Epsom and St Helier University Hospitals NHS Trust

St Helier Hospital and Queen Mary's Hospital for Children

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 St Helier Hospital and Queen Mary's Hospital for Children

Good ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at St Helier Hospital and Queen Mary's Hospital for Children.

We inspected the maternity service at St Helier Hospital and Queen Mary's Hospital for Children 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.

St Helier Hospital and Queen Mary's Hospital for Children provides maternity services to the population of south west London and north east Surrey. St Helier and St Mary's Hospital for Children is 1 of 2 sites for maternity services for the trust. Maternity services at St Helier Hospital comprise of a consultant led delivery suite, alongside midwifery led unit and a 40-bed maternity ward providing ante and post-natal care and an induction of labour bay. There is a maternity assessment unit and triage space, on the delivery suite, and antenatal clinics. Between April 2022 and March 2023 there were 2,220 deliveries at St Helier Hospital. Maternity services are operated as one service over 2 sites (St Helier Hospital and Queen Mary's Hospital for Children and Epsom General Hospital) with the same leadership team and governance processes.

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

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

Our rating of this hospital stayed the same, we rated it as Good because:

Our rating of Requires Improvement for maternity services did not change ratings for the overall hospital.

We rated safe as Inadequate and well-led as Requires Improvement in maternity services.

We also inspected other maternity services run by Epsom and St Helier University Hospitals NHS Trust. Our report is here:

Epsom General Hospital - https://www.cqc.org.uk/location/RVR50

How we carried out the inspection

We provided the service with 45.5 working hours notice of our inspection.

We visited maternity assessment unit, triage, delivery suite, maternity theatres and the maternity ward which included post and antenatal inpatient care and induction of labour bay.

Our findings

During the inspection we spoke with specialist midwives, 16 midwives and support staff, and 3 doctors. We also spoke with spoke with 1 woman or birthing person. We received 66 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 7 patient care records, 7 observation and escalation charts and 7 medicines records.

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

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

Maternity

Requires Improvement ↓

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

- The service provided mandatory training in key skills. However, not all staff had completed all training.
- The service did not have enough midwifery and nursing staff in the right areas with the right qualifications, skills and training to care for women, birthing people and babies. Staff working in transitional care bays did not have the qualifications and competence for the role they were undertaking.
- The environment in some areas was not fit for purpose and bereavement and recovery facilities did not meet national standards. On the maternity ward this posed an infection prevention and control risk.
- The service did not manage safety well. It was not operating clear triage processes. Medicines were not always managed in a safe way. Records of care provided were not always fully completed.
- Leaders did not operate effective systems and processes nor have clear oversight of maternity services to keep women, birthing people, and babies safe. The service did not always ensure the privacy, dignity and respect of women and birthing people. Some women or birthing people did not feel listened to.

However:

- Staff worked well together for the benefit of women and birthing people and understood how to protect women and birthing people from abuse. The service managed safety incidents well and learned lessons from them. The service had enough medical staff with the right qualifications, skills and experience.
- Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and staff were clear about their roles and accountabilities. The service engaged with women and birthing people 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. All staff were committed to improving services continually.

Is the service safe?

Inadequate ↓↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most staff completed it. However, not all anaesthetic staff had completed the required mandatory training.

Maternity

The service made sure that most staff received multi-professional simulated obstetric emergency training. The target for mandatory maternity training was 90%. The service provided training compliance figures for all staff which related to both maternity locations, as staff worked across sites.

Midwifery staff received and kept up to date with their mandatory maternity training. At the end of August 2023, 95% of midwifery staff had completed CTG training, 89% simulation and human factors training and 89% newborn life support.

Medical staff received and mostly kept up to date with their mandatory maternity training. Medical staff compliance with training targets was 89% for CTG and 89% for simulation and human factors. However, only 62% of anaesthetic staff had completed required human factors and simulation training. This did not meet the trust target. Managers told us there was a plan to ensure anaesthetic staff completed the required training in order to meet the requirements of the Clinical Negligence Scheme for Trusts (CNST). However, there was a risk this would not be met in a timely way to enable the service to declare compliance in 2023/24. Following our inspection, the trust told us all remaining anaesthetic staff were scheduled to attend this training in November 2023.

The service told us basic and advanced life support is provided yearly by the Resuscitation Council UK. However, they did not provide figures for the number of staff who had completed this. This meant we could not be assured staff had training to provide lifesaving treatment to women and birthing people in their care.

Staff had practiced how to evacuate women, birthing people and babies from the birthing pool in an emergency, in May 2023.

The mandatory maternity training was comprehensive and met the needs of women and birthing people and staff. The service had a training needs analysis and guideline. It was in date, version controlled and next due for review in May 2025. The training needs analysis outlined all mandatory maternity training required to be completed by different maternity staff groups. The training needs analysis linked to national recommendations and showed the compliance required to meet the recommended standards. It was supported by core competency framework 3-year plan for 2021-2024 which outlined when training would be delivered to meet the target of 90% compliance.

Training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Managers monitored mandatory maternity training and alerted staff when they needed to update their training. Staff said they were alerted as to when to renew their training. The service had a team of specialist midwives across the hospital services including 1.5 whole time equivalent practice development midwives who worked across both maternity service locations.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse.

