Midwives called an ambulance with paramedic personnel for transfer to the closest obstetric unit. Staff continued to provide care and support whilst waiting for assistance. Staff informed the midwife in charge of delivery suite who informed the appropriate medical team and the special care baby unit (SCBU) when needed. In some circumstances it may be appropriate to be met in the emergency unit.

Midwives completed discharge notifications when mothers and babies were fit for discharge and sent them electronically to the local community teams who visited them at home. From day 5 women were invited to postnatal clinics so that staff could complete national newborn screening, check babies and review maternal health.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Managers told us that they had not completed a recent audit on wait times within the Eastbourne day assessment unit. However, appointments were planned.

Midwifery Staffing

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

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

The service did not always have enough midwifery staff to keep women and babies safe. Leaders produced a quarterly 'Maternity Workforce, Acuity, & Red Flag Incident Reporting' report. From December 2021 to April 2022 leaders closed the Eastbourne Midwife Unit because there were not enough midwives 'trust wide' to care for women and babies. This was to make sure that there were enough midwives at the Conquest Hospital to provide care for women during childbirth.

Maternity

Managers calculated and reviewed the number of midwives, maternity care assistants and administrative support staff needed for each shift in accordance with national guidance. Leaders monitored compliance with four-hourly reporting and the Birthrate Plus team reviewed this weekly. Staff met daily to review staffing within the EMU and community teams. Leaders met each morning remotely to discuss staffing on the obstetric unit.

The number of midwives and healthcare assistants did not match the planned numbers. Records from the 1 July 2022 to 30 September 2022 showed that trust wide the service was unable to fill 64% of vacant shifts. Most of the gaps in staffing occurred during the night.

Managers reported 'red flag' incidents via the trusts incident reporting system. However, the Maternity Workforce, Acuity, & Red Flag Incident Reporting' report acknowledged that due to workforce challenges reporting was not always accurate. The National Institute of Care and Excellence (NICE) published guidance 'Safe staffing for nursing in adult inpatient wards in acute hospitals (2014)' to ensure safe staffing. Leaders must identify delays in care to improve service. One delay in transfer incident was reported as a red flag incident.

Staff told us that at night there was one midwife and one maternity support worker on the EMU. The midwife was responsible for assessing care, completing administrative duties, and answering the emergency triage phone. If a woman presented in established childbirth, the midwife called a community 'on call' midwife to attend as the second midwife for when the baby was born.

However, we were told there were one when one midwife was present at the birth of the baby because they were multitasking and unable to call the second midwife. This meant that the midwife was unable to answer the triage phone; at this point the triage line was diverted to Conquest Hospital. At times the support worker answered the triage line, but they were unable to offer clinical advice or make decisions. The impact of this was delays in care for those women at home who had concerns about their pregnancy.

Maternity services trust wide reported 32 babies were born before the arrival of a midwife from April 2022 to October 2022. Information received from the trust showed incident reporting forms and ongoing follow up telephone calls were not completed. Therefore, leaders were unable to identify how many of these women had planned to give birth at home, length of time it took for the midwife to arrive and follow up care following birth.

The service had a reducing vacancy rate. Leaders completed a 3 monthly midwifery staffing review to demonstrate compliance to safety action 5 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. Records from the July 2022 to September 2022 review showed that as of 30 September 2022 the maternity midwife vacancy rate was 9.4%.

The service had reducing sickness rates. Records from the July 2022 to September 2022 confirmed that sickness levels had reduced from 7.3% to 2.8% trust wide. The service also reported 14 staff currently on maternity leave.

Managers used bank and agency staff and requested staff familiar with the service. The service did not use agency staff on the midwifery led unit. Records showed that the service used bank staff to backfill shifts. Bank use varied dependent on the time of the year. For example, in June 2022 12.4% of shifts were covered by bank and in September 2022 6.7% of shifts were filled by bank. The service used familiar staff to work on the unit.

Leaders completed staffing risk assessments to ensure oversight of staffing issues trust-wide and to assure the board that the service was safe. Records showed that leaders had systems to divert services at the EMU when necessary.

