Gateshead Health NHS Foundation Trust

Queen Elizabeth Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Queen Elizabeth Hospital

Good

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

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

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

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

We last carried out a comprehensive inspection of the maternity and gynaecology service in 2016. The service was judged to be Good overall. We previously inspected maternity jointly with the gynaecology service, so we cannot compare our new ratings directly with previous ratings.

How we carried out the 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.

Maternity

Good

We rated it as Good because:

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

Is the service safe?

Good

Mandatory training

The service had mostly completed all mandatory training. The maternity services specific training was on target for all staff.

Staff were mostly up to date with their mandatory training. Leaders told us they were aware not all mandatory training figures met the trust target. Training included fire safety, equality and diversity and information governance. Data received from the trust during the inspection showed the maternity unit met the trust target of 85%. The midwifery team's overall compliance was 85.05% and additional clinical services were 88%. Medical staff were not compliant with the trust target with 76% of staff compliant. However, following the inspection the trust provided further data which showed training compliance had improved.

The service had a training needs analysis protocol for mandatory training and skills and drills training. Staff were alerted to when their training was due via email and the service had created gaps within staffing rotas to increase opportunities for staff to complete mandatory training.

The mandatory training, we saw was comprehensive and met the needs of women and staff. The training delivered by the service included trust wide mandatory training, maternity specific training and simulated maternity emergency training. Mandatory training was delivered via e-learning and recently returned to face-to-face training.

The service had a newly appointed practice development midwife and there had been a recent return to face to face emergency simulation training within clinical skills and PROMPT (practical obstetric multi-professional) training.

Maternity

All obstetricians and midwives who cared for women in labour were required to complete annual training and competency assessments on cardiotocograph (CTG) interpretation and auscultation. Training was a mixture of online and face to face sessions. Data showed 100% of obstetric consultants, 90% of obstetric trainees and 96% of midwifery staff had completed the CTG training which met the compliance of above 90% for all staff groups as required by the Maternity Incentive Scheme year 4.

Multidisciplinary emergency training took place between 1 December 2021 to November 2022 overall compliance was obstetric consultant 100%, obstetric trainees 95%, midwifery 100%, maternity support worker 93%, anaesthetic consultant 100% and anaesthetic trainee 92%.

All staff were compliant in neonatal life support with 90% midwives and 100% paediatric consultants completing the training.

Training included but was not limited to, fetal monitoring in labour, SBAR (situation background assessment and recommendation) handovers and human factors training. The service provided external training for midwives and medical teams, such as, perineal repair, maternity emergencies in the community, waterbirth and consent in maternity care.

Perinatal mental health training was included in the core competencies framework and staff completed training on birth trauma and Trauma Risk Management (TRiM) training.

TRiM training was an evidence-based approach using a trauma risk management (TRIM) methodology. This helped to identify risks for people who may suffer poor mental health following a traumatic experience.

The training needs analysis (TNA) was developed in line with the Maternity Incentive Scheme and the trust followed the outlining reporting timescales.

Safeguarding

Staff understood how to protect woman and birthing people from abuse and the service worked well with other agencies to do so. Not all staff had received training on how to recognise and report abuse.

Staff were not all up to date with safeguarding training. At the time of the inspection training records showed that not all staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

Medical staff had 80% compliance in Level 3 safeguarding children's training and 70% compliance in Level 3 safeguarding adults. Midwives within all areas of the maternity unit were under 60% compliant in Level 3 safeguarding children and specialist midwives were 70% compliant.

Training figures were calculated yearly from April 2022 to March 2023 therefore, the training figures for midwives were not fully complete. In adult safeguarding Level 3, 81% of antenatal and postnatal ward midwives, 70% of midwives in the delivery suite and 67% of midwives in the pregnancy assessment unit had completed the training. We were told that they service aimed to have a compliance of 85% for maternity staff by March 2023. Following the inspection, the trust provided further data which showed that most maternity staff were compliant in their safeguarding training. However, the midwifery team in the pregnancy assessment unit continued to be below trust target.

Maternity

Safeguarding training was in the process of being changed to inhouse training for both face to face and online. Training was provided by the local authority. However, the trust had recognised that the sessions were both limited and frequently cancelled.

Staff were provided with safeguarding training specific for their role and staff we spoke to knew how to recognise and report abuse. The service had safeguarding training guidance which set out the safeguarding level 3 children and level 3 adult safeguarding training.

Training comprised of e-learning assessed training, trust specific multi-disciplinary safeguarding training. Training included topics such as the impact of adverse childhood experiences, babies cry and you can cope, knife crime and domestic violence and female genital mutilation (FGM).

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

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

The service had a specialist midwife for safeguarding and were in the process of recruiting maternity safeguarding champions to support staff in the unit. Staff were able to access safeguarding alerts through the electronic system and the safeguarding team were currently working with local GPs to roll out full access of patient health records to highlight potential safeguarding implications and strengthen safety for vulnerable expectant women and birthing people.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. During our inspection we saw cleaners, cleaning all areas throughout the day. The flooring in the clinical areas and associated corridors allowed for effective cleaning.

Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff used the right level of PPE, which was stored on wall mounted displays. Staff were bare below the elbow and hand sanitiser gels were available throughout the service. Laminated hand washing posters demonstrating best practice in techniques were on display above sinks. However, training data for infection prevention and control training was not recorded for midwifery staff and only 77% compliance recorded for medical staff.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Leaders completed regular infection prevention and control audits and hand hygiene audits. On the day of inspection, we saw weekly cleaning records were up to date and areas were clean. Data collected from November 2022 to February 2023 showed the maternity unit scored 97% for cleaning audits.

The service monitored staff compliance with hand hygiene in weekly audits. We reviewed weekly hand hygiene audits from January 2023 to February 2023 and found staff were 100% compliant.

Staff cleaned equipment after contact with woman and birthing people and labelled equipment to show when it was last cleaned. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Environment and equipment

The maternity unit was on the maternity risk register due to being a stand-alone consultant led unit. The service put mitigations in place to make sure the design and maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of women and families. Maternity estates were top on the services risk register and leaders recognised the potential risks to women and birthing people due to being a stand-alone consultant led maternity unit with no direct links to the main hospital. The maternity unit did not have a high dependency unit (HDU) or critical care teams in house, but staff were able to liaise with both the HDU and the critical care team within the main hospital for advice and support.

Leaders told us there were plans in place to mitigate the risk of being in a separate building and there had been no recorded incidents related to the estate. The service planned elective caesarean sections in advance, with any high-risk women being booked into the main theatre at the main hospital site. The high dependency unit (HDU) was next to main theatres.

If there was an acute emergency, women would be stabilised in the maternity theatre. Either the critical care team would be called to the unit to support, and emergency 999 call would be put out to transfer women or birthing people to the main hospital.

The maternity unit was fully secure with a monitored entry and exit system. Visitors were asked to identify themselves before they were allowed entry.

Woman and birthing people could reach call bells and staff responded quickly when called.

Staff carried out daily safety checks of specialist equipment. Records showed that adult resuscitation equipment and baby resuscitaires throughout the maternity department were checked daily.

Maternity

The patient assessment unit (PAU) was open 24 hours a day. The PAU provided care for women from 16 weeks of pregnancy up to 4 weeks postnatally for pregnancy related issues, support and monitoring of high-risk pregnancies. The unit also provided support to women and birthing people experiencing complications postnatally.

The PAU was spacious and contained four rooms, scan room and a large triage area. There was a storage, equipment room and sluice area. The unit had Cardiotocography machines (CTG's) in every room. Cardiotocography is the monitoring of the fetal heart and assessing the fetal wellbeing during pregnancy.

All equipment was visible clean, and we saw 'I am clean' stickers with the date the equipment was cleaned.

Antenatal and postnatal care were based on one ward. There was one bay for antenatal women which consisted of three beds. There were 16 beds for postnatal women with two adjoining bathrooms. There were 4 single rooms with en-suite facilities, each with a chair for partners to stay over. The ward had a family room where women, birthing people and their families could relax, and older children could play. All bays and rooms were well equipped and clean.

All equipment and store cupboards were clean, tidy and uncluttered. A fridge specifically for infant milk storage was kept in a locked room which stored medicines and dressings. The name, hospital number, date and time expressed were written clearly on all labels. The milk-fridge was checked daily to ensure it was always locked, maintained at the correct temperature for safe storage.

The service had suitable facilities to meet the needs of woman and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. Labour ward had enough suitable equipment to safely care for women and babies. The labour ward included a spacious, open reception area.

The service had enough suitable equipment to help them to safely care for woman and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. There were 6 delivery suites all with en-suite facilities. There was one newly renovated pool room for labour and birth which was spacious and well designed with a ceiling hoist and plenty of space around the pool area. Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water.

The large room opposite the midwifery station was used for women who needed closer monitoring before being transferred to the high dependency unit in the main hospital.as a high dependency room for women who needed closer monitoring.

The ward had designated individual rooms for women and birthing people who were due to have their labour induced.

The designated bereavement room was currently under renovation during our inspection although it was just awaiting new furniture. The room was spacious and had its own secure entry and exit point. The service currently used two larger side rooms opposite from the bereavement room for bereaved women whilst the renovations were ongoing.

The labour ward had two adjoining maternity theatres which were fully theatre compliant. There was a separate recovery area with two beds. The units second theatre was newly developed and had been designed specific for the unit's requirements with plenty of space and a designated anaesthetic area.

Staff disposed of clinical waste safely. Waste was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance.

Maternity

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon woman and birthing people at risk of deterioration.

Staff used a nationally recognised tool to identify woman and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman. We reviewed MEOWS records and found staff had completed them fully and had escalated concerns to senior staff. However, the service did not complete regular auditing of warning scores.