Not all staff received training specific for their role on how to recognise and report abuse. Level 3 safeguarding training was provided to staff in line with national intercollegiate guidelines. Only 39% of doctors had completed level 3 safeguarding adults training and 68% level 3 safeguarding children. However, 87% of midwifery staff had completed level 3 safeguarding adults training and 92% level 3 safeguarding children, which met the trust's target for compliance with this training.

Maternity

We looked at the contents of the safeguarding training that staff completed; it covered the expected modules for safeguarding level 3 training. Training included female genital mutilation (FGM), domestic abuse, substance misuse and mental health as well as recognising and reporting signs of abuse or neglect.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics. Staff attended the multidisciplinary vulnerable women's forum to share information with other services such as health visiting or children's services on women and birthing people at risk due to protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had specialist appointments with the safeguarding team and individual birth plans with input from them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team of 2 part time safeguarding midwives and a safeguarding lead midwife who staff could turn to when they had concerns. Staff told us there was a clear escalation policy within each local authority and safeguarding midwives had good working relationships with local authorities. Staff could access ad hoc safeguarding supervision from the safeguarding lead midwife and a member of the safeguarding team attended the daily safety huddle.

Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted in December 2022 and identified some areas for improvement. The learning was shared with staff in the daily safety huddle. However, the action plan to make improvements had not been completed at the time of our inspection.

Cleanliness, infection control and hygiene

The service did not always control infection risk due to the environment in some clinical areas. However, staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean.

Though most maternity service areas were visibly clean, not all areas had suitable furnishings which were well-maintained, and which could be cleaned effectively. For example, on the maternity ward, the induction of labour bay had peeling paintwork and damp mould on the wall. This meant there was a risk to women and birthing people of developing respiratory issues. The visitor's toilet had broken ceramic tiles and ingrained graffiti on the door, meaning they could not be cleaned effectively. We escalated these issues to senior managers during our inspection and they took immediate action to replace tiles and doors and close the induction of labour bay to deal with the mould and damp.

The service had a spot check of the environment and cleanliness in July 2023. This showed that on the delivery suite the standards had been met on 177 points and failed on 15 and on the maternity ward the standards had been met on 62

points and failed on 14. The service did not provide any further information on the areas for improvement or any action plan. The service generally performed well for cleanliness. Managers conducted monthly audits of the environment and there had been no infection outbreaks in the last 3 months. However, staff told us, and we saw that all areas were cleaned regularly. The delivery suite had a dedicated cleaning team 24 hours a day, 7 days a week.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. We looked at the most recent audits which showed compliance with correct hand hygiene procedures was 97%. Staff completed infection prevention and control training as part of annual mandatory training and compliance was 100%.

Staff cleaned equipment after contact with women and birthing people and labelled equipment with green 'I am clean' stickers to indicate it had been cleaned and was ready for use.

Environment and equipment

The design of the environment was not fit for purpose in all areas. The use of facilities and equipment did not always keep people safe. However, staff were trained to use them and managed clinical waste well.

The service did not have suitable facilities to meet the needs of women and birthing people and their families. Though there were shower and bathing facilities available, these did not always meet the needs of women and birthing people. This was because the ensuite facilities on the delivery suite did not have a door to separate them from the main room, only a shower curtain. This included the ensuite facilities in the bereavement room. We escalated our concerns to the trust. The service told us the size of the rooms did not allow for a wall/ door installation. They told us alternative bathroom and toilet facilities were situated on the unit for women and birthing people and birthing people to use should they wish to do so.

The bereavement room was situated within the delivery suite, opposite the sluice and adjoining a delivery room and was not soundproof. The door to bereavement room was directly from the corridor on the delivery suite and had frosting over the glass panel. However, this was damaged so anyone who wished could look into the room through the damaged area. This was not in line with national guidance, Health Building Note 09-02: Maternity care facilities. We escalated these concerns immediately following our on-site inspection. The service told us the bereavement room was isolated from the recovery area and the other labour rooms by two sets of double doors. They stated within the double door area there was a separate exit from the unit, so families did not need to walk through the delivery suite if they did not wish to do so. They provided evidence to show the privacy frosting had been fixed to ensure privacy for women birthing people and their families using the room.

The recovery room did not comply with the Association of Anaesthetists' recommendations for standards of monitoring during anaesthesia which state 'recovery should be available within the delivery suite theatre complex'. The recovery room was not adjacent to or within the theatre complex.

The 2 operating theatres opened directly onto the corridor of the delivery suite and did not have secure access. This meant there was risk of unauthorised entry by any person on the delivery suite, including women and their visitors. Managers told us this had been recognised as a risk and there was a plan to put secure swipe access in place. We raised this during, our inspection and were told this plan would be expedited and signs were placed to indicate this was the access to theatres and entry was restricted.

Maternity

In response to concerns raised regarding the estate and facilities, the service acknowledged some of the current arrangements were not ideal, but this was due to the limitations of the building. The service told us a new building programme was planned and proposals were progressing. However, it was not clear when the new building would be agreed or be in place.

