Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Royal Hospital

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inadequate**

Our findings

Overall summary of services at Gloucestershire Royal Hospital

Inadequate 

We carried out this unannounced focused inspection of maternity services on Wednesday 6 April and Thursday 7 April 2022 because we received information giving us concerns about the culture, safety, and quality of the services. As this was a focused inspection, we only inspected safe, well-led and parts of the effective key questions.

See the Maternity section for what we found.

How we carried out the inspection

During the maternity inspection we spoke with 43 staff including the head of midwifery, consultant obstetric lead, divisional management team, consultants, clinical matrons, fetal monitoring midwife, specialist midwives, midwives, community midwives and maternity care assistants. We spoke with a service user and their relative.

We spent a day in the Gloucestershire Royal Hospital maternity services and a day in the community where we visited the community teams at Stroud and Cheltenham. At the time of the inspection the birth units at Stroud and Cheltenham were closed. We reviewed 10 sets of women's records, reviewed clinical guidelines and governance documents. We completed six staff interviews after the on-site inspection.

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.

Following the inspection, we issued a section 29a warning notice to the trust as we found significant improvement was required to midwifery safety, leadership and governance. The section 29a warning notice has given the trust three months to act on the significant improvements we identified.

Maternity

Inadequate

We carried out this unannounced focused inspection of maternity services on Wednesday 6 April and Thursday 7 April 2022 because we received information giving us concerns about the culture, safety, and quality of the services. As this was a focused inspection, we only inspected safe, well-led and parts of the effective key questions. We did not inspect all of effective, responsive or caring on this visit, but we would have reported on them if we found areas of concern. At our previous inspection in 2016, caring, responsive and effective were rated as good.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Previous ratings were not all updated during this inspection. The maternity rating for safe and well-led went down to inadequate. The previous rating for effective, caring and responsive remained as good. Overall, the service was rated as inadequate.

We visited the delivery suite, maternity triage, maternity ward where care was provided for antenatal and postnatal care women and babies, and the midwifery led birth centre at Gloucestershire Royal Hospital. On the second day of inspection we visited the community midwifery teams based in Cheltenham and Stroud.

Please refer to the 'areas of improvement' section for more details.

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

- The service did not always have enough staff to care for women and keep them safe. Not all staff had updated their training in key skills. Not all equipment checks were completed daily. Some safety incidents were not investigated fully, or in a timely way and lessons were not always learned from them.
- Not all staff felt respected, supported, and valued. The service did not have a clear vision, values or strategy, although this was in development. There was not sufficient leadership capacity to focus on governance and risk management. Leaders did not always have reliable information systems to support them to monitor services.
- There were not sufficient competency frameworks for midwives and the professional midwifery advocate (PMA) service, to support midwives, had been significantly reduced due to vacancies within the team. Managers did not have effective systems and processes to proactively monitor and improve services.

However:

- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Midwifery staff knew how to make a safeguarding referral and who to inform if they had concerns.
- Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records demonstrated that most areas were cleaned regularly. Staff disposed of clinical waste safely.
- Leaders understood the priorities and issues the service faced. Most were visible and approachable in the service for patients and staff.

Maternity

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 but not all staff had attended yearly training updates. The training offered was comprehensive, but attendance was low due to staffing levels.

Mandatory training was offered but not all staff were up to date. The mandatory training programme was updated in September 2021. Records showed in the first seven months of the programme, overall compliance for staff with updating both parts of the practical obstetric multi-professional training (PROMPT) training was 32% for midwives and 21% for maternity care assistants (MCAs) and maternity support workers (MSWs). Medical staff training compliance ranged from 20% at junior doctor level to 58% for consultants. The midwives mandatory update day had 32% attendance while the maternity care assistant and maternity support worker mandatory update was only 26%. Staff explained that mandatory training was still being offered but only staff able to work additional hours and be paid bank pay were able to attend. Not all staff were able to work these additional hours. With ongoing staff absence levels remaining high, managers were not confident that mandatory training targets would be met by the end of the training year in September 2022. Following the inspection, we received information from the trust to state that the NHS Resolution Scheme had extended the timeframes and submission deadline for the Maternity Incentive Scheme (MIS) year four until 5 January 2023. This meant the PROMPT training year was extended from the proposed finish in July 2022 to the end of December 2022. Additional PROMPT sessions were planned to achieve the 90% training compliance target and MIS safety action eight by December 2022.

Resuscitation training records showed maternity and medical staff adult basic life support compliance was 59%. Trust training targets were not available, but this level of compliance was not expected to meet the trust training target. There was a risk staff caring for women and their families would not be up to date in resuscitation practice and there could be delays to care and treatment.

The mandatory training was comprehensive and met the needs of women and staff but not all staff had completed it. Trust training updates were completed electronically in response to COVID-19. Maternity staff compliance for manual handling was at 75%, infection prevention and control level 1 was 85% and level 2 was 78%, and the three yearly health and safety was at 84% while the annual fire safety compliance was 77%. We did not receive information on the trust targets, but these would have been unlikely to meet them. The highest compliance was noted to be NHS conflict resolution at 96%, although this training was three yearly, so staff had longer before they needed to complete this online learning.

Maternity specific training was planned and organised by the maternity practice development team. The trust had developed a multi-disciplinary learning environment focused on all aspects of obstetric and midwifery skills to deliver safe, emergency care. The PROMPT multidisciplinary study day was delivered into two parts. The theoretical part was virtual, and the second part was in person in the setting usually worked by staff members.

Not all staff had completed yearly cardiotocography (CTG) training to ensure staff were aware of latest evidence for interpreting CTG monitoring. The training programme was restarted in November 2021 with a whole day dedicated to this training. All midwives, including those working in the community, were expected to complete this training. All staff

groups met the 90% CTG training compliance before November 2021. Data showed low CTG training completion with overall compliance of 27% in the five months of the new programme. Of these rates, 21% midwives, 23% consultants and 38% registrars had attended the yearly update at the time of inspection in April 2022. Accurate fetal monitoring is vital to assess fetal wellbeing. There was a risk staff would not be up to date with the latest evidence for interpreting CTG monitoring.

Clinical staff completed training on recognising and responding to women with mental health needs, but training did not include learning disabilities, autism or dementia. Maternity staff mandatory training included mental health and teenage pregnancy. Staff completed trust equality, diversity and human rights training every three years, with all maternity staff compliance at 88%.

Managers monitored mandatory training and staff were alerted when they needed to update their training. The practice development team monitored mandatory training and staff received emails from the trust when they needed to update their training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Not all staff had completed training updates on how to recognise and report abuse. Baby abduction drills were not completed regularly.

Most midwifery staff received training specific for their role on how to recognise and report abuse. Midwives were required to complete level three adult and children safeguarding training. Records showed compliance with updating safeguarding adults level three training was 75% with 45% midwives updated on safeguarding children level three training. There was a risk staff would not recognise and act on safeguarding concerns, however staff commented that referrals had increased since COVID-19 in line with the national trend. Supervision for midwives was available twice a week via a digital platform in response to COVID-19 social distancing restrictions.

Not all medical staff received training specific for their role on how to recognise and report abuse. Junior medical staff did not receive level three safeguarding children training. This is not in line with the intercollegiate guidance by the Royal College of Nursing. Of consultants, only 57% had been updated on level three children safeguarding training, while 78% had been updated on level three adult safeguarding. Junior medical staff compliance remained low at 61% for level three adult safeguarding. There was a risk medical staff would not recognise and act on safeguarding concerns to keep vulnerable women and babies safe.

Staff we spoke with could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Patient hospital records flagged women who had safeguarding issues with a green referral form, which was also shared with the vulnerable women's team. The vulnerable women's team included specialist mental health, substance use and teenage pregnancy midwives. This team had oversight of the maternity safeguarding referrals and maintained a database of concerns. The electronic patient records system did not easily identify families needing extra support, however band 7 midwives in triage and delivery suite had access to the maternity central database and national Child Protection Information Sharing (CPIS) system. This access helped staff identify safeguarding concerns for women who were new to area.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.Midwifery staff knew how to make a safeguarding referral and who to inform if they had concerns. Most booking appointments were held in the woman's home. As part of the assessment, midwives routinely asked questions on mental health, domestic violence and female genital mutilation. This was in line with national guidance. Midwives

completed a safeguarding referral and placed a referral form in the woman's hospital notes. The vulnerable women's team supported women with safeguarding concerns and midwives looking after women who were not cared for by the vulnerable women's team. Safeguarding concerns were uploaded onto a central database which was accessible to all band 6 staff and above. Staff used the database to check the detail of safeguarding concerns when the paper referral form was not available. Community midwives wrote reports if they were unable to attend safeguarding case conferences. Staff knew who the lead for safeguarding was but there was no protected time for this role.

Staff followed the baby abduction policy and occasionally undertook baby abduction drills. Access to all areas was through locked doors which staff had swipe cards for. Staff controlled entry and exit to the wards and challenged a member of the inspection team to ensure they were allowed on site. Staff labelled babies at birth and placed an electronic tag on each baby to keep babies safe. The electronic tag would sound if a baby was near to the ward exit. We observed staff on the maternity ward responding quickly to alert sounds. Following the inspection, the trust told us baby abduction drills would be completed yearly. Learning was identified from the last baby abduction drill which took place 11 months before our inspection. Future abduction drills were being planned and would include the midwife led birth centres, however the dates planned were over 12 months from the last drill. Following the inspection, we were also informed that a baby tagging training session had been held in April 2022.