Carbon monoxide (CO) screening was performed in 5 out of 6 set of notes reviewed in line with best practice guidance. The trusts maternity dashboard showed the service met all but one of the national smoking targets. Data showed 78.28% of women were offered CO testing at 36 weeks, this did not meet the national target of 80%. However, data showed the service had consistently reduced the levels of women and birthing people smoking at booking.

Staff used a standardised evidence-based tool to identify women and birthing people at risk of deterioration using a red, amber and green RAG rated system on the electronic notes system. Patients could attend the pregnancy assessment unit through a pre booked appointment or self-referral following a telephone triage with an experienced midwife.

Midwives documented the time women and birthing people arrived at the unit and the time they were seen. All women attending with reduced fetal movements were seen by a clinician within 15 minutes of their arrival onto the unit.

Women and birthing people arriving in term labour or suspected labour were prioritised and seen immediately and escalated to the medical team. Staff told us that the service was currently working towards using a more standardised process for triage and that an audit to review waiting times was being reviewed. We were not shown evidence of PAU auditing during our inspection or in the data received.

Staff completed risk assessments for each woman on arrival to triage, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for women and birthing people. Staff used the 'Saving Babies' Lives Version Two (2019), a nationally recognised care bundle to assess women during pregnancy. Saving babies lives is an evidence-based bundle of care designed to reduce the numbers of stillbirth and early neonatal deaths bringing together areas identified as best practice, these included reducing smoking in pregnancy, raising awareness of reduced fetal movement and effective fetal monitoring during labour.

The maternity dashboard showed the service did not meet national targets for reducing women and birthing people smoking in pregnancy. The trust was below the national target of 80% for CO testing at antenatal booking and under 36 weeks of pregnancy.

Leaders and staff told us that women received 1 to 1 care in labour and the labour ward co-ordinator was mostly supernumerary. The trust provided data from July 2022 to September 2022 to show the percentage of times the labour ward co-ordinator was supernumerary. Information showed that during August 2022 the labour ward co-ordinator was supernumerary 89% of the time and this improved to 92% in September.

Staffing was monitored four hourly and a red flag was placed on the live staffing system when the labour ward co-ordinator was not supernumerary. Ward managers and the acute matron monitored this weekly.

Maternity

Staff knew about and dealt with any specific risk issues. Staff we spoke to knew how to identify women at risk of sepsis and manage specific risk issues. The service used the maternal sepsis screening tool and maternal Sepsis-Six pathway.

There was a central monitoring system for cardiotocograph (CTG) monitoring on the delivery suite. We saw trust data to show that monthly audits of cardiotocography (CTG's) were completed.

From August 2022 to January 2023 the service had completed reviews on 444 CTG's. The data showed that 71 of those CTG's were not taken within 15 minutes of arrival, 10 CTG's had missed a fresh eyes review. However, 100% of CTG's were escalated if required.

There was not a specific transitional care bay for babies who needed additional care. The service told us they provided transitional care to any baby who required it as part of the maternity service's model of care in line with the 'Avoiding Term Admissions into Neonatal units Programme' (ATAIN). The service had a staffing model for transitional care and all babies needing additional care received a specialist review following delivery of baby and then reviewed daily by the consultant.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. The trust did not provide data to show that a newborn early warning trigger audit was completed.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support woman and birthing people with mental health concerns.

The service had clear processes for staff to follow which included the contact details of the onsite and out of hours psychiatric liaison teams. The service had a specialist perinatal mental health link nurse who attended a weekly antenatal clinic.

Staff shared key information to keep woman and birthing people safe when handing over their care to others. The patient care record was on a secure electronic patient record system used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and handovers included all necessary key information to keep woman and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep woman and birthing people and their babies safe was shared. Staff had 2 safety huddles a day to ensure all staff were up to date with key information.

Each member of staff had an up-to- date handover sheet with key information about the patients. The handover shared information using a format which described the situation, background, assessment, recommendation for each patient. Medical handovers took place at 5pm at the change of consultant obstetric and anaesthetic team and again at 8pm at the change of medical team.

There was a twice daily ward round on the delivery suite as per national guidance. There was comprehensive consultant presence on-site, consultants provided 12-hours on site, seven days per week, and night-time on-call cover. Medical teams placed on call were automatically given the next morning or day off to make sure medical staff were not too tired.

The clinical lead and labour ward lead attended a weekly risk meeting, where serious incidents and incident reporting forms were reviewed. Information from the meeting was communicated to maternity staff through the weekly safety message.

Maternity

Maternity leads also attended a monthly safe care meeting and monthly perinatal meeting. These meetings were multidisciplinary attended.

The service followed the 'Five Steps to Safer Surgery' World Health Organisation (WHO) checklist which included a sign in, time out and sign out checks. Patients had a copy of the 'Five Steps to Safer Surgery' WHO checklist in their notes. Data received showed that from August 2021 to January 2022 there was 100% compliance in completing the WHO checklist within maternity.