Though, staff carried out daily safety checks of specialist equipment these were not effective. We found out of date items on neonatal resuscitation equipment trolleys which had been signed as checked. We raised this during our inspection and the service took action to check neonatal resuscitation equipment and ensure all out of date equipment was replaced and to put in place additional oversight of equipment checks.

The service did not have enough suitable equipment to help them to safely care for women and birthing people and babies. Resuscitaires across the service were past their service contract, this was on the risk register as an extreme risk. However, the controls in place were identified as inadequate. The service reported a serious incident where the resuscitaire was not ready for use and this caused a delay in obtaining the correct mask and suction. Though this had not impacted the outcome in this case there was a risk that controls in place were not adequate to protect babies in future.

The service had a system to monitor equipment checks which were completed, However, this did not record when planned preventative maintenance was due. We reviewed the equipment checking log and saw 435 items of 806 listed did not have a maintenance date recorded. Incident data from the National Reporting and Learning System showed staff were reporting environment and equipment issues such as the temperature control in theatres, broken call bells, handheld IT devices not working and centralised CTG monitoring not in working order.

We sought assurances and leaders told us the service does not rely on the CTG central monitoring system to review CTG's at the Epsom General Hospital. The central monitoring system is primarily used to aid discussion and teaching. CTG reviews and CTG peer reviews were undertaken in person in the woman or birthing person's room.

We found a number of out-of-date items in store cupboards on delivery suite including blood bottles, neonatal blood bottles and insulin pen tips dated 2019. We told staff about this during our inspection, and they removed the out-of-date items.

The birth partners of women and birthing people were supported to attend the birth and provide support. There were reclining chairs in each birth room to enable birth partners to stay overnight.

The alongside birth centre was located at the end of the delivery suite and this was accessed through double doors. It had 3 birthing rooms with birthing pools, chairs and equipment. The rooms were large, nicely decorated and well maintained and had adjustable ambient lighting. Pool evacuation nets were available in the office within the birth centre. Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

Ligature point risk assessments had been completed for maternity services and showed controls in place to minimise risks.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins.

Assessing and responding to risk

Maternity

Staff did not consistently complete nor update risk assessments and did not always take action to remove or minimise risks. Staff did not always identify and quickly act upon women and birthing people at risk of deterioration.

Staff used the Modified Early Obstetric Warning Score (MEOWS) nationally recognised tool to identify women and birthing people at risk of deterioration. However, staff did not consistently fully complete MEOWS. We reviewed 7 MEOWS records and found 2 were incomplete. Leaders completed a quarterly audit of records to check they were fully completed and escalated appropriately. Audits for June to August 2023 showed at least one of every 5 MEOWS records were incomplete. This meant deterioration of the woman or birthing person's health may be missed and not escalated to the appropriate healthcare professional for treatment.

Midwives were required to carry out 'fresh eyes' checks on continuous cardiotocograph (CTG) hourly. CTG monitoring is used to monitor fetal heartbeat and uterine contractions during labour. Audits for January to August 2023 showed hourly 'fresh eyes' reviews did not always take place. Compliance with this review was improving through the year but remained low at 65% for August 2023. Following our inspection, we requested further assurance. Leaders told us the frequency of the fresh eyes audit has been increased to fortnightly and a pilot scheme of "Buddy System" was to be implemented by the end of September 2023. CTG monitoring has also been included in the Patient Safety Incident Review Plan as an area for local focus.

Staff knew about and dealt with some specific risk issues. Staff reviewed care records from antenatal services for any individual risks. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The August 2023 CTG audit showed 100% of cases audited had both the trace and computerised Dawes Redman report scanned and updated to electronic records.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool. Staff used a prioritisation risk assessment tool for maternity triage. However, after initial assessment the time to be seen by a doctor in line with the prioritisation guidance fell below 100% for all of the time and was as low as 31% in May 2023. We wrote to the service requesting further assurance. The service told us they reviewed audits against prioritisation categories, and this showed 97% of the most high-risk women and birthing people in the red or amber category were seen within the recommended timescales.

The 'maternity triage waiting times for review' audit for April to July 2023 showed midwives reviewed 98.5% of women and birthing people within prioritisation guidance. An exception audit of time seen on arrival in triage showed women and birthing people were seen quickly and any waiting to be seen for an initial assessment was rare.

Women and birthing people contacted a central pregnancy advice line if they had any concerns. Staff told us due to staff sickness and absence; the pregnancy advice line was frequently diverted to the telephones on the delivery suite or birth centre. There was no dedicated triage phone line, and the call could be answered by any member of staff on delivery suite. We were not assured staff answering the telephone had the appropriate training and skills or that the call would be answered in a timely manner when acuity on the delivery suite was high.

We raised these concerns during inspection and the trust took some action. They allocated and increased core triage midwifery staff. They installed a dedicated triage telephone line to be answered by the dedicated triage midwife. Following our inspection, the trust told us the telephone was always answered in a timely manner even when acuity on the delivery suite was high.

Maternity

The process for women attending maternity assessment unit (MAU) or triage was unclear. There was no clear or written guidance for staff on when women and birthing people should be directed to triage and when they should be directed to maternity assessment unit. Data from the national reporting and learning system showed how this lack of clarity put women and birthing people at risk. .Another patient attending MAU was given the wrong test. There was a risk women or birthing people who required a prioritisation risk assessment would not receive this if they were directed to MAU.