Cleanliness, infection control and hygiene.

The service did not always control infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection but did not always follow social distancing guidance. They kept equipment and the premises visibly clean.

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

The service generally performed well for cleanliness. Cleaning records demonstrated that most areas were cleaned regularly. Cleaning audits were completed and audited for most but not all areas. From the records we reviewed it was unclear what actions had been completed when cleaning audits showed concerns and compliance fell below 100%.

Most staff followed infection control principles including the use of personal protective equipment (PPE). There were enough hand washing sinks and alcohol-based hand sanitiser in all areas of the service we visited. Personal protective equipment (PPE) such as gloves, aprons and masks were available to staff to ensure their safety when performing procedures. Staff wore uniforms and PPE in line with trust policy and were bare below their elbows. However, staff did not adhere to local signage of room occupancy limits introduced in response to COVID-19. Over 12 staff were seen in the maternity ward staff office, which had an occupancy limit of 5 people. Staff explained the social distancing requirement of 2 metres had been reduced to 1 metre, but the signs visible to staff, women and their visitors had not been updated to reflect this. It was not clear who was responsible for updating information in line with policy.

Hand hygiene audits were completed monthly in the midwifery led birthing units and compliance varied between 80 and 100%. It was not clear from the data received that hand hygiene audits were completed on the maternity ward, triage or delivery suite at Gloucestershire Royal Hospital, although compliance for the women's and children's division also showed compliance of 80 to 100%. Records did not show the action taken to improve compliance.

Women had point of care polymerase chain reaction (PCR) coronavirus tests on admission to the delivery suite or birth centre. Results of COVID-19 testing were displayed on patient boards in the midwife offices. However, there was no sign outside of a woman's room or bay to indicate to staff or visitors that extra PPE precautions should be taken in line with the PPE policy. Staff we spoke with advised this was to avoid discrimination of women found to be positive to COVID-19.

There was a risk staff responding in an emergency, or support staff who had not viewed the testing results on the patient board, would not be protected against infection control risks. At the time of our inspection, eight women were recorded on the patient board to be COVID-19 positive. Following the inspection, the trust confirmed that two of these women were COVID-19 positive, the remainder had been exposed to COVID-19.

Most staff cleaned equipment after patient contact but not all equipment was labelled to show when it was last cleaned. On the delivery suite we saw some use of the 'I am clean' stickers, but this was not consistent. Disposable curtains were in use. Not all curtains displayed the date the curtain was last changed.

Not all midwifery staff knew how to clean birth pools. There were birth pools in the Gloucestershire Royal Hospital, Stroud and Cheltenham birthing units. Staff explained housekeepers cleaned the room and midwifery care assistants cleaned the birth pools where there was exposure to bodily fluids. Staff gave different explanations of how to clean the birth pools, the quantities of cleaning product needed, and the volume of water required in the birth pool at the time of cleaning. There were no guidelines for preparing the cleaning products where the cleaning products were stored. There was an infection control risk birth pools were not being fully disinfected between use. Subsequent to our inspection we were provided with evidence of guidelines to support staff on cleaning the birth pools.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe. Not all equipment was checked regularly. Staff managed clinical waste well.

Women could reach call bells and staff were seen to respond quickly when called. Information received prior to our inspection suggested that call bells were not always responded to quickly. At the time of our inspection staff had been redeployed from the stand-alone birth centres in Stroud and Cheltenham to the maternity ward at Gloucestershire Royal Hospital. Staff explained there were more midwifery care assistants working than usual because of the birth centre closures. This was a temporary measure.

The design of the environment followed national guidance. There were two maternity theatres located next to the delivery suite. A second team was needed to support category two emergency caesareans outside of daytime working hours. This was added to the risk register and a business case had been completed for a second theatre team.

Staff carried out some but not all safety checks of specialist equipment. There were gaps in the daily checking of all emergency trolleys we reviewed. Records showed gaps in all daily trolley checks, while almost all weekly checks were completed in line with local policy. Daily checks ensure equipment is available in an emergency. In the month before our inspection, records showed six to 17 days where trolleys were not checked. This included four neonatal resuscitation trolleys, a post-partum haemorrhage trolley on delivery suite, a sepsis trolley, and two resuscitation trolleys. The printed sepsis guideline was six months beyond the review date meaning in an emergency staff may follow out of date guidance. Some items were found to be past their expiration date on an emergency resuscitation trolley, which had lapsed its weekly safety check. These were highlighted to staff and replaced. There is a risk equipment would not be available or in date in an emergency, therefore there could be delays in providing the necessary care with equipment that is assured to be safe.

The service had suitable facilities to meet the needs of women and their families. There were two bereavement rooms available for women and their families who had a bereavement. The rooms provided a homely environment that was less clinical. One room was accessible from outside of the delivery suite, however one room required women and their families to walk through the delivery suite. Staff were aware of the emotional impact this could have with women being aware of celebrating families, but the environment prevented the creation of a separate access.

Maternity

All labour rooms on delivery suite had a baby resuscitaire in. A baby resuscitaire is a device which combined a warming therapy platform along with the components needed for clinical emergency and resuscitation.

At the time of our inspection the service did not always have enough suitable equipment to help them to safely care for women and babies. There was no postpartum haemorrhage (PPH) box available on the maternity ward, where secondary postpartum haemorrhages could occur after birth. There was no PPH or eclampsia box on Gloucester birth centre. A postpartum haemorrhage is severe vaginal bleeding after childbirth and is an obstetric emergency. Postpartum haemorrhage and eclampsia boxes are designed to ensure necessary equipment is readily available in an emergency so that care is provided without delay. There is a risk of delays in providing emergency care as equipment would not be available. Following the inspection, the trust confirmed there is a PPH emergency box on the maternity ward and Gloucester birth centre.

However, community midwives had access to standardised home birth equipment. The red home birth bags had recently been reviewed and standardised. This meant community midwives could open the bags and locate what they needed without delay. Community midwives also had access to 21 bilirubinometers with a further 10 expected to be released from medical engineering. Bilirubinometers are gold standard equipment used to accurately assess jaundice in newborn babies.

Staff disposed of clinical waste safely. Sharps boxes were placed out of reach and were not seen to be over filled. Waste bins were clearly labelled and not overfilled.

Assessing and responding to patient risk

Most staff completed but did not always update risk assessments for each woman and took action to minimise risks. Staff did not always use tools to identify and quickly act upon women at risk of deterioration. Lack of staff meant there were times when midwives were very busy which posed a risk to the safe assessment and monitoring of all women and babies.

Staff did not always complete the nationally recognised tool to identify women at risk of deterioration and did not always escalate them appropriately. Some staff used a modified obstetric early warning score (MEOWS) chart to assess and monitor changes from accepted observations including blood pressure, heart rate and temperature. There was inconsistency between the guideline and chart as to the spelling of the abbreviated chart name. We reviewed the 'severely ill obstetric woman recognition and management' trust guideline, which stated that 'following labour and delivery, MOEWS should be monitored in all maternity inpatients'. Guidance stated 'postnatal observation and examination are no longer routinely carried out in the community' but that 'a MOEWS chart' should be retained in the notes in case of concerns during the postnatal period.

Of the ten completed records reviewed, five did not contain a MEOWS chart. Staff did not always follow trust policy as a MEOWS chart was not always used to assess the health of a woman after the birth. Of the five charts reviewed, one scored a yellow rating and required repeat observations in one hour. This was not completed in the required timeframe, with observations noted on the chart the following day. This meant observations showing deterioration were not always repeated or escalated as per guidance.

We inspected the service in response to a high number of serious incidents associated with adverse outcomes for mothers and babies. There was not always evidence that lessons had been learnt from incidents, or managers had the oversight of the use of MEOWS charts used to identify risk of patient deterioration. Following the inspection, we requested the MEOWS audit and associated action plan. This was not provided. The trust responded that they had not completed a planned, formal MEOWS audit since 2019 due to continuing operational pressures.

Maternity

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed booking assessments when women presented for care. The mother's medical, social and emotional history were recorded and prepopulated on to a paper assessment tool which was then input onto an electronic record. This helped to place women on the appropriate care pathway. Staff used a standardised health visitor and GP liaison form to share vulnerability assessments with the multi-professional team to ensure the correct level of support was provided for each woman. An initial assessment of risk was visible on the front of the woman's handheld records for all 10 records reviewed, however three women's risk status was not always re-assessed at 36 weeks of pregnancy. There is a risk staff would not recognise changes in a woman's wellbeing or assessment of risk which would place a woman on an inappropriate care pathway.

Staff completed triage risk assessments for each woman on arrival, however these were consistently not completed within the 15-minute required timeframe. Triage was one of the top three risks on the maternity risk register. The inability to meet 15-minute wait times on a daily basis meant there was a potential delay in care and treatment which could lead to poor outcomes for mother and baby In response to the triage wait time performance the trust implemented the Birmingham Symptom-specific Obstetric Triage System (BSOTS) assessment tool, were monitoring the wait times and were capturing this data on a monthly report attached to the Delivery Suite Birthrate Plus report. Birthrate Plus is a staffing calculation tool based on an assessment of clinical risk and needs of women and babies. A full Birthrate Plus report was due.