During our inspection we spoke with 5 women, and all were very happy with their care and the experience they had received. We also received 49 feedback forms from women who had used maternity services following our inspection. Six out of 49 forms were positive, 23 provided mixed feedback, and 20 were negative. There were common themes within the negative feedback. Themes included women not always feeling listened to by staff and partners not being able to stay overnight on the postnatal ward.

Midwifery Staffing

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

Data for the service showed over 50% of booked admissions requiring elective admissions and operative procedures were high risk women and birthing people. The service used Birth Rate Plus for recommended staffing levels. The trust agreed a business case to complete a recruitment process, and this had been in place since April 2022. Since this time 10.84 whole time equivalent clinical midwives had been recruited, which meant maternity was at full establishment.

There was an increase in specialist midwifery posts and a recruitment and retention specialist midwife had recently started in post. The service also had in place a fetal monitoring specialist, risk management and public health specialist midwife.

Staff told us that there was a decrease in health care assistants (HCA) and the service had secured funding to increase recruitment into the role and to develop band 2 HCA to a band 3. Retaining healthcare assistants to the unit had been recently added to the risk register.

Staffing levels matched the planned numbers during our inspection. Staff told us the labour ward coordinator was supernumerary, on the rare occasion there were staff shortages the labour ward co-ordinator would support the midwives on shift but would not care for a woman or birthing person in established labour.

There, were 3 listening events for staff between October and November 2022 to talk about and gain feedback on the staffing requirements for current midwifery models of care.

The service planned midwifery staffing on a 22% uplift in staffing establishment to allow for absences including sickness, annual leave, training, and maternity leave.

Sickness rates were monitored, and staffing levels were monitored by managers daily. Additional staffing concerns were fed up to board level to ensure oversight and support from leaders.

Staff sickness and annual leave was covered by staff or bank staff. The service did not use agency. Bank staff had a full induction and knew the service.

There was a preceptorship programme for newly qualified midwives, this included a 12-week supernumerary preceptorship programme with a rotational period of 4 weeks in each area. However, this was currently under review following feedback from band 5's who felt that it would be more beneficial to have a longer time within each area of the maternity unit.

Managers made sure staff received any specialist training for their role. For example, there were 6 midwives had received funding for specialist training in the professional midwifery advocate course. The role supported staff through a continuous improvement process that aimed to build personal and professional resilience, enhance quality of care and to support preparedness for professional revalidation.

There were a number of specialist midwives' roles within the service and staff told us the specialist midwives were visible within the service. For example, there were specialist roles for digital transformation, stop smoking service, practice development, recruitment and retention, infant feeding, preterm birth team, diabetes in pregnancy, safeguarding and antenatal and newborn screening.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. There were no reported red flags within the inspection reporting timeframe.

There was a shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Managers moved staff according to the number of woman and birthing people in clinical areas, but staff told us this was not often.

The service made sure staff were competent for their roles. A practice development (PD) midwife was new in post. The role of the PD midwife was to increase the face to face skills training following the pandemic, work with local universities to increase student midwife numbers and to work alongside clinical staff to support students and newly qualified midwives.

Managers supported most staff to develop through yearly, constructive appraisals of their work. We were given examples of how staff had been supported to develop through training and support. Data showed maternity staff appraisal compliance was 82%.

Retention and recruitment were managed by a specialist midwife who was new in post. The service had employed 17 band 5 midwives who had previously been student midwives in the unit.

Medical staffing

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

Maternity

The service had enough medical staff to keep woman and birthing people and babies safe. The medical staff matched the planned number. The obstetric team consisted of 9 obstetric and gynaecological consultants, 2 consultants who provided a small number of additional obstetric support, 7.2 whole time equivalent (WTE) tier 2 doctors and 8.4 WTE tier 1 doctors. Total medical cover onsite was 73 hours per week plus 12 hours per week for elective section lists.

The service had low vacancy, turnover and sickness rates for medical staff. Data showed the only vacancy within the medical team was 0.8 WTE. There was a low sickness rate for medical staff. However, there was some staff on long term sickness as well as a number of doctors who restrictions on their shift patterns which created pressure on teams to fulfil the on-call rota.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

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

There was always a consultant on call during evenings and weekends and the service had a comprehensive consultant presence within obstetrics. Consultants completed two daily ward rounds as per national recommendations and spent the daytimes visible and available on the wards.

There was a consultant present on weekdays from 8 am until 7pm, weekends and bank holidays 8am to 5pm on site. Outside of these hours the consultant was on call from home. Staff told us doctors were approachable and available for urgent reviews.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The service provided teaching sessions to medical staff weekly and junior doctors told us they felt well supported. The appraisal rates for medical staff were 100%.

Records

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

Woman and birthing people's notes were comprehensive, and all staff could access them easily. The trust had been using an electronic notes system for the last four years and staff told us they felt confident and competent to use the system.