Leaders told us these incidents were clinically reviewed and that the clinical management and plans were appropriate.

During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. However, the handover audit for 'situation, background, assessment, recommendation' (SBAR) handover format was not always used and had not been embedded into staff practice.

Staff in maternity theatres used the World Health Organisation (WHO) surgical safety checklist. Data showed leaders completed monthly audits of WHO checklist compliance in maternity theatres. Data showed for April, May and June 2023, most checklists were consistently completed in full.

The service had a specialist midwife for perinatal mental health Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people.

The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Midwifery Staffing

The service did not have enough maternity staff in the right areas with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Though managers regularly reviewed and adjusted staffing levels and skill mix, the staffing establishment for inpatient maternity services did not meet requirements.

The service did not always have enough midwifery staff in inpatient maternity services. Midwifery staff, including specialist midwives, worked across St Helier Hospital and maternity services at Epsom General Hospital. The service was not able to provide the most recent staffing report. They told us this would be finalised in September 2023. However, the service provided the perinatal quality surveillance measures report for March 2023. This showed the service had not met the trust target of 94% fill rate for midwifery staffing in November and December 2022 nor January 2023, across both hospitals. In January 2023, the fill rate was 90%. To mitigate this, matrons, managers and specialist midwives had worked clinically.

The service continued with 6 continuity of carer teams, despite the challenges faced in ensuring there were enough staff in inpatient midwifery services to ensure safe care and treatment. Leaders told us there was a plan to reduce the continuity of carer provision to 2 teams in order to ensure safe staffing was maintained in inpatient services. The service was consulting staff at the time of our inspection and planned to make the changes by January 2024.

Maternity

The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 ‘Safe midwifery staffing for maternity settings'. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. Between March and August 2023, the service reported 49 red flag incidents across both hospitals. The largest number of incidents were reported for the labour ward coordinator not being supernumerary and delays to induction of labour, with 23 red flags each. The service had submitted a bid to the Maternity Incentive Scheme (MIS) fund to help achieve compliance with supernumerary ward coordinator status.

The delivery suite had 2 supernumerary coordinators, 1 allocated as labour ward coordinator and 1 allocated as triage midwife and scrub midwife for elective and emergency caesarean sections. This meant when they attended theatre as a scrub midwife, the second coordinator became triage midwife. There was a risk that at busy times the second coordinator could not be triage midwife and maintain supernumerary status. Leaders told us a business case had been provided to the trust to recruit nurses to be scrub and recovery nurses. However, this had not been approved at the time for our inspection.

However, in March 2023, the service reported 98.7% compliance with provision of one-to-one care in labour.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in July 2022. This showed staffing at St Helier Hospital met requirements but there was a shortfall of 12.06 band 3 to 7 maternity staff at Epsom General Hospital. As staff worked across both hospitals, this meant there was a shortfall of 11.06 whole time equivalent across the service. This was on the risk register, as the service had not met the requirements of the Clinical Negligence Scheme for Trusts (CNST) the previous year, partially due to this.

The delivery suite coordinator reviewed staffing levels daily using a nationally recognised staffing and acuity tool. They recorded actions taken to address any shortfalls in staffing. The service had a maternity operational staffing and escalation guideline which aligned with the operational pressures escalation levels maternity framework and escalation policy for London.

We asked for but the service did not provide vacancy, turnover and sickness rates and rates of use of bank midwives.However, following our inspection the service provided data which showed that in September 2023 they had 12.5 whole time equivalent nursing and midwifery vacancies and a sickness absence rate of 5.6%. However, leaders told us they did not have an issue with the recruitment and retention of midwives and had no vacancies. The service had employed 2 internationally trained midwives and leaders told us they had been supported by the trust to over recruit, so all vacancies were filled quickly. Managers told us gaps in rotas were mainly caused by sickness absence and other leave. This meant staffing issues identified related to the deployment of staff in inpatient services, not to overall all staffing numbers taking into account community services and continuity of carer teams.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. Managers told us they used their own internal bank staff or regular agency staff, so they were confident they were familiar with the service.

The service did not always make sure staff were competent for their roles.

Not all staff received specialist training for their role. For example, staff caring for transitional care babies did not have the qualification and competence for the role they were undertaking. The transitional care bay was staffed by a

maternity support worker and midwife with no neonatal nurse presence. This was not in line with British Association of Perinatal Medicine guidance. The service had recognised this risk in the risk register and had a transitional care action plan. All babies on transitional care bays were reviewed daily by a neonatologist. Since our inspection, the service has recruited a designated neonatal nurse lead to oversee development of the transitional care pathways.

Staff supporting women or birthing people following a caesarean section had not been trained to the same standard as for all recovery practitioners working in other areas of general surgical work. This was not in line with the Royal College of Anaesthetist guidelines for the provision of anaesthesia services for an obstetric population 2023 which recommends staff working in recovery should have been trained to the same standard as for all recovery practitioners working in other areas of general surgical work, should maintain their skills through regular work on the theatre recovery unit and should have undergone a supernumerary preceptorship in this environment before undertaking unsupervised work.