Maternity

Managers made sure all bank and agency staff had a full induction and understood the service. The service used bank staff who worked for the service and did not send agency midwives to the EMU.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Records showed that only 30% of midwives at the EMU and 50% of band 6 Eastbourne community midwives had their annual appraisal. At the time of the inspection the band 7 midwife had not received their appraisal date which was overdue. The impact of this is that staff do not have the opportunity to continue their professional development and the trust cannot be assured that staff continue to work within their remit.

Records

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

Women's notes were comprehensive, and all staff could access them easily. Women and birthing people accessed their maternity care records via an electronic application provided during the booking in process at the beginning of pregnancy. Records included risk assessments, screening information and results, appointment times and information leaflets.

Staff across maternity services accessed women's care records via an integrated electronic maternity patient record system. Paper information was scanned into the electronic care record by the administrative team. This included midwifery led unit admission risk assessments.

When women transferred to a new team, there were no delays in staff accessing their records. This was because electronic records could be accessed across both maternity units and within the community setting.

Records were stored securely. Women and pregnant people were provided with secure log in details to access their personal maternity care records. Staff across maternity were provided with secure password protected log in information.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Staff used trust guidance to administer medication. Records confirmed that the services' 'Supply and Administration of Medicine under Midwives Exemptions' guidance included lists of all medication that midwives are exempt from a legal requirement for a prescription for administration.

Midwives reviewed each woman's medicines regularly and provided advice to women and carers about their medicines. Midwives working on the EMU and community midwives reviewed medication from pregnancy to the post-natal period. They offered women vitamins during pregnancy. Midwives had access to generic antibiotics to treat urine infections during pregnancy. The medication was prescribed remotely. Pain relief was administered under midwives exemptions during childbirth. In addition, the service had trained some midwives to administer the contraceptive injection for vulnerable women once they had given birth to their babies.

Staff completed medicines records accurately and kept them up-to-date. Records we reviewed confirmed that midwives completed records accurately.

Maternity

Staff stored and managed all medicines and prescribing documents safely. Community midwives stored generic medication in a locked cupboard within their base room. Medication was checked and dated

The service ensured women's behaviour was not controlled by excessive and inappropriate use of medicines. Midwives reviewed women's social history at booking and throughout pregnancy. If women disclosed, they misused substances, midwives asked them to produce a urine specimen for toxicology testing. Also, doctors reviewed medication for women on long term pain relief or strong mental health medication.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services. Staff told us they completed annual 'Drug Calculation' tests.

Medical gases were stored safely within the EMU. Medical gases were stored in a locked cage within a recess of the corridor which was well ventilated.

Staff learned from safety alerts and incidents to improve practice. Records confirmed that staff received newsletters and incidents influenced the following years training schedule.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, incidents were not always investigated within national timeframes.

Staff knew what incidents to report and how to report them. Staff on the EMU knew how to use the electronic incident reporting system to report incidents and workforce concerns.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff knew what to report. However, staff told us that they could not report all incidences due to workforce pressure, especially during the night when staffing was limited.

The service had 'no' never events on the Eastbourne Midwife Unit (EMU).

Staff reported serious incidents clearly and in line with trust policy. Records showed that staff reported serious incidents when they occurred in line with trust policy. Data showed from January to September 2022 there were no serious incidents related to care at the EMU.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Staff understood the importance of being open and gave examples of how they apologised if required.

Staff received feedback from investigation of incidents, both internal and external to the service. The governance lead created newsletters, updated staff during handovers and staff received a fortnightly theme of the week to make sure they were aware of changes to practice.

Staff met to discuss the feedback and look at improvements to the care of women. If a serious incident occurred on the EMU managers made sure immediate actions were discussed at the safety learning huddle.

Maternity

Leaders used the Perinatal Mortality Review Tool and produced quarterly reports in line with national guidance. Records showed that cases were reviewed to identify themes and share learning. Actions were recorded within the report. The governance lead worked alongside the quality improvement lead. Training was influenced by the previous year's serious incidents. Staff attended multi-professional training to improve care.

There was evidence that changes had been made because of feedback. Records from a Health and Safety Investigation Bureau (HSIB) serious incident review in February 2020 action plan showed that the trust had listed the recommendations, assigned staff to action the requirements and set deadlines.