When woman and birthing people transferred to a new team, for example, back to their GP or to community teams. There were no delays in staff accessing their records.

We reviewed 6 electronic records and found records were clear and complete. Confidential information could not be accessed without a password and all computer screens were kept locked at all times.

Records were fully completed, and we saw that the electronic system was easy to navigate. The service ensured the allocation of named midwives or consultants to women. Venous thromboembolism (VTE) score checklist, partogram (a composite graphical record of key maternal and fetal data during labour), World Health Organisation (WHO) checklist used in theatres, charts for growth and early warning scores were completed.

Maternity

Potential safeguarding issues were flagged electronically so all clinicians could recognise and act on safeguarding concerns.

All pregnant women could access their maternity notes online. Woman had individualised care plans for pregnancy and labour, there was an antenatal screening and assessment of risk to promote safe treatment. The web-based portal allowed them to view their notes securely and until they were discharged from maternity care.

Women who were unable to access electronic maternity notes were provided with handheld antenatal records which they took to all appointments. Maternity teams continued to enter all information electronically to ensure consistency and no errors in communication.

The service completed an audit of antenatal notes and found records had evidence of discussions around the importance of fetal movements by sonographers performing growth scans, paper notes arranged for women had no access to records electronically, referrals for specialist care such as female genital mutilation (FGM), safeguarding, diabetes and perinatal mental health support.

However, the audit found midwives were not always documenting whether they had asked a question on domestic violence and whether non-speaking patients were offered a translator.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Woman and birthing people had prescription charts for medicines that needed to be administered during their admission. We reviewed 8 prescription charts and found staff had correctly completed them.

Staff reviewed each woman's medicines regularly and provided advice to woman and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them up to date. Medicines records were clear and up to date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored within automated medicine cabinets with biometric access in the labour ward and stored in secured locked cupboards within the pregnancy assessment unit and the antenatal/postnatal ward.

Clinical fridge temperatures were maintained between a minimum and maximum recommended temperature. They were checked daily to ensure required medication was stored at the correct temperature to maintain drug efficacy.

Incidents

Maternity

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave woman and birthing people honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff followed trust guidelines on how to identify and report incidents. The service used an online incident reporting system and updated national Strategic Executive Information System (STEIS) if a serious incident was declared.

Staff could describe what incidents were reportable and how to use the electronic reporting system. The trust had a process for managing and reviewing incidents. There were 4 incidents over 60 days old which were currently still under investigation, one of which was classed as severe harm. Incidents classed as severe harm are any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. The trust held weekly risk review meetings to discuss current cases and recommendations from the Healthcare Safety Investigation Branch (HSIB) and any serious incidents. The meetings were attended by midwifery managers and clinical lead. There were no current cases submitted to HSIB. Learning and risk was identified and actioned quickly to improve care for women and birthing people without delay whilst awaiting initial feedback and final reports.

The trust had one reported incident within the last 3 months, and we found the incident was reported correctly.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning and actions were shared with the staff via interactive boards, emails and on staff message groups.

Quarterly maternity mortality and morbidity reports were submitted to the trust mortality and morbidity steering group. The mortality and morbidity steering group submitted a report of actions to the Quality governance committee. All serious incidents were shared with the trust board.

The service monitored stillbirths, fetal loss, neonatal and post-neonatal deaths using the Perinatal Mortality Reviews Summary Report (PMRT) tool and produced a quarterly report. The total number of perinatal deaths reported to MBRRACE-UK perinatal mortality surveillance from April 2022 to September 2022 was 6.

There had been no reported never events.

Staff understood the duty of candour. They were open and transparent and gave woman and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of woman and birthing people and their families in investigations and monitoring of how duty of candour had been completed. Matrons and specialist midwives disseminated quarterly messages amongst staff which included learning from incidents. Staff met to discuss the feedback and look at improvements to patient care.

Is the service well-led?

Good

Maternity

Leadership

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

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. There was a clear leadership structure in place. The head of midwifery (HOM) reported to the chief nurse and operational manager. The head of midwifery was supported by the lead midwife for quality risk and safety, acute service maternity matron and community midwifery matron.

The maternity leadership team were supported by a number of specialist midwives and band 7 midwives.

Leaders were visible and approachable in the service for woman and birthing people and staff. Leaders were respected and staff told us, leaders were supportive, approachable and keen to drive improvement.

The service was supported by maternity safety champions and non-executive directors. The non-executive director (NED) was a maternity safety champion and was there to provide objective and external challenge. Their remit was to understand the current outcomes of the service, review services, current maternity risks and report to board. The NED visited the maternity unit and liaised with outside representatives such as the maternity voice partnership group to review services and provide the board with a report of maternity services.

Leaders supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. The maternity service had in place the Quality and Safety Improvement Plan 2022/2024.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services at The Shrewsbury and Telford Hospital NHS Trust had revised the vision and strategy to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders and staff understood and knew how to apply the vision and strategy and monitor progress. The plan was aligned with the recommendations within the NHS Long Term Plan and Maternity Transformation programme for maternity and neonatal services.