There were further delays in triage as medical staffing job plans did not allow for dedicated rostering of doctors within triage. An action plan was developed by the trust in September 2021 as part of their risk mitigation. Actions were to be completed between 13 May and 1 August 2022 but were not due to be reviewed until 29 June 2022. At the time of our inspection medical attendance was still a concern, with no protected time for medical staff to review triage or the antenatal ward rounds. These were considered additional duties registrars and consultants were required to complete alongside their rostered Delivery Suite or Gynaecology shift.

Staff caring for women in labour completed assessments using, partograms, cardiotocograph (CTG) readings. A partogram is a graphical presentation of a woman's progress of labour, whilst a CTG measures the baby's heartbeat and monitors the contractions of the uterus. Findings were documented in the care record.

Based on national recommendations the trust had implemented a fresh eyes approach to interpreting CTGs. Records we reviewed showed fresh eyes reviews were being completed.

Staff completed a theatre checklist for women transferred there during labour for invasive procedures which included a caesarean section and for planned surgeries. The checklist followed World Health Organization's (WHO) 'Five Steps to Safer Surgery Checklist'. In addition, two staff were responsible for counting swabs and making sure all instruments used accounted for.

Most staff knew about and dealt with any specific risk issues. Women were recommended to take vitamins which would include vitamin D, throughout their pregnancy, although vitamin D was not seen to be stated in any of the ten records reviewed. Since the inspection, the trust advised that discussions about vitamins are included on the maternity booking system and recorded on the printed booking summary. Other risk factors like obesity, diabetes, social deprivation and maternal age were factored into the risk assessments and women assessed as high risk were referred for obstetric assessments.

Maternity

Staff did not always use MEOWS charts to identify a woman's deterioration in health. This deterioration could be due to sepsis. Sepsis is a life-threatening reaction to an infection. Following the inspection, we requested the sepsis care audit and action plan. The trust told us that the audit was paused due to operational pressures due to staffing, but an audit was planned for September 2022 following implementation of a revised policy in January 2022. Risk managers did not have oversight of sepsis management and were not identifying learning to improve care.

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). Staff had access to an on-site 24/7 mental health liaison team, should a registrar assess a woman as being at risk of suicide or self-harm.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Community midwives assessed a woman's mental health at booking and at 36 weeks. Of the 10 records reviewed, all 10 had a mental health assessment using a recognised assessment too. Community midwives were required to check the woman had received an outcome letter when they were seen at their next appointment.

Specialist clinics were held weekly for women on moderate or high-risk care pathways. These were multi-professional clinics attended by a psychiatrist, obstetrician, and mental health midwife. Women seen in this clinic received a personalised 32-week mental health birth plan. Staff told us this plan contained signs and symptoms of mental health deterioration for the woman and the preferred management strategies. Copies of these birth plans were shared with the woman, community midwife and the acute hospital in the mental health birth plan box. However, at the time of the inspection there were barriers to communication as the mental health specialities used different electronic systems, causing potential delay in communication.

The centralised booking team did not always arrange interpreters for initial booking appointments completed by community midwives. These are long appointments designed to assess a woman's health history, family history and pregnancy risk status and gain consent for screening and care options. Staff spoke of using telephone interpreters, with some occasions when there was no interpreter availability for the language required. Staff rebooked these appointments when an interpreter would be available, although there was a risk care would be delayed.

Shift changes and handovers did not include all necessary key information to keep women and babies safe. During the inspection we observed handovers at the Gloucester birth centre, delivery suite and maternity ward. Handovers were completed between individual midwives, with the previous shift midwife handing over directly to the next shift midwife. We observed that maternity care assistants were not included in these handovers. The midwife leading the ward and attending the unit safety huddle had oversight of the care needs through speaking with individual midwives. However, a whole team and ward safety overview was not held before individual patient handovers. This meant not all staff working on the ward were aware of the activity and care need on each shift. There was a risk that in an emergency staff would be unaware of the emotional, social, and physical care needs and risks for each woman and baby. Staff spoke of times when it would have been helpful to know the social background of women before answering call bells. There was a risk staff would be unaware of any social concerns or restricted visiting, in addition to an awareness of service pressures, safety messages or incidents. Following the inspection, the trust told us routine handovers are supplemented by detailed team safeguarding meetings, when required. There was also a risk staff would be unaware of one another's support and training needs, which was a concern during our inspection when staff had been redeployed to a new work areas in response to the stand-alone birth centre closures. However, the trust informed us that all redeployed staff had a conversation with their line manager prior to redeployment.

Maternity

Midwifery staffing

The service did not have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm or to provide the right care and treatment all the time. Managers regularly reviewed and adjusted staffing levels and skill mix, but these did not always meet local demand. Redeployed staff did not always receive an orientation or induction to new work areas.

The service did not have enough midwifery staff to keep women and babies safe. Maternity leaders closed the two stand-alone birth centres at Stroud and Cheltenham the day before our inspection. This was in response to 25% of the midwifery workforce being unavailable for work due to vacancy, sickness and secondment. Women assessed as low risk were still able to birth on the midwife led birth centre at Gloucester and at home. Staff explained the trust COVID-19 infection control policy required staff to remain off work for 10 days after a positive COVID-19 infection. This was to reduce the spread of infection but impacted on staffing availability. Data received following the inspection showed there was 23.88 whole time equivalent (WTE) combined band five, six and seven absence in March & April 2022. Of this level, in April 2022 the service was down 4.78 WTE on the maternity antenatal and postnatal ward (band five and six midwives), down 2.2 WTE (band five and six midwives) on triage, and down 3.19 WTE band 5 and 6 midwives and 1 WTE band 7 midwife in the East community hub and Cheltenham Aveta birth centre.Due to midwifery staffing the standard of one-to-one care in labour was not met in the six months prior to our inspection. Staff across the service told us they were exhausted, and morale was low with staff experiencing stress and anxiety.

Women did not always receive one-to-one care in labour. Data provided showed 95% compliance with this standard in March 2022 due to a shortage of midwifery staff.

Managers made changes to the midwifery preceptorship programme to help recruit and retain staff. Newly qualified band five midwives were moved onto band six pay after 12 months, while they continued to have preceptorship until 18 months past qualification. Managers told us this was introduced in response to staff feedback.

Managers calculated and reviewed the number and grade of midwives and maternity care assistants needed for each shift in accordance with national guidance. The midwifery workforce was presented to board by the chief nurse and director of quality in the Midwifery Staffing Report. The report was last presented for board assurance in March 2022, but records showed the maternity staffing report had not been presented for over a year.

Managers adjusted staffing levels daily according to the needs of women in labour but there were not enough staff. The maternity assurance dashboard had gaps in workforce data. This meant it did not give assurance of the midwifery staffing. Managers used a nationally recognised live acuity tool to review staffing on the unit. The tool risk rated staffing levels through the day and highlighted periods of unsafe staffing. Red flags were assigned to shifts with unsafe staffing. Records showed there were 174 red flags on delivery suite and Gloucester birth centre between 1 October 2021 and 12 April 2022. A red flag is a warning sign that something may be wrong with staffing, for example, when there is a delay in care. Managers were awaiting a Birthrate Plus report in Spring 2022 to confirm the required staffing numbers and distribution of staff needed to safely staff the service.

The number of midwives and maternity support workers rarely matched the planned numbers. If staffing levels were unsafe, staff followed the maternity escalation policy and called the unit on call midwife into support. Matrons managed the staffing levels when covering the ‘8 of the day’ rota and attended the delivery suite safety huddles. Due to staffing levels, despite this escalation process actual staffing did not meet planned staffing.

Use of bank staffing was high. Many shifts went unfilled and community staff were previously used to backfill shifts, but this had reduced with the introduction of an acute unit on call rota and the closure of the stand-alone birth centres.

Maternity

Community midwives were still recorded to work additional hours on top of their on-call hours for homebirths. Agency staff covered 67 shifts from 1 October 2021 to 30 April 2022. Managers had created financial incentives to encourage staff to work extra hours, but some staff told us they were too exhausted to work more than their contracted hours. From October 2021 to February 2022, there were between 558 and 692 bank shifts advertised per month. This increased to 903 bank shifts in March 2022 during a time of unprecedented staff absence levels, largely due to the need for staff to isolate in response to COVID-19. Records confirmed managers requested bank shifts in all areas to attract staff to fill the bank in their area of preference. Staff not working a bank shift may be moved to a different work area to improve staffing levels and maintain safety. We saw this during our inspection.

Managers made decisions to close midwifery led birth centres when there were not enough midwives available to safely staff the whole service. This included the stand-alone birth centres in Stroud and Cheltenham, to allow the staff working to support the main maternity department in Gloucester. Stroud birth centre was reopened within three weeks of the inspection when midwifery staff absence levels reduced to 25 whole time equivalent roles in line with the December 2021 obstetrics and gynaecology pandemic illness staffing plan.