Managers investigated incidents thoroughly most of the time. Leaders attended daily incident meetings and prioritised serious incidents. However, we saw that managers did not always complete 72 hour rapid reviews within the set timeframe due to workforce challenges which meant immediate learning could not be identified. This was not in line with national guidance that states a rapid review should be completed to identify immediate actions that necessary to mitigate risks to other people.

Records confirmed that there were 14 incidents related to the EMU had not been reviewed for over 60 days. This does not conform to best practice. The governance lead told us that this was not currently achievable due workload and availability of staff. Outstanding incidents included failed postnatal discharges, because community staff had not received the full information and missed an opportunity to visit mothers at home, which had a negative effect on care. Records confirmed one recurring theme was delays in answering the triage phone. The action section states triage to transfer calls at night. However, staff told us this still did not happen. The impact of delay in the review process means that any shared learning is delayed, and the issue may re-occur.

Women and their families were involved in these investigations. The service had bereavement pathways. The lead midwife for bereavement involved families in all aspects of the investigations and provided parents with links to external support services to help them process their grief.

Managers debriefed and supported staff after any serious incident. The service had implemented TRiM (Trauma Risk Management) which is an evidence based, peer delivered risk assessment and ongoing support system, designed specifically to support staff after a traumatic event. There were several TRiM advocates at the trust to debrief staff involved in serious incidents.

Is the service well-led?

Good

We rated it as good.

Leadership

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

Maternity

Maternity services were part of the 'trust-wide' Women and children's, sexual health and audiology division at Eastbourne. The leadership team was recruited within the last 8 months and the director of midwifery (DOM) had only been in post for 4 weeks at the time of our inspection. However, the DOM had provided maternity assurance to the trust board since April 2022.

The non-executive director (NED) is a maternity safety champion and provided objective and external oversight of the decisions made about maternity services. Their remit is to understand the current challenges of the service. review services, maternity risks, and report to board. The NED visited the maternity unit and liaised with outside representatives such as the maternity voice partnership to bring together a range of internal sources of insight to strengthen board oversight for maternity and neonatal safety by understanding the current outcomes of the service. The NED worked with the director of midwifery and the chief nurse to review services and updated the board bi-monthly.

The head of midwifery (HOM) managed maternity services trust-wide alongside the service manager, the deputy head of midwifery (DHOM), 2 consultant midwives and the maternity transformation lead. The HOM reported to the director of midwifery, director of nursing and the divisional director of Women and Children's Services and the trust board.

The HOM was one of five maternity safety champions trust-wide, safety champions included a consultant obstetrician, the chief nurse, a consultant paediatrician, and the non-executive director.

The consultant midwives reported to the HOM and worked cross-site and were responsible for running the birth options clinics, quality improvement and research.

The deputy head of midwifery had a large remit, they were responsible for the day to day running of the Eastbourne Midwife Unit (EMU) the community teams and the antenatal ward and day assessment unit and reported to the HOM. They had been in post since April 2022.

The DHOM line managed 13 band 7 matrons cross-site, these included but was not limited to, the community matrons the antenatal ward and day assessment unit matrons and the labour ward matrons. The management of such a large workload had meant that the DHOM had limited time to review all relevant policies and processes on the EMU. For example, they were unaware of the most recent guideline for the EMU, found it hard to track guidelines via the trusts intranet and had lost sight of staff appraisal rates which meant that staff were not given time to structure their continued professional development.

Matrons were recruited at band 7 of the Agenda for Change knowledge and skills framework. This did not reflect the NHS Knowledge and Skills Framework (NHS KSF) and the Development review process (2004). This is because nationally matrons are accountable for management at divisional level, with a focus on patient centred services, they monitor standards and contribute to quality improvement, Also, they are on call for the service, policy reviews and managing budgets. Therefore, matrons are banded a level 8a. Matrons we spoke to confirmed that their role was a combination of the band 7 team leader role and the band 8 matron role, but their job description did not always reflect their responsibilities or accountabilities. This meant that some matrons worked differently from others.

Vision and Strategy

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

Maternity

Woman and children services had a five year strategic plan. The 'Maternity strategy' set out the direction for services over the next five years and included specific plans relating to pregnancy, childbirth, and care of the newborn.