During our inspection, we were told midwifery staff working in triage and midwifery staff working on the ward may answer the triage telephone. They had not received additional training about triage and prioritisation of women and birthing people.

Following our inspection, we requested further assurance. The service told us there would be a one-day in-house training session for the multidisciplinary team focusing on assessment and prioritisation of women and birthing people attending triage provided to the core triage midwives by the end of October 2023. They told us all staff had received the update triage guidelines in daily safety huddles, by email and on posters.

Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. Eighty-one per cent of midwifery staff had completed an annual appraisal.

A practice development team of a clinical practice facilitator, and an education midwife supported midwives. There was also a team of retention and recruitment midwives.

Medical staffing

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

The service mostly had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had 12.7 (whole time equivalent WTE) consultant doctors, 8.1 WTE middle grade doctors and 7 WTE junior doctors. The service maintained 7 days a week obstetric consultant presence on site and facilitated twice daily consultant led ward rounds in line with national guidance. However, staff told us, and we saw in audits there could be delays in doctors attending triage and maternity assessment unit to review women and birthing people. Information provided by the service showed women and birthing people in the highest risk category were reviewed by doctors within appropriate timescales 97% of the time. We reviewed the perinatal quality surveillance measures report for March 2023 and saw 100% of obstetric doctor shifts had been filled between January and March 2023.

Maternity

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. The service completed medical speciality job planning which included specialist programmed activity hours for each consultant.

The service always had a consultant on call during evenings and weekends. Staff and managers told us consultants reviewed the middle grade doctor rota monthly to ensure the service had enough middle grade doctors. They told us consultants were available whenever contacted by a middle grade doctor, including out of hours.

However, the service did not have enough medical staff deployed to maternity assessment unit and triage to ensure women and birthing people were seen in a timely way. We raised this with managers during our inspection who told us consultant cover for triage was provided 24 hours a day 7 days a week by the consultant covering delivery suite and there was a named consultant for maternity assessment unit.

The service did not provide vacancy, turnover and sickness rates for medical staff but managers told us these were low.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Managers told us the majority of vacant shifts were filled by their own doctors; where locums were used these are sourced through approved agencies.

Records

Staff did not always maintain detailed records of women and birthing people's care and treatment. Records were, stored securely and available to all staff providing care.

We found inconsistencies in the completion of care records including records where risk assessments and tests were not recorded, and inaccurate records of actual care provided. Missing records included carbon monoxide monitoring, blood tests results. This meant there was a risk that the service did not have effective oversight of care provided and a risk of errors in care and treatment.

The services audit of patient records fro March to June 2023 showed similar omissions were identified and included a missing swab count and a missing 'fresh eyes' review of cardiotocography monitoring.

Data within the National Reporting and Learning System showed 2 incidents of incomplete or inaccurate records were reported.

We raised this with leaders who told us their audit of compliance with CO monitoring at booking was at 93%. They told us they continued to audit and monitor patent records and shared findings with staff in order to improve compliance.

Records were stored securely and available to all staff providing care. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

Systems and processes to safely prescribe, administer, record and store medicines were not always effective.

Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. However, during our inspection the electronic prescribing system had failed so staff were using paper prescription charts. The service had a business continuity plan for when the electronic medicine management system

was offline. However, not all staff could clearly describe how to use the paper-based medicines prescription system. Staff told us medicines given under the list of midwife exemptions were kept on the electronic system and there were no printed material/lists for midwives to be used in the event of IT failure. Following our inspection, managers confirmed the list of midwives' exemptions was available on the trust intranet whilst the electronic system was not available. However, not all midwives were aware of this.

The trust's audits of paper prescription charts found no evidence of pharmacy checks, a missing date of birth and a missing weight record. We escalated this to the service, and they told us they conducted a trust-wide audit of prescription charts and took immediate action to correct any errors. They confirmed no moderate or severe harm had been caused due to these omissions.

On the maternity ward, we saw a medicine, which should have a reduced expiry if stored at room temperature without the date written on. This meant that the service could not be assured that they were still safe to use. We highlighted this to staff, who removed it immediately.

The service had systems in place to check staff competency in using medicines and when using midwives' exemptions. However, the service did not provide evidence of how many staff had completed the competency assessments or how frequent these were. Midwives completed medicines management training as part of induction or preceptorship, but there was no further medicines management training required after this period. Doctors completed training on prescribing annually, but the service did not provide evidence of compliance rates for this.

Data from the National Reporting and Learning System reported 16 incidents relating to medicines management between December 2022 and June 2023, including omission of medicines, medicines given at the wrong time and medicines given without positive identification confirmation.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. However, managers did not always ensure that actions from incidents were implemented and monitored.

Serious incident panels took place where all incidents (hospital wide) could be reviewed by senior leaders and clinicians. A root cause analyses was carried out for each incident and a list of lessons learned was produced. For example, following an incident, an identified lesson learned was 'a full set of modified early obstetric warning score (MEOWS) observations should be undertaken whenever a woman attended either maternity assessment unit or Triage'. However, this lesson learned had not been fully embedded into practice because we found missing MEOWS observations for women and birthing people attending triage in records we checked.