The number of maternity care assistants (MCAs) and maternity support workers (MSWs) matched the planned numbers, but the number of midwives did not meet the planned numbers. At the time of inspection maternity care assistants due to work at the stand-alone birth centres had been redeployed to the maternity ward.

The service had higher than average vacancy rates. Staff recently recruited were due to start work in October 2021, but many newly qualified midwives accepted but then declined their offer of work. This, combined with staff reducing their hours, retiring and new leavers, left a midwifery vacancy rate of 10.24 whole time equivalent (WTE) in April 2022. Managers were recruiting to fill midwifery roles. Managers were also working with nearby trusts to recruit international staff.

The service had high sickness rates. In October 2021 there were 8.85 WTE Midwives on long term sick leave. This reduced to 6.92 WTE midwives in March 2022, however this does not include short term sickness. Staff were on long term sickness for a mixture of personal and professional reasons, some in response to clinical incidents.

Managers did not always make sure all redeployed bank staff had a full induction and understood the service. We spoke with three staff who had not received an orientation to the ward when they were moved from their usual workplace. Following our inspection, we requested the current competency framework for midwives, maternity care assistants and maternity support workers and the process for redeploying staff who were due to work at the stand-alone birth centres. This information was not provided. We could not be assured there was a process for ensuring staff were competent to work in these different work areas. The trust told us all redeployed staff had a discussion with their line manager prior to their redeployment.

The service did not have enough administrative staff supporting midwives across maternity including in the community. Information provided following the inspection confirmed the number of administrative support vacancies in the maternity service was 2.87 whole time equivalent at the time of inspection in April 2022. There were plans for increased reception and ward clerk cover for triage, central delivery suite and the maternity ward.

An escalation policy supported staff during times of increased activity and staffing pressures. Staffing activity was recorded for the acute site and birthing centre, but it was not clear if community acuity or activity was recorded. The standard operating procedure (SOP) for community on calls “procedure for on-call within maternity” recognised that community staff who had worked a 7.5-hour day should only work for an additional 4.5 hours when called in escalation to Gloucestershire Royal Hospital. It was noted this timeframe was less than the accepted homebirth hours as the acute

setting was unfamiliar, and the intensity of work increased. This standard operating procedure appeared to be developed around the time of our inspection as it included reference to the new band 8 of the day rota, which was introduced in December 2021. There was no publication date or details of the staff member approving the standard operating procedure. The standard operating procedure did not include how this would be monitored.

Community midwives on call hours were not monitored on one system. At the time of the inspection there was no contemporaneous oversight by the maternity leadership team of hours undertaken by the community staff who were often called in line with the escalation policy. Community midwife call outs had mostly reduced since the introduction of the Gloucester midwives on call rota as community midwives were further down in the escalation plan. However, on calls for the Stroud and Cirencester community teams had increased. Additional hours worked continued to be worked across all the community teams, especially the Gloucester and Forest of Dean community midwives. Staff absence was high and there were not enough midwives working to meet the needs of the care needs of the women and families, without working additional hours. Following the inspection, the trust informed us the service had been working with the digital midwife and roster team to ensure community midwife call outs were recorded electronically.

We were told women and their families were supported by the equality diversity and inclusion (EDI) midwife and health visitor. We requested to speak with the EDI midwife but were told the role was unfilled following a recent resignation from the role. No alternative member of staff was identified for interview.

Medical staffing

The service usually had enough medical staff with the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service usually had enough medical staff to keep women and babies safe. The medical staff usually matched the planned number. Out of hours, consultants covered from home and could access information remotely and provide advice. Staff told us consultants attended swiftly when called in. However, staff told us that if the morning consultant is unable to finish the ward round before leaving to attend their antenatal clinic, the delivery suite medical team then completed the ward round. This meant there was potential for delays in the ward round being completed and the medical team responding to the triage reviews.

The service had low vacancy and turnover rates for medical staff. At the time of our inspection there was vacancy for 1 whole time equivalent (WTE) registrar and 0.5 WTE resident consultant but no other consultant or senior house officer vacancies. Staff gave examples of trainee grades regularly seeking to return to Gloucestershire Royal Hospital for employment. This meant the medical workforce was relatively stable.

Sickness rates for medical staff were usually low. Staff were required to isolate for 10 days due to a positive COVID-19 result.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service had reducing rates of locum staff usage.Managers could access locums when they needed additional medical staff. Records showed the number of locum shifts for registrars and senior house officers was relatively stable between October and December with the number then reducing to March 2022. However, from the data we received it was unclear whether all locum shifts were filled.

The service always had a consultant on call during evenings and weekends. Consultant obstetrician job planning was being completed during the inspection. The trust job plans for 12 hours resident consultant cover on delivery suite during the week and on weekends, giving a total of 79 hours cover. All consultant obstetricians we spoke with remained resident beyond the job hours. Staff advised that once completed the job planning exercise should inform the total commitment required for resident cover.

Records

Staff kept detailed records of women's care and treatment. Records were usually clear, up to date, stored securely and easily available to staff providing care. Entries were not always timed.

Women's notes were mostly comprehensive, and staff could access them easily, but not all notes entries were timed, and risk re-assessments were not always documented. The service used a combination of paper-based and electronic records. Community midwives could access the digital care records in the community. Staff told us the transfer of information was not always easy because the wider multi-professional team were not all using the maternity computer systems. Community midwives were not always directly informed of the outcome of referrals. Women referred to the perinatal mental health team received a personalised letter with the outcome of their referral, and community midwives would check this had been received at the 16-week appointment, after their booking. There was a potential for delays in referrals if the initial referral was not received.

We reviewed 10 sets of completed records. Times were not always recorded next to the entries in seven of the 10 records. Times were added to the labour and postnatal care entries more often than the antenatal care entries which were mostly completed by community midwives. Risk assessments for mental health and overall pregnancy assessment were completed at booking but not always completed at 36 weeks, in three of the 10 records. Three of the records showed no evidence of a domestic abuse assessment. In the records reviewed there was no evidence of female genital mutilation (FGM) assessment. However, staff showed and told us the booking questionnaire included FGM assessment. This was a mandatory question meaning all women would have to asked if they had received FGM before the booking could be completed electronically.

Staff we spoke with told us the maternity service had plans to introduce electronic records, although this had been delayed. Electronic records would allow referrals to be stored and easily accessed by all necessary staff.

When women transferred to a new team, there were usually no delays in staff accessing their records. Women kept handheld paper records (a file of all the information related to their pregnancy) for their care, which were started at their first antenatal booking appointment. The paper hospital notes for each mother were stored at their intended place of birth. These could include a green vulnerabilities form or purple mental health form. There were three main maternity sites for these records to be kept, in Stroud, Cheltenham or Gloucestershire Royal Hospital. We saw one occasion when there was a small delay on receiving the main hospital notes for a woman with safeguarding concerns.

Most but not all records were stored securely. Paper records were stored in cabinets in the midwife offices. The electronic patient systems were only accessible through password protected systems to authorised staff. This included safeguarding concerns listed on the vulnerabilities database which was only accessible by band 6 or more senior midwives. However, we found a set of records in the room allocated for the inspection team's interviews. Records showed there were concerns with the tracing of records, with the December 2021 divisional newsletter reminding staff of the importance of tracing women's notes.

Maternity

Medicines

The service used processes to prescribe, administer and record medicines but we had some concerns with the storage of medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Paper prescription charts were in use across maternity services. The service had plans to use electronic records and electronic prescribing in line with the trust roll-out plan, but at the time of our inspection there was no agreed timeframe for introducing electronic records.

Staff completed medicines records accurately and kept them up to date, but it was not always clear how medicines were being prescribed. We reviewed five prescription charts. Some signatures were unclear or recorded as initials only, staff roles were not documented, and prescribing dates and times were not always recorded. Registered nurses had recently been employed to support the maternity ward due to the staffing shortages. Nurses not able to use midwives' exemptions would need medicines to be prescribed.

It was not always clear whether medicine was administered under the instruction of a patient group direction (PGD) or a midwife exemption. For example, in the administration of paracetamol.

Women's weights were not recorded on four of the five prescription charts. There was potential for medicine to be administered in too high a dose if women were less than 50kg.

Staff stored and managed most medicines and prescribing documents safely, but we were not assured the temperature of non-fridge stored medicines were monitored. We noted the clean utility on the maternity ward to be very warm. This room stored medicines which did not require refrigeration. A fan was in use but there was no temperature monitoring of the room. There was a possibility that medicines with a maximum temperature storage requirement were being stored at temperatures above their maximum and no action taken as a result because the temperature was not monitored.

Incidents

Safety concerns were not consistently identified or addressed quickly enough. The approach to reviewing and investigating incidents was too slow, but there was some evidence learning from adverse events led to improvements in safety. Managers shared lessons learned with the whole team and wider service, but staff did not always have time to familiarise themselves with learning from incidents.

Staff knew what incidents to report and how to report them, however not all incidents were reported. Managers described the service as not having an incident reporting culture and could not be assured staff were reporting all incidents. The service was understaffed, staff had been redeployed to wards within the Gloucester maternity site to help support the service and staff did not have time to report all incidents or near misses. Most staff said they would raise concerns with their manager but would not always report them as an incident through the electronic system.