The plan had a focus for working collaboratively with partners within primary care as well as perinatal services and East Sussex maternity voices partnership (MVP). The MVP is a working group of women, birthing people, their families, commissioners and midwives and doctors working together to review and contribute to the development of local maternity care. The plan was based on four national aims, maternity safety, continuity of carer, personalised care, and safe staffing.

The service set a deadline to achieve their vision within the next five years and were keen to be the first choice for families and staff.

Leaders were clear that they wanted to offer a safer, more personalised and centred around the individual needs and circumstances of each woman and their baby. The service already created two continuity of care services the Lighthouse team who worked with young vulnerable pregnant people and the Ivy team who worked with low risk women.

There were four fundamental values the trust promoted staff to use within their working practice, which were:

- Working Together - To build on people's strengths
- Improvement and Development – To strive to be the best
- Respect and Compassion – Acting with kindness
- Engagement and Involvement – Involve people in planning and decision making

Records confirmed their achievements so far. Leaders had implemented the Saving Babies Lives Care Bundle. With detection rates of babies who are small for gestational age increased to 48% in 2021 (this is higher than the national average of 41%) and they continuing to see improvements. 100% of women/people reporting reduced fetal movements received computerised Cardiotocography in line with national guidance.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

Leaders reviewed the results of the maternity staff survey to identify and act on themes. Records showed that leaders used the traffic light system for categorising themes and update progress on strategies to improve the culture and wellbeing of staff. Community staff teams had reported that they felt neglected in view of the fact they were not always based in the main hospital. Leaders implemented visits to community teams and organised 4 two 6 weekly listening events to improve staff wellbeing.

Leaders listened to staff and created a maternity staff survey action plan to improve staff well- being and communication. The top priority focused on workforce planning and delivery. This is because staff said they were feeling emotionally exhausted and burnt out because there weren't enough staff to do the job well. Actions included an increase in midwives by the end of October 2022, rotating specialist midwives onto the clinical roster and promoting staff wellbeing via the Staff debriefing midwives and recruitment and retention lead.

Staff told us that the divisional leadership team rarely visited the birth centre, this meant some staff felt that leaders did not have insight into the challenges the service faced, especially at night. However, leaders told us that they wanted to increase their presence on site and planned to cross site several times a month.

Women, pregnant people, relatives, and carers knew how to complain or raise concerns. The service had a complaints process. The service clearly displayed information about how to raise a concern in women and visitor areas. We saw clearly displayed information on the EMU and on the trusts website.

Staff understood the policy on complaints and knew how to handle them. The matron reviewed complaints made about the service. Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. The matrons for EMU and community worked with the quality improvement midwife to investigate complaints, speak to staff involved and write formal responses within set times frames. Complaints responses were reviewed by patient advice and liaison team and responses were signed by the chief executive.

Managers investigated complaints and identified themes. Records showed that negative feedback regarding the EMU was low. However, women were frustrated if the service closed. As a result, leaders apologised and explained why services were reduced during staff shortages, because it was safer.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff received regular newsletters, and within the EMU a notice board shared outcomes and improvement information for women, pregnant people, and families.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders demonstrated effective trust board oversight of performance. The maternity governance process consisted of several groups and forums, and each had their own remit as follows: -

The Women's Risk Group managed the Avoiding Term Admissions into Neonatal Units (ATAIN) and The Saving Babies Lives Specialist Midwife' monitored The Prevention of Cerebral Palsy in PreTerm Labour (PReCePT) audits, reviews, and investigations.

The 'Women's Risk' forum looked at national guidance, referrals, and recommendations by the Health Safety Investigation Branch (HSIB), compliance to NHS resolution, each baby counts and UK Obstetric Surveillance System (UKOSS).

The Midwifery Improvement forum was responsible for reviewing compliance and feedback for Better Births (2016) , the National Maternity Survey and the staff survey.

Additional clinical governance included oversight of audits and antenatal and postnatal conference.

Leaders attended bimonthly maternity board meetings. The meeting was chaired by a consultant obstetrician, and attendees, included the associate director of operations, the head of midwifery (HOM) the maternity transformation lead and the clinical governance support officer. The board reviewed the maternity action log, discussed compliance to the Clinical Negligence Scheme for Trusts (CNST) and discussed the maternity transformation programme.