Perinatal mortality reviews along with lessons learned were shared with the board along with any action taken. Incidents were reported to the Healthcare Safety Investigation Branch (HSIB) appropriately, so investigations were carried out any recommendations were shared with the board. Any harms were graded in line with guidance. Updates and progress reports about actions plans in response to serious incidents were monitored. For example, following a serious incident, an audit was completed to demonstrate that all babies who required a jaundice check had this completed by the time of discharge and guidance was updated.

Maternity

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed incidents reported in the 6 months before inspection and found them to be reported correctly. An equality impact assessment was carried out as part of incident investigations.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations. The service was compliant with the Duty of Candour requirement to be open and honest when things go wrong. Women and birthing people were sent reports and invited to attend meeting to discuss investigation outcomes. The lead midwife for clinical governance and risk met with the patient experience co-ordinator to review all open investigations and send interim update letters to women and birthing people.

Managers shared learning with their staff about never events that happened elsewhere. Staff told us they were confident to report and always got feedback about changes made in response to the incident. There was a 'sharing lessons' notice board on delivery suite and a risk newsletter as well as a message of the week about statistics and how the service was performing.

Managers debriefed and supported staff after any serious incident.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

An action plan was developed in order to increase staff morale and increase the presence of senior midwives in clinical and ward areas. Staff told us they were supported by the director and head of midwifery, by Matron and by medical staff. They told us the director of midwifery had been hosting 'open mornings' so staff could ask questions.

There was a clear management structure for maternity services. There were divisional directors including a medical director, a director of midwifery and head of midwifery. Matrons and specialist midwives supported midwifery teams and non-registered staff within inpatient areas, the community and clinics.

Leaders had an understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. Staff told us they were kept informed about developing changes to the staffing model.

Maternity

The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service was supported by maternity safety champions and non-executive directors.

Vision and Strategy

The service had a vision for what it wanted to achieve but no clearly defined plans to turn this into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service had a vision for what it wanted to achieve with broad objectives aligned to the Epsom and St Helier Hospital Group strategy for 2023 to 2028. The maternity service strategy was for 2023 to 2025 but we did not see clear and developed plans to turn the vision and strategy into action. There was no evidence that key stakeholders and staff had been involved in developing the vision and strategy. This was an area for improvement identified at our 2019 inspection of maternity services.

An Ockenden assurance visit was undertaken in May 2022. The purpose of the visit was to provide assurance against the 7 immediate and essential actions from the interim Ockenden report (December 2020). The service was able to demonstrate compliance across all of the essential actions.

Culture

Dignity and respect were not always intrinsic elements of the culture. However, staff felt respected, supported, and valued. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Dignity and respect were not always intrinsic elements of the culture. The environment and organisation of wards and clinical areas (the bereavement room, maternity ward and recovery room) had a negative impact on the privacy and dignity or women and birthing people. Within all birthing rooms and the bereavement room the ensuite facilities had a shower curtain instead of a door. This did not respect the privacy or dignity of women and birthing people.

The maternity voices partnership had received feedback from woman and birthing people feeling coerced into procedures such as induction of labour. This concern was also identified as a theme within our ‘give feedback on care responses’ as was lack of care and compassion from doctors and midwives. We raised concerns regarding privacy and dignity and feedback about staff attitude following our inspection. The service told us staff had been made aware of this feedback and attitude and behaviour would continue to be monitored through trust formal processes and ongoing feedback from women and birthing people and birthing people. However, we also received feedback praising midwifery staff for their care and compassion.

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

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas.

Staff understood the policy on complaints and knew how to handle them. All complaints were investigated and responded to.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Risk assessments and tailored communication methods such as interpreting services and written information provided in preferred languages along with additional mechanisms to support woman and birthing people had been developed.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service was compliant with the duty of candour requirement to be open and honest when things go wrong. Women and birthing people were sent reports and invited to attend meeting to discuss investigation outcomes. The lead midwife for clinical governance and risk met with the patient experience co-ordinator to review all open investigations and send interim update letters to women and birthing people.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Local governance systems operated across both Epsom General and St Helier Hospital maternity services. They did not effectively identify risks and issues. During the inspection, we saw several issues with the estate and premises which we raised with the service.

Systems to ensure emergency equipment was checked and safe for use were not effective. We found out of date and missing equipment on the neonatal resuscitation trolley, even though the trolley had been checked daily.

The leadership team did not take timely action to make change where non-compliance with national guidance was identified. The service did not declare compliance with 4 key safety actions of Clinical Negligence Scheme for Trusts (CNST) in 2022/23. On inspection, there was a lack of clarity from managers and leaders about whether the service was on track to make improvements and declare compliance for 2023/24. Actions to address areas of CNST non-compliance were not timely. The Birthrate Plus report in July 2022 identified a shortfall of midwives, in January 2023 this had not been addressed and the service was not able to declare compliance with safety action 5 on midwifery workforce planning.

The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. The divisional management team met monthly, as well as a risk and governance group. The risk and governance group included representatives from maternity services at both hospitals as well as neonatology and anaesthetics. There were a dedicated complaints managers working for the women's health division who attended the governance meetings.

Maternity

Leaders monitored key safety and performance metrics through governance meetings and a comprehensive maternity dashboard. They had a team to look at CNST compliance, which reported to the risk and governance group. The perinatal team looked at upcoming difficult births and put plans in place.