The service used a standardised reporting tool accessed online, and staff knew how to access it. A lead midwife for risk checked the reporting and investigation of all incidents across the maternity service. They reviewed policies, key performance targets, investigations and fed back concerns to the lead for risk and governance. As of 27 April 2022, there were 400 recorded investigations within the maternity service, with 317 under investigation and 83 awaiting approval to close. Of these 75% were recorded as out of date, as the investigation has not been completed and closed within 30 days, in line with the trust target. The chief executive had made comment in the March 2022 divisional senior leadership team meeting that there were a high number of maternity investigations open beyond 30 days. Records showed managers and specialist midwives were unable to review and close incidents on time as they were needing to manage

the staffing levels or because band 7 specialist midwives were being redeployed to support the clinical workload. A member of staff was tasked with collating the incidents into themes to support the review and bulk closure of incidents. Following the inspection, the trust confirmed that all incidents had been reviewed by the maternity risk team to assess the level of actual or potential harm.

The service had recently had a never event. A never event is a serious incident which is entirely preventable. The service reported a never event towards the end of 2021. This related to a retained swab after an instrumental birth. Staff we spoke with were not aware of learning from this incident.

We reviewed serious incidents reported by staff. Managers debriefed staff after a serious incident, but not in a timely way and staff did not always feel supported or that learning was shared. Managers reported high harm incidents in line with national guidance. This included reporting to the Healthcare Safety Investigation Branch (HSIB) and MBRRACE-UK. Staff completed perinatal mortality review tool (PMRT) reviews but quick review meetings were not usually held within the expected 72 hours following an incident. PMRT reviews are multi-disciplinary, high quality reviews of circumstances and care leading up to and surrounding stillbirths and neonatal deaths. There were delays to serious incident scoping meetings. Staff and records advised this delay was due to poor staffing levels and staff availability. This meant there was a risk immediate safety actions were not quickly identified and corrected to prevent incidents reoccurring.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Records of three recent incident scoping meeting minutes showed duty of candour was completed. Staff met to discuss the feedback and look at improvements to patient care. Staff involved in incidents were invited to participate in a 'learning forum of communication and reflection' to help the service identify changes which could be made to prevent incorrect advice or support being provided.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff were able to request direct feedback from incidents submitted using the trust incident reporting system, however these were not always timely as incident reviews were over the trust 30-day target. We saw learning after significant event recommendations (LASER) posters displayed in both the hospital and community settings. These posters showed a summary of incidents and relevant learning; however, they were not seen to be discussed at a delivery suite safety huddle meeting. The posters explained the situation of the incident but did not clearly identify the lessons learnt to prevent future repetition of incidents.

There was evidence that changes had been made as a result of incidents. Staff explained and records showed that postpartum haemorrhage rates were improving since learning was identified because of a serious incident. Postpartum haemorrhage was included on the mandatory multi-disciplinary training and there were quality improvement projects to reduce the postpartum haemorrhage rate. However, this was not yet fully established as equipment to manage a postpartum haemorrhage was not always available. Following our inspection, the trust confirmed that an emergency postpartum haemorrhage box was available on the maternity ward and Gloucester birth unit. Previously the maternity service's 3rd and 4th degree tear rate had been in the upper 75% of all organisations. The trust position had improved following the identification of learning.

A Healthcare Safety Investigation Branch (HSIB) serious incident report published in January 2022 highlighted concerns that interpreters were not always used while women were in labour. Staff spoke of this learning being shared across the maternity service. We saw laminated posters on the birth centre and delivery suite to remind staff how to access

interpretation services in labour. Most staff knew how to contact interpreters and were familiar with the findings of serious incidents which recognised the need for interpreter support for non-English speaking women and their families. A recent 72-hour report for an incident also referred to HSIB suggested that interpreter use had improved, with an interpreter also being used for duty of candour conversations.

Is the service effective?

Inspected but not rated

We inspected but did not rate effective in relation to evidence-based care and treatment, patient outcomes, competent staff and multidisciplinary working.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice most of the time.

Staff followed policies to plan and deliver high quality care according to evidence-based practice and national guidance, but not all printed policies staff were accessing were in date.

The service was implementing the Better Births five-year forward plan in line with the Local Maternity and Neonatal System and were seeking to benchmark against maternity services in the local area. The service had implemented the Saving Babies Lives care bundle and appointed a midwife and an obstetrician as fetal monitoring leads.

Staff in the community did not always have computers to be able to access guidelines while providing care to women. Guidelines we reviewed were not always in date. The delivery suite sepsis trolley contained a printed guideline which was due for review six months earlier in October 2021. There was a risk care practices could be outdated. Following the inspection, the trust advised all policies were in date on 30 April 2022 and each policy included a statement to encourage staff to only use online versions.

Records of the maternity and neonatal safety champions meetings showed challenge and performance comparison with other trusts. We saw comment in March 2022 that the recent local maternity and neonatal system (LMNS) board meeting identified the induction rate in Gloucester as being static in comparison with the rest of the country. The records said that an action plan was needed “to bring all actions together” and improve training but it was not clear when this would be completed to ensure care was in line with evidence.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and mostly achieved good outcomes for women. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. This included the National Maternity and Perinatal Audit (NMPA). The service was accredited by the Clinical Negligence Scheme for Trusts (CNST).

Maternity

The service had an audit midwife. The audit midwife role was created one year ago but at the time of our inspection it was not a permanent role. The trust had plans to make this a permanent post. The practice development team previously managed audit.

The Obstetric Anal Sphincter Injury (OASI) audit identified a midwife who was the lead for a number of the births where a third- or fourth-degree tear occurred. Remedial training was provided for the midwife and student midwife who worked together for these births.

A quarterly obstetrician led audit assessed the management of the small for gestational age baby in line with the saving babies lives care bundle. Records reviewed on site showed midwives were plotting these measurements on the growth charts, however these were older records of care completed a year prior to the inspection. There was no process for assessing the monitoring of fetal growth, to identify trends and concerns prior to the service being noted as an outlier by the local maternity and neonatal system (LMNS). Following the inspection, the trust confirmed measurements were routinely plotted on growth charts and the service audited the care of babies at risk of measuring small.

Outcomes for women were mostly positive, consistent and met expectations, such as national standards.

When performance was identified as being outside of accepted levels, improvements were made. Better monitoring was needed for early identification of improvement needs. Staff spoke of the trust quality improvement team being supportive at helping to improve quality of care. Postpartum haemorrhage (PPH) rates were seen to be reducing having been identified as an outlier.

Managers and staff used the results to improve women's outcomes. Postpartum haemorrhage rates of over 1.5 litres had been consistently high but had started reducing to within accepted levels, however more work needed to be done to bring the rates within the target level of less than 2% of births. Following the inspection, the trust had plans to review this target in line with the higher national benchmark.

Managers and staff carried out a programme of repeated audits to check improvement over time. The care group implemented the Avoiding Term Admissions to Neonatal Units (ATAIN) model of monitoring care of newborn babies. We reviewed the maternity audit tracker which showed the ATAIN audit was quarterly in 2021-2022.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the most outcomes over time. Managers implemented an action plan and the rates improved, with the service no longer being an outlier. The service was also an outlier for jaundice related non-elective neonatal readmissions within 28 days of delivery. This was re-audited within Gloucester and a coding error was identified. To improve assessment of jaundice and prevent readmissions to the neonatal unit the service had purchased additional bilirubinometers. These were being prepared by medical equipment at the time of inspection.

Managers shared information from the audits but staff did not have time to read the audit findings.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised medical staff's work performance but did not appraise all maternity staff. There was no formal support or supervision for midwives.

Most staff were experienced, qualified, and had the right skills and knowledge to meet the needs of women. The service organised mandatory training updates to help keep staff up to date with evidence-based care and current practice,

however compliance figures were low as staff were moved from training sessions to provide clinical care. Staff able to work additional hours attended training updates and were paid bank pay rates. This had been the process for over six months as staffing levels were significantly less than planned. Gloucester maternity services were funded for a 21% uplift, allowing for staff training. Managers hoped the birth rate plus report would support a greater uplift in staffing numbers. There was a risk training updates were not being prioritised and the quality of care provided could be affected if staff were not aware of best practice.

Managers gave new staff a full induction tailored to their role before they started work, but not all staff had an induction when temporarily moved to a new clinical area. The service had a comprehensive preceptorship programme, although there was no date or version control on the document shared with us so staff may not be working to the latest version. Staff told us they did not have a full induction or orientation to their temporary workplace when the standalone birth centres were closed, and staff were redeployed. There was a risk staff would be unfamiliar with the systems, processes and management of care in these settings. However, all midwives were expected to complete the cardiotocograph (CTG) update day and the practice development team provided an orientation day for rotational midwives before they rotated to a new work area. This helped to remind staff of the risks and priorities in each clinical area.

There was no training recovery programme in response to the impact of COVID-19 and high staffing absence levels. This meant while there was some oversight on gaps and shortfalls, there were no identified timeframes to ensure all staff received updates to safely care for mothers and babies. Following the inspection, the trust submitted a training recovery plan to achieve 90% compliance by the end of December 2022.