Maternity

All provided reports to the maternity board, and fed into the governance and accountability meeting, which fed back to the integrated performance review, quality, and safety committee and finally the trust board. Recent challenges were overall compliance to one of the four elements of the Saving Babies' Lives care bundle, which was reducing smoking in pregnancy

Records confirmed that historically the service was not capturing information about women's smoking choices at 36 weeks of pregnancy. Because of this, leaders improved data collection on the electronic patient record to include mandatory fields so that staff made sure they asked the relevant questions and provided the correct information about the risks of smoking in pregnancy and beyond.

Managers followed the services Escalation Policy for Maternity Services. Records showed that escalation was influenced by several 'triggers' that included but was not limited to workforce challenges, issues with capacity, serious incidents and lack of capacity at the special baby care unit. Triggers were prioritised using a traffic light system, green meant no concerns and red meant that the maternity service was unable to manage demand. Managers met frequently to review staffing and capacity, and these were discussed at the cross-site managers huddle and the internal staff huddle. Actions had to be signed off by either the director/head of midwifery or a delegated lead obstetrician.

Records showed that The EMU was closed from December 2021 to April 2022 due to staff shortages and the risks that posed to patient safety. Records showed that community midwifery staffing remained on the internal risk register and leaders had taken steps to limit the risks. For example, increasing specialist midwives clinical support, overtime incentives and twice daily safety huddles to assess staffing levels.

Community matrons voiced concerns about staffing and on call cover because community staff were often called upon to support the midwife unit and maternity services at Conquest Hospital

Also, managers told us that when the EMU closed, some women in the community refused to go to the Conquest to give birth to their babies. Instead, they stated that they wanted to 'free birth'. Free birthing means that you give birth to your baby at home without the care or support of a trained competent healthcare professional. It is illegal for anyone present during the labour or birth, to be undertaking the roles of a midwife or doctor (RCM 2020). But it is not illegal for a woman or birthing person to decline care. Records showed that from March 2022 to August 2022 3 'Free birth' incidents had been reported. Women said they would free birth if the unit was closed were counselled about the risks associated with giving birth unaided.

Community leaders were working closely with third party groups to reduce the amount of women wanting to free birth because it carried associated risks. The Maternity Voices Partnership and other community groups were pivotal to communicating with women the risks of this practice. Records showed that several baby's had been born at home without a midwife which had resulted in the babies being cold and needing additional care.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. However, some policies such as, clinical guidance – personalised care was due for review in May 2021. Three staff we asked to find policies during the inspection had difficulty identifying the correct policy.

Management of risk, issues, and performance

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

Maternity

The Maternity risk management strategy linked to and supported the overarching Risk Management Policy and Procedure for maternity services and Incident Reporting and Management Policy and provides a framework for the management of risks within a specific clinical area of the Trust**.**

Leaders met monthly for the maternity safety meeting. Attendance was recorded and decisions were captured and assigned to key leaders to report on.

The clinical governance lead produced a monthly Quality and Safety Report. However, we inspected in October 2022, but we only received records for April 2022, which made it difficult to assess themes and trends over the whole year. A graph was included which showed monthly incidents up to April 2022. Records confirmed that there was a sharp increase in incidents in March and April 2022.

The trust completed an internal risk register, which was reviewed quarterly at the women's risk meeting. Risks were scored and Red Amber Green (RAG) rated. Two of the top 4 risks related to the EMU and community setting were related to the number of limited community hubs, clinic space within EMU and to provide a separate area for labouring and postnatal women. During the inspection leaders were unable to provide evidence of a recent environmental risk assessment of the Eastbourne Midwife Unit (EMU). However, this was submitted during the factual accuracy process.

The potential impact was noted as privacy and dignity being compromised for labouring and newly birthed women, because confidential discussions took place in limited space, and reduced security due to the high level of daily outpatient activity. Leaders were in the progress of creating a business plan to rebuild the EMU.

Leaders did not have full oversight of all risks; the trust had not implemented a personalised RAG rated prioritisation risk assessment for the day assessment unit or for staff answering the triage telephone and wait times had not been monitored which had the potential to cause harm.

However, records from the minutes of the September 2022 maternity board meeting showed that there were plans for an ambulatory care pathway, which is a modified process for assessing and caring for women in the day assessment unit, community, and antenatal clinics. Although, it was not clear how the service planned to reduce the risk to women waiting in day assessment unit whilst the plans were being approved and implemented.