Serious incidents, ongoing investigations, the maternity dashboard, the risk register, health and safety and any safeguarding within maternity services were discussed at risk meetings. A maternity risk report was produced and presented monthly to the Women and Children's Health Divisional Board Meeting. It was also presented quarterly to the Clinical Quality Assurance Committee, for the purposes of sharing with the trust board.

There were opportunities for managers to meet with the senior management team on a monthly basis. The divisional senior management team met with the Chief Nurse and the senior leadership team monthly.

Staff followed up-to-date policies and guidelines to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed key policies such as the guideline for care of women in labour and the guideline for fetal monitoring in labour. We found they were in date, version controlled and referenced relevant national guidance.

Management of risk, issues and performance

Leaders and teams did not always used systems to manage performance effectively. They identified and escalated relevant risks and issues but did not always take timely action to reduce their impact. However, the service had plans to cope with unexpected events.

Though leaders identified and escalated some risks and issues, local systems, and audits to manage risks and performance did not effectively identify risks and issues we identified at this inspection.

Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. Monthly risk meetings were held. We reviewed meeting minutes for the May 2023 and saw the management of significant risks was discussed.

However, the risk register did not reflect issues found on inspection such as the triage model, transitional and enhanced care and recovery pathways. For example, the recovery area was not adjacent to theatre and staff supporting women or birthing people following a caesarean section had not been trained to the same standard as for all recovery practitioners working in other areas of general surgical work. This was not placed on the risk register. Leaders were not aware centralised CTG monitoring equipment on labour ward was not in working order. These issues had not been identified through maternity safety champion walk rounds or environmental audits. The issues had therefore not been acted on. Following our inspection, the service told us they did not consider all these issues as areas of risk. They had established a working party to develop and deliver an improvement action plan for transitional care and governance processes had already identified this as a risk.

Staff responsible for supporting babies requiring transitional care had not had additional neonatal training and there was not a designated neonatal nursing lead (Band 7) for neonatal transitional care as recommended by the British Association of Perinatal Medicine. There were no effective mitigations in place to manage these risks. We sought assurances and leaders told us that Midwives working on postnatal care were appropriately trained to provide neonatal transitional care based on an in-house training and neonatal drug administration competency assessment. The service told us all babies on transitional care bays were reviewed daily by a neonatologist. Since our inspection, the service had recruited a designated neonatal nurse lead to oversee development of the transitional care pathways.

Maternity

The risk register did not have adequate controls for all risks identified. Of 17 risks on the register, 1 extreme risk and 1 high risk had no controls in place. Nine risks had inadequate controls.

Action to address risks were not timely. Resusitaires required for the emergency treatment of newborns were out of service date, this risk remained uncontrolled. A risk relating to the storage of ultrasound scans was added in July 2021 and remained 'uncontrolled'. Following our inspection, the service told us it did not expect to have full mitigation of all risks identified. The recognised risk register database had options to record controls through a drop-down menu as adequate (meaning the risk had been mitigated), inadequate (meaning further actions were required to fully mitigate the risk) or uncontrolled (in the case of the resuscitaires, where full replacement was required to remove the risk).

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. Managers tracked the progress of relevant clinical audits and any associated action plans.

However, we saw found some areas where audit had not led to improvement. Where local audits identified issues, the service did not take timely action to address these. We reviewed the records audits provided and saw issues identified were repeated in our review of 7 records on inspection.

However, the service had a local maternity dashboard to monitor outcomes and clinical data. During this inspection we reviewed the service's maternity quality dashboard. The dashboard reported on antenatal, intrapartum and postnatal clinical outcomes such as carbon monoxide monitoring, induction of labour rates, post-partum haemorrhage, 3rd and 4th degree tears, admissions to neonatal unit and admissions to high dependency care.

The dashboard allowed the service to benchmark itself against national indicators and other providers in Southwest London.

The service's dashboard had statistical process control (SPC) which was used to interpret the data presented and analysis the 6-month trend pattern. SPC uses statistics to identify patterns and anomalies and helps to distinguish changes which need to be investigated from normal variation in data points. The service used the Robson Ten Group Classification System (TGCS) to compare all perinatal events and outcomes. This meant the service could interpret the data and knew when there was an issue that needed investigation.

The service clearly monitored indicators that contributed to health inequalities through the dashboard. For example, they looked at the ethnicity of all women or birthing people who were admitted postnatally to high dependency or intensive care units to identify if this was a theme or factor in admissions. This was also examined within the data for stillbirths and neonatal deaths.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. For example, the MBRRACE-UK perinatal mortality report for 2021 births showed the trust stabilised and adjusted stillbirth and extended perinatal mortality rate was around the average for similar trusts. The stabilised and adjusted neonatal mortality rate was lower than the average for similar trusts. The service reviewed perinatal deaths using the Perinatal Mortality Review Tool (PMRT). The PMRT panel met monthly to review all cases, investigations and action plans.

The service had received an Ockenden assurance visit in May 2022 and this found the service had demonstrated compliance with all the immediate and essential actions outlined in the Ockenden report.

Maternity

The service had an escalation policy in place to proactively manage activity and acuity across the trust. They followed a standard escalation policy across the local area. The unit had not closed or diverted in the last 12 months.