Maternity

The service vision was to remain focused on delivering personalised and safe maternity care through:

1. Improved Patient Safety.
2. Improved Clinical Effectiveness.
3. Improved Experience for mothers, babies and their families.
4. Focus on Leadership, learning and best practice, teams, improving data collection and quality and innovation.
5. Improve staff culture and experience.

There was a clear safety and quality strategy which included the implementation and audit of the Ockenden recommendations.

Alongside the safety and quality strategy was the trusts digital maternity strategy which detailed four specific aims:

1. Support care and to provide safe, quality care across the area.
2. Empower women to access and share care information.
3. Evaluate and learn through use of data to assess and improve services.
4. Attract development funding.

Culture

Most staff felt respected, supported, and valued. However, not all staff we spoke to felt they were able to raise concerns to senior leadership. The service promoted equality and diversity in daily work, and provided opportunities for career development.

Staff were focused on the needs of woman and birthing people receiving care. Women and birthing people and their families could raise concerns without fear.

Most staff felt respected, supported, and valued. Staff were mostly positive about the department and its leadership team and mostly felt able to speak to leaders about difficult issues and when things went wrong. Results from the NHS Staff Survey 2021 showed maternity staff were mostly positive about their work and the organisation cared about staff's wellbeing.

For example, the survey showed out of 2,081 staff asked, 1,910 staff either agreed or strongly agreed that they were trusted to do their job. Out of 2,078 staff there were 1,500 staff who either agreed or strongly agreed that they were able to approach their immediate manager.

During our inspection, staff we met were welcoming, friendly and helpful. Staff were keen to talk to us about their work and the improvements being made within the unit. For example, the purpose built second theatre, new bereavement suite and pool room.

We spoke to staff across most grades and disciplines. Staff were proud to work for the trust and mostly felt valued and respected by management. Staff described healthy working relationships within teams and felt respected and able to raise concerns with immediate managers.

Maternity

Staff were focused on the needs of woman and birthing people receiving care. Staff worked within and promoted a culture that placed patient care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Leaders understood how health inequalities affected treatment and outcomes for woman and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

From August 2022 to February 2023 the maternity safety champions had completed regular walk around's of the maternity unit 7 times. There was a timetable of dates to show staff when the maternity safety champions were due to visit for walk around the units and to talk to staff. In one of the scheduled visits, we saw there was time designated to talking to staff about the continuity of carer teams, as staff were concerned around how the teams could impact on staffing and the potential work pressures within maternity teams.

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

Professional midwifery advocates (PMAs) had additional training to support the practice and development of midwives. PMA's supported restorative supervision, provide leadership to midwives, supported local governance, risk management and staff development. Staff told us the PMA midwives listened and spoke to women about their maternity experiences to ensure the care provided was responsive to women and birthing people's needs.

Women and birthing people were given the opportunity to complete a patient research experience survey. The survey received mostly positive feedback, with people welcoming the opportunity to take part in the survey and share their experiences.

The service clearly displayed information about how to raise a concern in woman and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

The service had an open culture where woman and birthing people, their families and staff could raise concerns without fear. Woman and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. For example, we saw evidence of where women were invited to work with the service to improve services and staff attitudes for women and birthing people with learning disabilities. The service worked with the trust learning disability nurse and welcomed learning disability nursing students into the maternity service to gain a wider learning and understanding.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used woman and birthing people's feedback to improve daily practice.

Governance

Maternity

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

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

The trust had maternity safety champions working across service boundaries to develop partnerships and develop a clear structure for sharing risks from the ward through to board.

For example, the board level safety champions provided information to the board regarding the Saving Babies Lives, the Maternity Safety Incentive Scheme, serious incidents, and Healthcare Safety Investigation Branch (HSIB) cases. They supported the implementation of learning from national and local initiatives and provided feedback to the board on key priorities for maternal and neonatal safety.

Midwifery, obstetric and neonatal safety champions were responsible for prioritising maternal and neonatal safety at a local level. They contributed to the implementation of the local safety improvement plan and fed this up to the board level safety champions, maternity voice partnership group and the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP).

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

The service had an audit planner in place for 2023/2024. The planner included the monitoring of Ockenden 7 IEAs, the Maternity Incentive scheme and quality improvement. The action plan showed the service was on track to deliver outcomes in all areas.

The trust was able to fully demonstrate safe staff requirements as per guidance from the maternity national team and Ockenden to deliver the maternity continuity of care model. The continuity of care began in June 2020 and currently offer care for up to 480 families within the area.

Women and birthing people were identified through 6 GP practices within the most deprived areas or higher rates of lower pregnancy outcomes. For example, low birthweight babies, antepartum stillbirths, preterm deliveries, and women under the age of 20.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team.