The service contributed to several national audits, this included the national pregnancy in diabetes audit, the Maternal mortality surveillance and confidential enquiry (MBRRACE), the perinatal confidential enquiry and the perinatal mortality review tool. Audits were allocated to project leads and time frames were set for completion.

Managers and staff carried out a programme of repeated audits to check improvement over time. Records confirmed that maternity services had an annual audit programme, assigned to project leads with time frames for completion. Audits included but were not limited to; Improving personal care support plans, shared decision making, care out of guidance and midwifery workforce planning. Staff told us that there were no EMU specific audits. However, data captured from the electronic patient record fed in to trust wide audits.

Managers and staff used the results to improve women's outcomes. Leaders had implemented the 'PETALS' programme in July 2020 in line with national guidance. To reduce notable physical and psychological effects of Obstetric Anal Sphincter Injury (OASI). Outcomes for women were positive, and met expectations, such as national standards. Records showed that the incidence of trauma had halved in the first year (July 2020/21). The programme and audits will continue for the next three years, and outcomes were shared with staff,

Managers shared and made sure staff understood information from the audits. Managers shared outcomes with staff via training and newsletters, and within the EMU a notice board shared outcomes and improvement information for women, pregnant people, and families.

Improvement is checked and monitored. Leaders reviewed and reported outcomes to the trust board, maternity safety champions, the Local Maternity and Neonatal Systems quality and safety group, and the maternity voices partnership.

The service was accredited by the Clinical Negligence scheme for trusts and submitted data on a biannual basis to ensure standards were met. This year improvements had been made to capture smoking data.

Information Management

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

The trust published and made public the bespoke Maternity Safety Improvement strategy. The service had implemented a national maternity electronic patient record (EPR). The service employed a digital midwife who worked hard to support staff with training and updates on the EPR and draw relevant data. Because of their large workload leaders were in the process of recruiting a support midwife to help.

Women and pregnant people had password protected access to their personalised pregnancy records. Information included diagnostic results, and patient information leaflets and could be accessed via smart phones.

The EPR collected numerous data sets. Most managers accessed this information quickly and created spreadsheets of various indicators when required. However, some managers we spoke to did not have access to this aspect of EPR. After the inspection service leaders told us that all managers had access to the information.

The trust had internal intranet systems, which were password protected, all staff could access policies and guidelines. However, during our inspection several staff had difficulty finding policies and told us it was a common theme. The impact of this is that staff do not have access to safe processes and procedures when needed.

Leaders reviewed data quality at the bi-monthly maternity board meeting. Records showed that leaders had identified the need to code data to reflect national requirements and inform the maternity transformation programme.

Engagement

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

Leaders followed the national recommendations made in the Ockenden Report (2020 & 2022) immediate essential action number 2: Listening to women and their families and could evidence a robust mechanism for gathering service user feedback, collaboration with women and families through the local Maternity Voices Partnership (MVP) to coproduce local maternity services. They had also identified an executive director responsible for maternity services and a non-executive director to support the board safety champion.

Maternity

Maternity services had co-created the most recent maternity strategy with input from the MVP and engaged with them at quarterly MVP meetings. Members of the MVP were invited onto the unit to 'walk the patch' which led to a report. The MVP provided a bi-annual workshop to review the themes and created action plans which were reviewed regularly.

Leaders were keen to engage with women, pregnant people, and their families in various settings to ensure they captured feedback to improve services. Within the community setting various third party services were service user ambassadors, this included antenatal educators, doulas, and specialist mental health practitioners. The ambassadors submitted feedback monthly and local actions were implemented because of working together.

For example, the continuity of carer midwives had smaller caseloads and cared for vulnerable women and pregnant people or women choosing to give birth outside of national guidance. The trust had introduced continuity of carer in 2021 and this was aligned to national guidance NHS England's 'Delivering Midwifery Continuity of Carer at full scale (20/21) to reduce inequalities and poor outcomes for vulnerable groups of women. Data confirmed that 33.3% of women/people from Black, Asian and minority groups had been booked onto continuity of carer schemes by 29 weeks of pregnancy.

As a result of feedback, a bereavement suite was opened in May 2021 for parents who had experienced loss of their baby to spend time with their baby and say goodbye.