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 service used a fully electronic patient record system.

The service collected reliable data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

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.

Engagement

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

We received 66 ‘give feedback on care’ forms. Feedback received indicated women had mixed views about their experience. Feedback included concerns about communication, and support needing to improve. Thirty-three women and birthing people gave negative feedback about the attitude of medical and midwifery staff. Ten women and birthing people told us they had a positive experience and described how supportive midwifery and medical staff had been. Other themes included cleanliness and maintenance of the environment on the postnatal and antenatal ward, staffing numbers resulting in a lack of support and long waits for procedures and pain relief.

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. Leaders and the MVP understood the needs of the local population. They worked with other organisations such as Healthwatch to engage with communities such as the Gypsy and Traveller communities. The MVP chairs told us leaders were responsive and inclusive. They were accessible and invited them to meetings and communicated any changes.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. The service had a maternity cultural transformation group to improve experience and outcomes for Black and Asian and ethnic minority women and birthing people. Work had been carried out to change practice and to improve staffs cultural understanding.

Maternity

The CQC Maternity Survey results for 2022 showed, in comparison to other trusts, Epsom and St Heliers University Hospitals NHS Trust scored 'much better', 'better' or 'somewhat better' than expected for 4 questions and 'about the same' for 47 questions.

Many respondents reported satisfaction with their care and treatment. Concerns were reported around, clinical care and competency, communication, choice, pain management and psychological and physical support especially in postnatal inpatient care.

The NHS staff survey (a trust wide survey and not specific to maternity services) scored similar to the average of comparable trusts. The workforce race equality standard measures showed experiences for non-white staff were poorer. Workforce disability measures showed poorer experiences for staff with long term conditions or illness.

The 2022 General Medical Council National Trainee Survey (GMC NTS) which trainees complete in relation to the quality of training and support received, showed scores for most indicators, including 'overall satisfaction' were similar to the national average.

Learning, continuous improvement and innovation

Staff had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies.

The service employed a consultant midwife and a transformation and improvement lead midwife. There was a research team participating in research studies such as pre-eclampsia screening. Midwifery led studies about antenatal care, smoking cessation, breech births and testing for group B streptococcus were underway to improve outcomes for woman, birthing people and babies.

A risk management newsletter was produced. The newsletter for spring 2023 outlined mandatory consultant presence, situations, and scenarios where a consultant must attend. Learning from local trusts, perinatal mortality reviews, complaints, rapid response reviews, healthcare safety investigation reports and the maternity services risk report were shared.

'Monday meetings' were held with consultants, doctors and midwifery staff attending to discuss clinical risks and share learning.

The service had successfully recruited 346 women and birthing people to the research study Pregnancy Circles against a target of 344.

The service was the first Train the Trainer cohort in an international trial of the Group Care Model and had successfully recruited 108 participants against a target of 80.

Maternity

Outstanding practice

We found the following outstanding practice:

- The service had a strong focus on health equity. The service actively worked with Black and Asian women or birthing people via focus groups to explore their experience of maternity care and any barriers to safe and effective maternity care and support. This work had resulted in improved outcomes such as vitamin D uptake in non-white women or birthing people.

- The service had robust and embedded systems to monitor indicators that contributed to health inequalities through the maternity dashboard.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure all staff are up to date with maternity mandatory and safeguarding training modules. Regulation 12(1)(2)(c)

- The service must ensure premises and equipment are secure, suitable and properly maintained. Regulation 15 (1)(b)(c)(e)

- The service must ensure it assesses and mitigates risks to women, birthing people and babies. Regulation 12 (1)(2)(a)(b)

- The service must operate clear triage processes to ensure the safety of women, birthing people, and babies. Regulation 12 (1)(2)(a)(b)

- The service must ensure medical staffing for maternity triage is reviewed so there are sufficient numbers of staff to review women and birthing people in a timely manner. Regulation 12 (1)(2)(a)(b)

- The service must ensure staff accurately complete, and document modified early obstetric warning scores in order to identify and escalate women and birthing people at risk of deterioration. Regulation 12 (1)(2)(a)(b)

- The service must ensure that staff caring for transitional care babies have the appropriate level of qualifications and additional training. Regulation 18 (1)(2)(a)

- The service must ensure the role of recovery practitioner is role is carried out by staff with the right level of qualification and additional training. Regulation 18 (1)(2)(a)

Maternity

- The service must ensure records of the care and treatment provided are accurate, complete and contemporaneous. Regulation 17 (1)(2)(c)

- The service must ensure it operates effective systems and processes to maintain clear oversight of maternity services and enable it to assess, monitor and improve the quality and safety of services and mitigate risks to women, birthing people and babies. Regulation 17 (1)(2)(a)(b)

Action the trust SHOULD take to improve:

Maternity

- The service should continue to ensure the design and maintenance of the environment allows staff to detect, prevent and control the risk of the spread of infection.

- The service should ensure 'fresh eyes' checks of cardiotocography (fetal heart rate) monitoring are carried out hourly.

- The service should ensure staff use the 'situation, background, assessment, recommendation' handover format when handing over care of women, birthing people and babies.

- The service should ensure midwifery staff complete an annual appraisal.

Our inspection team

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