Information was shared back to sub-committees and all staff. We saw evidence of leaders providing listening events for staff, gaining feedback from staff and using this information when developing services. For example, several listening events took place to gain feedback on the continuity of carer model.

Maternity

There was a quarterly maternity operational board meeting, which leaders from within both the medical and midwifery teams attended. Board meeting minutes showed the meeting was designed around current risks or actions. Actions and feedback from these meetings were presented to board.

Standard operational procedures were in place in all departments including the pregnancy assessment unit (PAU). The PAU procedure clearly defined the role of the unit and the two streams of work they provided regarding planned appointments and emergency work. The PAU supported low risk women in induction of labor during times of high acuity on the labour ward. Staff told us there was good communication between the two areas especially when co ordinating care for women and birthing people.

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

The avoiding term admission into neonatal unit (ATAIN) meetings occurred monthly. All unplanned term admissions were reviewed as part of a multi-professional review and monitored on the maternity dashboard. This was to determine whether the admission was avoidable or not. Any learning was shared within an action plan and disseminated to staff.

Governance boards were clearly visible in every clinical area and offered information such as number of births and the number of babies born by caesarean section and whether planned or emergency. These were updated by the midwife in charge. There was a numerical overview for the week which included the number of open incidents, the number of incidents reported by staff and number of formal complaints.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was open communication between maternity leaders and the trust board, supported by risk and oversight meetings that took place regularly. A monthly departmental obstetrics and gynaecology safe care meeting took place with a maternity safety action log. The divisional safe care team attended meetings and reviewed specific safety guidelines and protocols such as management of reduced fetal movements, fetal monitoring and abduction and unauthorised access policy. All policies were in date and had been reviewed within the specified timeframes.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

A risk register was used to identify and manage risks to the service. The risk register included a description of each risk, alongside mitigating actions, and assurances in place. Leaders had good oversight of the dashboard and any emergent risks or concerns.

There were 11 risks on the risk register with 8 risks being ongoing and 3 actioned as currently managed.

We saw evidence that the trust identified safety issues within the dashboard, investigated and took steps to mitigate. For example, the unit's top risk was the maternity unit being separated from the main hospital. The concern on the register

was the risk of multidisciplinary teams being delayed to an emergency maternity or delayed critical care transfers for maternity patients due to the separate buildings. We saw that this risk was also monitored through the maternity dashboard, through identifying how many women were transferred to critical care and data on how many women had procedures in main theatre.

Leaders reviewed risks within the women's risk meetings and updated risk register entries and entered dates. Maternity staff attended the trusts weekly Safety Triangulation Group (STG) meeting and presented all maternity incidents and complaints.

The STG was a multidisciplinary panel discussion and was chaired by the trusts Head of Risk and Patient Safety. This meeting was followed by a weekly meeting with the Head of Risk and Patient Safety, Medical Director and Chief Nurse where a summary of all maternity cases, outline of actions and decisions relating to serious incidents from the STG were discussed and reviewed within the appropriate timeframes.

There was a standard operating procedure (SOP) for reporting of serious incidents and serious incidents were reported to trust board.

The service participated in relevant national clinical audits. Managers and staff used the results to improve women and birthing people's outcomes.

For example, the service had completed a smoking in pregnancy local audit, following a reduction in the compliance of testing for CO monitoring at antenatal booking. The audit found a low compliance and structures were put in place to continue monitoring. Following the audit, the service continued to audit compliance of CO monitoring, to embed a new service provision into the maternity unit and to present the audit to the maternity safe care and health inequalities board. However, the maternity dashboard showed CO monitoring for December 2022 and January 2023 were not meeting the national target of 80%.

Managers and staff did not always carry out a comprehensive programme of repeated audits to check improvement over time. The service completed some audits to present to board and to the perinatal mortality meeting, labour ward forum and safe care meetings. For example, the service completed a quarterly perinatal mortality review tool and serious incident report, maternal readmissions, 3rd and 4th degree tears, small for gestational age and fetal growth restriction.

There were plans to cope with unexpected events. The service had a detailed local business continuity plan, and processes to manage implementation and de-escalation of it. We saw evidence of clear documentation, assessment and communication around use of the business continuity plan.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. The service was compliant within all 10 of the safety actions as set out by the NHS resolution in the maternity incentive scheme.

Information Management

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

The service collected reliable data and analysed it. They had a live dashboard of performance which was accessible to senior managers. The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

The service had fully implemented a national maternity electronic patient record. The service had two digital specialist midwives and the trust was a national digital maternity model for other trusts. The lead digital midwife chaired the regional digital midwife group and was vice chair of the regional digital steering group. The maternity service had developed a 3-year digital strategy which was aligned to the trusts and local maternity neonatal systems.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Data was collected to support higher risk women at all booking appointments. This included women's ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced maternal age and co-morbidities. This data was used in planning women's care.

Managers also used this information to inform decisions around service delivery such as continuity of care teams and community caseloads.