There were not sufficient competency frameworks for midwives. Managers told us the competency framework was being reviewed. We asked to see the current framework and the reason for the framework being reviewed, but this was not provided. We received a draft competency framework for maternity support workers. This meant there was no current oversight of the competencies for midwives to monitor the number of staff able to perform tasks including suturing and intravenous infusions. There was a risk staff would not maintain their clinical skills which would be required when redeployed in times of escalation. However, managers told us staff were redeployed to work in areas most similar to their usual workplace therefore the skills required would be similar. Following our inspection, the trust confirmed there were competency assessments, but not at every band for every extended skill. The draft maternity support framework was submitted in error and the final version was provided after inspection.

Managers did not support all maternity staff to develop through regular, constructive clinical supervision of their work. Records showed 58% of Midwives and only half of MCAs and MSWs had received an annual appraisal, as of 31 March 2022. Managers told us it was difficult to complete appraisals as there were significant staff shortages. This meant midwives, MCAs and MSWs did not have an opportunity to discuss their training needs or ways to develop their skills and knowledge. Following our inspection, the trust submitted a document with their plan to improve the appraisal rate through the use of paid bank hours for the appraiser and appraisee, as well as band 6 midwives completing appraisals for MCAs and MSWs.

Staff reported that there was low morale and did not feel supported or valued. Staff felt demoralised and a number were reducing their hours or leaving the service. This decrease in staff availability added to the staffing challenges and low morale. The professional midwifery advocate (PMA) team had been significantly reduced due to staffing levels, so midwives had less access to support when an incident occurred. The team was due to be developed but there was no formal PMA service to support midwives. Staff advised it was possible to ask for one-to-one support from the four midwives trained in PMA, but only on an informal basis. There were plans to reintroduce the PMA team and A-EQUIP model but there was no agreed start date. A-EQUIP is a midwifery supervision model for ‘advocating for education and quality improvement’.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Appraisal compliance data showed medical staff to be 95% compliant. Medical staff had an annual opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers encouraged staff to attend team meetings, but not all meetings had minutes. Not all staff had access to full meeting notes when they were unable to attend. We requested minutes of all meetings but did not receive minutes from Stroud birth centre or the Aveta birth centre in Cheltenham. This meant there was a gap in communication with staff and key messages may not be shared effectively. However, staff used an encrypted social medial messaging service, installed on their work phones, to privately message one another urgent or important updates. Staff felt this was an effective messaging tool.

Managers identified poor staff performance promptly and supported staff to improve. Audit data identified the need for additional perineal support training for a midwife and the student midwife working alongside.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care, but this was not consistent across the service. The multi-professional team attended safety huddles. We observed the morning safety huddle on delivery suite, which was attended by midwives and medical staff. The huddle discussed capacity and acuity concerns, but we did not see a clear process for any learning to be communicated on a daily or weekly basis. There was no whole team safety briefing on the maternity ward meaning the team were not all aware of important care, learning or safety concerns for women or the service. There was a lack of focus on quality improvement or sharing what went well and lessons learnt. We received more information from the trust following our inspection which stated that there should be a maternity ward safety huddle after the one-to-one midwife handovers. This was not seen during our inspection. Information shared also showed plans to restart the bedside handovers to involve women and their babies, while an additional mid-shift huddle would be introduced to improve safety briefing and support for the maternity ward team.

Staff worked across health care disciplines and with other agencies when required to care for women. Speciality trainee medical staff reported good working relationships with the midwifery teams and excellent support from the consultant obstetricians. We requested an audit of consultant attendance at difficult births, and the maternity service classification of difficult births. We were told there was no audit completed at the current time due to operational pressures. Staff planned to review this data and present it at the August 2022 audit meeting before sharing it at the September 2022 maternity clinical governance meeting. This meant there was currently no management oversight of consultant attendance at difficult births. However, staff did not raise consultant support as a concern during our inspection.

Registered nurses were providing support on the maternity ward due to the severe midwifery shortages. This helped to care for women, but guidance needed to be clearer for all staff to be aware of what care could be provided by nurses. The expectations and management of these staff was unclear.

Bereavement support was available for the whole division, therefore the bereavement midwife supported families when a neonatal death occurred, as well as the loss of a baby during pregnancy or labour. There was a risk that support for the whole women and children's division was not available when the bereavement midwife was on planned or unplanned leave.

Maternity

Records showed multidisciplinary engagement had improved in response to the management of high postpartum haemorrhage levels. There was now obstetric representation on the Hospital Transfusion Committee.

Staff referred women for mental health assessments when they showed signs of mental ill health including depression. Records reviews showed women were assessed for signs of depression at the initial booking appointment and again at 36 weeks. Staff referred women to the mental health team if they responded positively to the recognised mental health assessment tool questions or showed deterioration in their mental health. The mental health midwives were included in the referrals and attended the weekly multi-disciplinary team triage meetings. These meetings included midwives, mental health nurses and psychiatrists. Women supported by the perinatal mental health team had a purple care plan within their maternity notes. There was a clear process for assessing women with mental ill health, but computer systems did not support the whole maternity service to be aware of women's mental health concerns. Staff told us computer alerts only related to safeguarding concerns, therefore staff relied on women disclosing their mental ill health when telephoning the service, for example, triage. This multi-professional communication could be improved to ensure staff were aware of women with anxiety, depression, and other mental health conditions. We were told this would be included in the new IT system; however, the alert restrictions had not been recorded on the risk register or incident reported.

Is the service well-led?

Inadequate

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

Leadership

Leaders had the skills and abilities to run the service, but the leadership team had undergone recent changes. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

At the time of the inspection the maternity service was led by a recently appointed head of midwifery (HoM), a consultant lead obstetrician, and an interim general manager. In line with the Royal College of Midwifes 2019 document 'Strengthening Midwifery Leadership: a manifesto for better maternity care' the service had a director of midwifery (DoM) who had worked within the Gloucester maternity service for over 20 years. The service was hoping to recruit a consultant midwife but had been unable to recruit to this post. Shortly after our inspection, local consultant midwives visited the service. The visit was part of a co-design project to help improve standards of care across services. We were told this visit helped to improve staff morale.

Maternity was part of the women and children's division. The senior leads, also known as the divisional triumvirate, included the director of midwifery, a chief of service who had been in post for a year and a divisional operations director who was appointed in August 2021. The divisional leadership team had experienced significant changes, however records of divisional newsletters showed open communication with staff and reflections on the current priorities for the division.

The maternity leadership structure was being strengthened, but this work was not complete. The service had plans to remove gynaecology from the head of midwifery (HoM) role to allow the HoM to focus on the maternity service.

However, a leadership strategy and succession planning had not been sufficiently considered by the leadership team. The leadership structures were not stable. Managers told us there were plans for additional leadership roles to make roles more effective and strengthen the maternity leadership. Following the inspection, the trust told us leaders had been offered individual coaching and shared a copy of the women and children's organisational development plan.

Not all staff followed the management structure when reporting or escalating concerns. Leaders explained some staff would choose to contact a more senior leader than their line manager to effect change or share concerns. Leaders wanted to be seen as being approachable but knew there was work needed to ensure concerns were able to be addressed at the correct levels within the governance and leadership structure, for all roles to be effective.

Leaders were aware of the challenges facing the service and made operational decisions to improve safety. The day before our inspection the service had made the decision to close the midwife led stand-alone birth centres in Stroud and Cheltenham. The Cheltenham birth centre had been closed for nine weeks from December 2021 and this was its third closure. Leaders felt supported by trust board and were not challenged in this decision, when the workforce was 25% reduced. Staff we spoke with commented that communication had improved from the closure in December, but staff being redeployed could have received more supportive communication. Leaders had implemented immediate measures to address midwifery staffing and had plans for medium- and longer-term plans to address the staffing and service issues further.

Most managers were visible through the service; most staff knew who they were and how to contact them. Leaders completed walkarounds of all sites and encouraged staff to share their views.

Some staff raised concerns about lack of communication from the maternity leadership team. Staff told us they felt leaders did not fully understand the impact of the operational issues on staff wellbeing. Lack of communication and the clinical workload meant some staff were reluctant to raise issues or concerns and report incidents. This separation between leaders and clinical staff increased the likelihood of a lack of manager oversight, placing women and babies at risk of significant harm. When we fed this back to the head of midwifery and director of midwifery, they understood there was a communication disconnect between the leaders and the workforce. Managers were making efforts to engage with the workforce through communication including listening events and clinical visits but commented that this was needing strengthening through a communication strategy. However, the band 8 of the day rota was introduced to provide leadership oversight and help reduce the separation between clinical leaders and clinical staff.

The medical director had been appointed as board level maternity safety champion, chairing the maternity safety group meetings. The maternity safety champion had a high level of understanding of maternity issues and national drivers.

Vision and Strategy

The service did not have a clear vision for what it wanted to achieve or a strategy to turn it into action. Clinical staff were unaware of the strategic direction for maternity services, although leaders told us it was in development.