Also, the service had co-produced Personalised care guideline "My Choices for Pregnancy, Birth and Beyond" is a Sussex wide personalised care and support plan (PCSP) that has been co-produced with service users.

On the trusts electronic patient record the service included a mandatory field which confirmed that women were involved with and agreed with decisions and plans made.

The service captured ethnicity data when women presented for their midwives booking. This data helped inform services for women and families from different ethnic groups. Currently only 8% of all women were from black, Asian, and other minority ethnic groups. Records showed that 11% of white women were from other ethnic backgrounds. We saw that services understood the additional needs of people with dark skin, for example additional free vitamin D supplements were available at booking and staff utilised interpreting services when needed.

While East Sussex was less ethnically diverse than other parts of the country, there were areas of significant deprivation, some areas were in the 10% of most deprived areas in the country. The named midwife for safeguarding had built good relationships with third party organisations and embedded the 'Think Family' safeguarding model to make sure vulnerable families were well supported.

Leaders kept staff informed about workforce issues. Records confirmed that leaders sent all staff a letter in July 2022 explaining the workforce situation and how leaders planned to manage shortfalls. Because workforce had been cited by staff as the biggest cause of anxiety.

Learning, continuous improvement and innovation

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

Maternity

Leaders were engaged with Sustainability Transformation Partnerships (STP) and their strategy was aligned to this and the trust board were fully engaged with the process. They had employed a project lead to oversee their maternity transformation programme and worked with the integrated care systems for Sussex Boarders. Their quality improvement programmes were informed by external regulators, the Local Maternity and Neonatal Systems (LMNS), The Clinical Negligence Scheme for Trusts and the CQC.

The trust provided specialist midwifery services aligned to national guidance to support women and improve outcomes. These were: stop smoking and public health and contraception; pregnancy growth scanning; infant feeding and tongue tie; birth stories and debriefing; perinatal mental health; bereavement and baby loss; and safeguarding for adults and children.

Several specialist teams provided support for: home birth; young parents; and people with a history of diabetes. The trust had also introduced the continuity of carer model in the last year.

The service encouraged staff to develop services. For example, the named midwife for safeguarding told us that they had worked alongside the bereavement midwife and NHS England National Maternity Safeguarding Network, other agencies and volunteers to develop 'HOPE Boxes' for women who were to be separated from their babies due to safeguarding concerns. The HOPE Boxes contain photographs, footprints a letter and poem for both mother and baby prior to their separation to promote an ongoing connection during safeguarding proceedings and support the mother through potential grief.

Outstanding practice

We found the following outstanding practice:

The service encouraged staff to develop services. For example, the named midwife for safeguarding told us that they had worked alongside the bereavement midwife and NHS England National Maternity Safeguarding Network, other agencies and volunteers to develop 'HOPE Boxes' for women who were to be separated from their babies due to safeguarding concerns. The HOPE Boxes contain photographs, footprints a letter and poem for both mother and baby prior to their separation to promote an ongoing connection during safeguarding proceedings and support the mother through potential grief.

Areas for improvement

MUSTS

Midwife Led unit

The service must ensure there is a prioritisation score to safely risk assess women calling the triage line and on arrival in the day assessment unit and monitors wait times effectively to ensure service users are seen within safe timeframes. Regulation 12 (1) (c)

The service must ensure that it has enough staff to ensure all services can run effectively Regulation 18 (1)

SHOULDS

Maternity

Midwife Led Unit

The trust should ensure that staff training for level 3 safeguarding meets the trust target of 90% for community, EMU midwives and medical staff responsible for planning care.

The service should consider introducing the nationally recognised 'I am clean' stickers for staff to use once equipment has been cleaned. So, all staff and service users are assured that infection prevention control measures keep people safe.

The trust should ensure that it improves staff training compliance for blood transfusion, basic life support and mental capacity training so that it meets trust targets.

The trust should ensure that all staff can access policies and procedures via the trusts intranet systems quickly.

Should ensure that all midwives working in the Midwife Led unit complete an 'Evacuation of the Pool' simulated training session and record attendance to monitor compliance.

The service should ensure that all staff receive their annual appraisal, to ensure continued professional development and safe practice.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and three other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, 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