Data or notifications were consistently submitted to external organisations as required**.**National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) in decisions about patient care. The trust had an active MVP that was implemented in 2019. The group has three co-chairs and they met monthly to go through current actions and quarterly with the link midwife or head of midwifery. The MVP were well embedded into the service and the trust was open in its engagement with the MVP and women and birthing people using the service in order to drive improvement.

The MVP had a number of key priorities. For example, to support and publicly talk about the work happening within the maternity unit such as the refurbishment of the bereavement room and upgrade of pool room.

Leaders understood the needs of the local population. The local area had a high population of Jewish people. The MVP and leaders worked to connect with Jewish women through meeting with local doulas in the community to provide leaflets specific for the Jewish community and support Jewish women by recognising the lack of technology within the community.

The trust worked with to gain feedback from the Jewish community at a recent event. The feedback was positive, with all women taking part stating that they had positive maternity experience.

There was a monthly feedback newsletter produced to give staff current key information. The feedback gave information on staffing updates, staff survey, safety champion walkarounds, continuity of care updates, Ockenden assurances, estates, compliments and staff aware. Staff told us the newsletter was informative and they were encouraged to read it.

Professional midwifery advocates (PMA) produced a monthly newsletter to promote their role in supporting staff. Staff told us that they were encouraged to complete the PMA training, and, in the newsletter, we saw highlighted the current number of PMAs and the number completing their training.

Staff at the trust worked closely with the local authority and external stakeholders to improve outcomes for women and birthing people and families. For example, organisations working specifically with young fathers, young mothers, and health visiting teams.

Safeguarding teams at the trust had trained staff to provide advice for ongoing support following postnatal discharge from maternity services.

There were information boards on corridor walls in most clinical areas. There was a summary of user feedback, comments and actions taken. Details of how to get different types of support, make a complaint and give feedback. Boards also included photographs of staff with their name and role.

The service had a new public health midwife and there was a new maternity public health plan in place. There were a number of key initiatives that had been launched in 2022. This included the Tobacco dependency in pregnancy service. Women and birthing people attending the pregnancy assessment unit were offered flu vaccinations by a team of trained midwives to support and increase pregnancy flu vaccinations.

The breast-feeding initiation rate was the highest in the region at 70.5% in 2022. The service had achieved Level 1 UNICEF accreditation. The service provided monthly UNICEF breastfeeding and relationship building multidisciplinary staff training, monthly breastfeeding steering groups, infant feeding café's reintroduced within three local community hubs and the infant feeding team were increased to include a maternity health advisor and a band 3 breastfeeding champion.

Learning, continuous improvement and innovation

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

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

Leaders encouraged innovation and participation in research. The trust employed a dedicated research midwife. The trust was currently taking part in research studies. The service had recently recruited 189 women and birthing people to take part in a research study to look at the best point for delivery for women with large for gestational age babies.

Work was taking place with local GP's and the safeguarding team to integrate the sharing of information for fathers or partners to risk assess both parents for any potential safeguarding concerns. For example, drug or alcohol misuse.

Maternity

There were several initiatives taking place within the midwifery diabetes team.

During our inspection we observed an antenatal clinic and the current work taken place to support women with gestational diabetes mellitus (GDM). The lead midwives for diabetes had developed a GDM education session and offered individual sessions to women and birthing people who were non-English speaking and required interpreting services.

Diabetes antenatal clinics provided a waiting area for women with GDM to provide healthy snacks and support and education from dietician.

The service collaborated with regional universities and charities to support research studies. The service invited learning disability students to work within the maternity unit after identifying the need for staff to develop further awareness and support around caring for women and birthing people with learning disabilities. The service was working with learning disability nurse to develop further training and to develop a pathway.

A grab bag project was in place to provide vulnerable women and birthing people fleeing domestic violence with basic amenities. An assessment would be made so that staff could determine what the person would need.

The service had introduced the implementation of postnatal contraception and advice and information given within antenatal clinics to support women with pre-conceptive advice on tobacco dependency, alcohol misuse, positive mental health, postnatal contraception, nutrition and physical activity.

Outstanding practice

We found the following outstanding practice:

- The lead midwives for diabetes had developed a Gestational Diabetes Melliutis (GDM) education session and offered individual sessions to women and birthing people who were non-English speaking and required interpreting services. Diabetes antenatal clinics provided a waiting area for women with GDM to provide healthy snacks and support and education from dietician.
- A grab bag project was in place to provide vulnerable women and birthing people fleeing domestic violence with basic amenities. An assessment would be made so that staff could determine what the person would need.
- The service had introduced the implementation of postnatal contraception and advice and information given within antenatal clinics to support women with pre-conceptive advice on tobacco dependency, alcohol misuse, positive mental health, postnatal contraception, nutrition and physical activity.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should ensure staff complete mandatory training, including safeguarding and regular updates.
- The service should ensure women and birthing people feel listened to by staff and their partners.

Our inspection team

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