Leaders told us the trust maternity strategy was in development. The service had been using the local maternity and neonatal system (LMNS) strategy and were working to the trust's strategic objectives. The head of midwifery, with support from the deputy director of quality and programme director for nursing and midwifery excellence were responsible for developing the maternity strategy but was new to post and the clinical staffing had reduced their ability

to prioritise this work. An initial meeting was held and in an interview after our inspection the head of midwifery was able to describe the initial plans. Maternity staff working clinically were not involved in the strategy development. Subsequent to our inspection the trust provided some more details on how they were developing their vision and strategy, with a presentation of the 2023-2028 five-year plan.

Managers spoke of plans to improve flow through the unit by creating an induction of labour suite on the delivery suite. This would allow some antenatal rooms on the maternity ward to support the transitional care service. It would also place the women who were likely to labour on the delivery suite nearer to obstetric support, should it be needed during the induction process.

Culture

Leaders were aware of the need to significantly improve the culture in the maternity service, but more support was needed to create and sustain change. Not all staff felt respected, supported and valued. There were high levels of staff sickness and vacancies and staff described a poor reporting culture.

Staff were unsettled following recent closures of the two stand-alone midwife led birth centres in Stroud and Cheltenham. It was the third time the Aveta birth centre in Cheltenham had closed and the first time for Stroud. At the start of our inspection we asked the maternity leads to share details on how staff could contact us to share their thoughts if we were unable to speak with them during the inspection. Thirteen members of the midwifery workforce contacted us after the inspection, each sharing their concerns about the culture and safety of the maternity service. Staff told us the staffing levels felt unsafe and did not support their wellbeing. There were high levels of stress and work overload. Financial incentives for completing bank shifts appealed to staff but additional hours added to some staff feeling overworked. Staff in the hospital were not able to take their breaks and most staff working clinically told us they felt exhausted and demoralised. We spoke with staff who chose to work in the community as they felt more supported. Staff told us there was a lack of response from management to concerns raised. Some staff were unclear on the reasons for the standalone birth centres closures but the continuity of carer teams continuing. Leaders told us the continuity of carer teams had been set up in areas to look after the most vulnerable families and counted for 10% of the women cared for by the maternity service. Continuity of carer midwives worked on delivery suite when women on their caseload were in labour or having a planned caesarean.

Listening events were held by leaders and advertised a month in advance through the divisional newsletter. This notice period was not always long enough for community midwives to attend the calls as their clinics may already be booked, and staff reported not having enough time to read these newsletters. Five days before our inspection, an extra call discussing the poor staffing levels had been held by the director of midwifery and was attended by approximately 80 staff. The service had over 300 staff members.

Staff described a poor incident reporting culture. There was a risk safety concerns were not consistently identified or addressed quickly enough. However, leaders were aware the culture was a concern and had made some attempts to improve the culture. The multi-professional PROMPT virtual skills training included a session on “improving work culture”. This included situational/self-awareness, language, communication, undermining and bullying. Staff wellbeing support was available through the trust trauma risk management (TRIM) practitioners, but it was not clear if staff knew to access this support or the trust freedom to speak up guardians. The Gloucestershire local maternity and neonatal system (LMNS) quality and safety surveillance oversight document outlined the recommendations from the Ockenden Review which focused on culture. This included an action to develop and oversee the implementation of a culture improvement plan. Following the inspection, the trust told us maternity staff had contacted the freedom to speak up guardians on a number of occasions, on a range of issues.

Maternity

Governance

The arrangements for governance and performance management did not always operate effectively. The service had not invested enough staff to support quality and governance in maternity services but had plans to review their management structure.

Some governance structures were not fully established. Band 7 committee meetings had been introduced with three meetings prior to our inspection. Minutes were not taken but leaders told us there would be minutes in the future. Maternity clinical governance meetings were held monthly and attended by key staff including community, although attendance was sometimes poor with more apologies than the number of staff present. However, monthly maternity staffing reports by the head of midwifery (HoM) were shared with the maternity delivery group. A monthly divisional board meeting was well attended by divisional leads and used to inform the trust board meetings.

Leaders described having good access to the divisional and trust board, with decisions made promptly to amend service provision for the safety of the service. This was evident with the April 2022 closure of the two stand-alone birth centres. The board were aware of the maternity staffing levels as the maternity staffing report was presented in March 2022. Records reviewed after inspection showed maternity was discussed again at the May 2022 board meeting, with review of service gaps in response to the Ockenden report. The final Ockenden report and recommendations were published on 30 March 2022.

Leaders told us they had plans to recruit a consultant midwife and a further midwifery matron. This was to release work from some leaders to help increase staff capacity to complete their role effectively and be more able to support service improvement and performance management. The divisional risk and governance lead role was large and could provide greater support and oversight, if the role was specific to maternity services. The safeguarding lead role had been added to a matron role with no protected time for safeguarding. This presented a risk that safeguarding would not be prioritised within the service or that there would not be enough oversight of safeguarding. There was no separate guideline midwife role, instead the progress of guideline development and reviews was overseen by the audit midwife, who was on maternity leave at the time of inspection. An experienced bank midwife was covering the role, but the role was still large. The maternity service had an audit programme but there were gaps in audit, with no MEOWS audits at the time of inspection. We saw from data requested following the inspection that an audit of maternal and neonatal early warning scores was due to be completed every six months. The previous audit had been completed in 2019. Following the inspection, the trust told us they had secured protected time funding for the named midwife for safeguarding role, enabling this to be removed from the matron's role.

Maternity guidelines were reviewed and ratified as part of the clinical governance monthly meetings. We reviewed minutes of these meetings. Many agenda items had "For information" noted with no further explanation of the discussions or learning identified and actions to be taken to improve safety and quality. There was a risk staff who sent apologies to these clinical governance meetings would not be fully aware of the risks or management of the risks present in the service. This had the further risk of meaning these leaders would not be able to share the progress with their workforce. A disconnect between leaders and the clinical workforce was acknowledged in the December 2021 divisional newsletter. It was recognised that at times of low staffing those providing the care may not be aware of the steps being taken by leadership to improve the service. This disconnect was clear to see during our inspection.

We reviewed records of meeting minutes to assess the communication from leaders to the workforce. We did not receive minutes for meetings in the community or at the birth centres in Stroud or Cheltenham. It was unclear if minutes were taken at these meetings, therefore there was a risk those not attending these meeting would not be fully aware of messages from the leadership team. Minutes of the band 7 and 8 senior management team meetings provided very little

detail and attendance at these meetings was not recorded. Communication methods were not seen to be effective, however staff told us important messages were shared via an encrypted messaging application on their work mobile phone. Following the inspection, the trust told us key leadership messages, including dates of listening events, were sent in emails to all midwives so staff do not need to rely on meeting minutes for information.

A 'Journey to Outstanding' action plan had been written and presented to the quality and performance committee. The action plan contained actions to improve the maternity service. These actions had been divided into seven areas of the maternity service; antenatal care; intrapartum/high risk care; midwifery led units and community midwifery care; postnatal care; environment; staffing; and governance. The action plan was presented in March 2022 by the chief nurse and director of quality to the quality and performance committee. The service acknowledged that projects would not be completed by September 2022 because of staffing issues. There were plans for these projects to have clear action plans to help ensure they would be achieved, but it was not clear who would monitor progress of these actions. Following the inspection, the trust told us the action plan was monitored by the divisional triumvirate each week and at the maternity delivery group meetings.

Staffing pressures and a lack of resource in the leadership team to focus on governance impacted on the timeliness and effectiveness of incident investigations. The service had a large number of incident investigations not completed within 30 days. Leaders explained this was due to staffing pressures. The overall risk lead was a divisional lead, which included maternity, neonatal, paediatrics and gynaecology services. The scope of this role was too large to be effective to manage the risks of the maternity service. Staff also explained how staffing levels prevented 72-hour rapid review meetings occurring on time to scope the incidents and identify any immediate learning. Records showed some incidents were reviewed at clinical governance meetings but there was little detail to describe the incident or provide awareness of the current safety risks within the service. The service reported clinical incidents to the Healthcare Safety Investigation Branch (HSIB) providing they met HSIB criteria. The report and actions plans were presented to the monthly safety and experience review group (SERG). We reviewed a HSIB report that made 10 safety recommendations to improve care and prevent the incident from occurring again. However, we had concerns that the associated 72-hour rapid review report had identified no immediate safety actions.

The service had a programme of clinical audits to monitor quality, and processes to identify where action should be taken. However, staff told us the outcome of audits were not always shared with them, or they did not have time to read the information. Following the inspection, the trust told and showed us that audit outcomes were communicated to all staff through a quarterly audit newsletter.

Leaders told us operational pressures prevented audits being completed and shared with external bodies. For example, the March 2022 maternity staffing report to trust board showed the service would monitor consultant attendance for clinical situations requiring a consultant to attend in person. This report covered the period July to December 2021, with the data obtained due to be presented to the LMNS, maternity delivery group and to the maternity safety champions to meet the NHS Resolution (NHSR) Maternity Incentive Scheme Safety Action 4 (2021).

We reviewed the last three safety experience report group (SERG) meetings for March, April and May 2022. Incidents were discussed and some actions noted but learning from incidents was not clearly recorded. Action plans were presented at these SERG meetings, but it was not clear from the minutes how many of the actions had been completed to improve care and prevent incidents from being repeated.

The practice development team was reduced in size due to vacancy. Leaders told us there was no recruitment in response to this vacancy as the team may be restructured. We requested the plans and timescales for the team redesign but instead we were sent an initial plan for the development of midwifery education, which would be managed by the team.

Management of risk, issues and performance

Leaders and teams used systems to monitor performance but did not always benchmark performance against other services. They identified and escalated relevant risks and issues and identified some actions to reduce their impact, but risks were not managed in a timely way. They had plans to cope with most unexpected events.

The maternity assurance dashboard included performance data on Apgar scores (a scoring system used to assess newborns at one and five minutes after birth), number of stillbirths, neonatal deaths, postpartum haemorrhage over 1.5 litres, postpartum hysterectomies, third- and fourth-degree tears and overall preterm birth rate as a percentage of all births. The trust had previously had a higher third- and fourth-degree tear rate, but the rates were consistently within the target level. An ongoing prospective audit had been introduced, with monthly figures on the maternity dashboard and analysis of rates with identification of individual staff training needs.

However, the maternity assurance dashboard showed the workforce data was incomplete and there was minimal benchmarking of data against other maternity services to help identify potential learning. Leaders told us there were plans to benchmark the service. A Birthrate Plus staffing review was being undertaken with the report due in Spring 2022. Leaders advised an action plan would be created and presented to the divisional board with any issues or concerns escalated. There were plans to present this completed report and action plan to the trust board to meet the NHSR Maternity Incentive Scheme Safety Action 5. Following the inspection, the trust told us they benchmarked against other providers through national audits and identified any outlier status from the national maternity dashboard. The head of midwifery, director of midwifery, clinical lead and divisional risk and governance lead described the top risks in the service as staffing, staffing of the second obstetric theatre team, and triage. This was similar but not fully in line with the risks presented by the maternity workforce and the risk register. After the inspection we requested the maternity risk register and action plan. This was not provided. Instead the trust shared a presentation on the March 2022 maternity risk register. This showed the top three risk themes as staffing, antenatal care and resuscitation and the highest-level risks as midwifery staffing and triage. These were recorded as extreme risks. Theatre was noted as high risk along with eight other risks, and obstetric theatre staffing was moderate risk. A full copy of the maternity risk register was provided after our inspection.

The service had plans for the management of services during a heatwave but did not have plans for other adverse weather conditions including snow or storms. It was not clear how the service would provide all the services including community visits and clinics in these adverse weather conditions. Following the inspection, the trust told us there was a trust-wide adverse weather business continuity management plan.

Information Management

The service collected data, but it was not always analysed to make decisions and improvements. The information systems were not integrated and there had been data breaches. Data or notifications were submitted to external organisations as required.

The service submitted data to external bodies as required. These included the National Neonatal Audit Programme and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). This meant

the service was able to benchmark performance against national outcomes. However, the maternity assurance dashboard contained minimal benchmarking against other trusts. The service was able to benchmark itself against LMNS targets including carbon monoxide monitoring at booking and the Department of Health ambition to reduce the national rate of pre-term births from 8% to 6% by 2025.

Data systems in the maternity service were old and records used a number of different systems. Staff told us this had been added to the maternity risk register. Staff knew of plans to upgrade the maternity records system to one system called 'Badgernet', although this had been purchased but was still in development and was not expected to be in use for a year. We saw records stating better technology for sound was needed before virtual huddles could continue, with the aim of including midwives from the stand-alone birth centres at Cheltenham and Stroud. Staff hoped this new system would allow easy sharing of referrals and clearly show patient risks including safeguarding alerts. The current process used a number of digital systems and was at risk of human error, with additional work arounds required to try and ensure information was successfully shared. However, the service employed a digital lead midwife and there was a trust strategy to improve the digital systems, with digital working a key feature of the maternity strategy which was in development.

The service had eight reported data breaches in the year from April 2021 to April 2022 with wrong patient details in women's notes. It was not clear if learning had been identified to prevent these breaches from being repeated, although there were no reported breaches in March or April 2022. This information was collected on the incident reporting system, however staff told us incidents were underreported partly due to time pressures with staffing shortages.

Leaders did not have clear oversight of the community midwifery workload or on calls. We heard of times when staff were absent, and another staff member had to drive to a clinic to assess the workload as there was no record of the appointments held centrally. Records confirmed the trust was purchasing an additional software feature for their electronic rostering tool to enable on calls to be auditable on the roster. There was a risk community workload was not always known in times of escalation, or when the service was assessing staffing requirements.

Engagement

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services but did not always create clear action plans to drive improvement. They collaborated with partner organisations to help improve services for patients.

At the time of our inspection the Gloucestershire Local Maternity & Neonatal System (LMNS) was responsible for oversight and scrutiny of safety, quality and delivery of the maternity transformation deliverables and long-term plan ambitions for maternity and neonatal services. The Gloucester maternity service was the only acute trust in this LMNS and were aware of the need to contact other trusts to benchmark their progress and share learning from incidents. Some of this benchmarking engagement work had started. For example, leaders spoke of working with local maternity services to recruit overseas midwifery staff to help improve their workforce levels.

The maternity service engaged with the Maternity Voices Partnership (MVP) to help plan and manage services. We saw posters in the community areas advertising Gloucester maternity services hypnobirthing classes, which were supported by the partnership. Records of January, February and March 2022 Maternity Voices Partnership monthly meetings showed maternity and gynaecology care was discussed, although specialist staff, including bereavement, did not always attend to present their update and there were no clear review of previous actions to ensure actions had been completed and work was progressing. Attendees names were listed but their roles were not identified. We were unable to assess how many staff from Gloucester maternity services attended these meetings.

Maternity

Communication and engagement with staff needed to improve. Leaders recognised there was a communication disconnect between leaders and the staff working clinically. Listening events had been held with some staff attending, but there was not always clear feedback on how services would be improved. The head of midwifery was working towards a communication strategy with the trust communications team, to improve communication methods. However, most leaders felt staff knew how to contact them for support, and staff across the service were aware of who the head of midwifery and director of midwifery were.

The service collected data from patient surveys, staff feedback and Friends and Family Tests (FFT) to help improve the service provision. We asked for evidence of feedback from staff listening events and staff engagement. We saw a letter shared in October 2021 with staff to explain the immediate actions being taken by management to support the service. We also received presentation slides from March and April 2022 which used a 'you said, we did' approach to answer staff concerns and share feedback.

Friends and Family Test results were monitored as a division. The trust had an action plan to improve care following feedback from Friends and Family Tests, however staff we interviewed were not clear on this process. Following the inspection, the trust told us feedback formed part of the divisional quality report and was reviewed at divisional board on a monthly basis, however we noted the quality and performance report was not available to be reviewed at the time of the December 2021 meeting. An action was taken to share the report after the meeting, but it is not known if this action was completed. Records showed there was trust oversight of the worsening maternity survey scores, with a comment that it was largely due to operational pressures. The divisions were expected to review their local Friends and Family Tests results and share improvement plans with the patient experience team and at monthly maternity quality delivery group (QDG) meetings. The trust had plans to combine the Patient Advice and Liaison Service (PALS) and Friends and Family Tests data and thematic analysis to help support the local improvement plans, however this work was ongoing.

Learning, continuous improvement and innovation

Most staff were keen to learn and improve services, but staffing shortages reduced staff ability to complete training or develop service innovations and participation in research.

The service had secured NHS England funding for a psychology led evaluation on staff emotional wellbeing. This psychologist review of wellbeing would help to plan the professional midwifery advocacy service to provide support to midwifery staff. It was expected that initial findings from the psychology evaluation would be shared in July 2022.

The bereavement midwife who provided support to women and their families within the division was recently awarded the Cavell Star Award for excellence. The Cavell Star Awards are a national awards programme.

Areas for improvement

Action the trust MUST take to improve

Maternity services must ensure:

- appraisals are completed for all staff within maternity services. (Regulation 18(1)).
- embed an effective system to ensure the service meets the trust targets for maternity specific mandatory training. (Regulation 12(2)(c)).

- there is a system to provide assurance the birth pools are cleaned in line with protocol after every use and were safe for women to use. (Regulation 12(2)(e)(h).
- all staff working in clinical areas including the maternity ward are included in a local safety huddle to ensure awareness of risks, pressures and safety concerns. (Regulation 12(2)(a)).

Action the trust SHOULD take to improve

Maternity services should:

- store all records securely and make sure they are tracked when moving between locations.
- review the capacity of leadership roles including safeguarding lead, bereavement, risk and practice development to make sure leaders are effective.
- monitor the use of interpretation services in the antenatal, intrapartum and postnatal care to ensure involvement of women and to enable fully informed consent and for procedures, referrals and decisions.
- review and monitor staff adherence to the process for prescribing and administering paracetamol.
- monitor the storage temperature of non-refrigerated medicines
- consider a separate dedicated medical staff rota for antenatal ward rounds and/or maternity triage.
- develop a maternity service vision and strategy and communicate this to the maternity workforce.
- continue to assess and monitor the culture to improve the wellbeing and retention of midwifery staff within the maternity service.

Our inspection team

The team that inspected the maternity service comprised a CQC lead inspector, a CQC inspector and two specialist advisors. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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