Royal Lancaster Infirmary

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Royal Lancaster Infirmary is operated by University Hospitals of Morecambe Bay NHS Foundation Trust. We inspected maternity services and services for children and young people at Royal Lancaster Infirmary.

We inspected the services provided by this trust as part of a focused inspection because we had concerns about the quality of services and we received information giving us concerns about the safety and quality of the services.

Where it is considered necessary to arrange a focused inspection outside of the regular core service inspection schedule, the focused inspection covers a targeted part of the service response to a specific concern. We do not assess or report on all the key lines of enquiry (KLOEs) in a focused inspection.

As we do not rate a trust following a focused inspection, we cannot update any provider level ratings following this inspection.

Throughout the inspection, we took account of what people told us.

We found the following areas of good practice:

- The services provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff had training on how to recognise and report abuse, and there were processes in place to escalate concerns.
- Staff completed and updated risk assessments for each patient and took action and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The services had enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The services 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 patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The services made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Local 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 patients and staff.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- 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 services.
- Local leaders used systems to manage performance effectively. Relevant risks were identified.

However, we also found the following issues that the service provider needs to improve:

- Leaders did not consistently operate effective governance processes throughout the services.
- Actions taken to mitigate risk were not always identified or actioned in a timely way.
- The services collected data and analysed it. However validated data was not easily accessible to all staff to allow them to understand performance, make decisions and improvements.
- We were not assured that processes to monitor equipment competencies were effective.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ann Ford
Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Maternity	Good 	We previously rated maternity service as good in 2017. However, this inspection was a focused inspection and no new rating could be made.
Services for children & young people	Good 	Children and young people's services were a small proportion of hospital activity. We previously rated this service as good in 2017. However, this inspection was a focused inspection and no new rating could be made.

Summary of findings

Contents

Requires improvement

Royal Lancaster Infirmary

Services we looked at
Maternity; Services for children & young people.

Summary of this inspection

Background to Royal Lancaster Infirmary

Royal Lancaster Infirmary is operated by University Hospitals of Morecambe Bay NHS Foundation Trust. The hospital is situated in the centre of the city of Lancaster and has around 426 beds. It provides a wide range of services including accident and emergency, medicine, surgery, maternity, critical care, end of life care, outpatients and diagnostic imaging and a children and young people's service, including a neonatal unit.

This inspection was a focused inspection that looked at maternity services and services for children and young people.

Our inspection team

The team that inspected the services comprised two inspection managers, two CQC lead inspectors and specialist advisors with expertise in governance, maternity and services for children and young people. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Royal Lancaster Infirmary

At this focused inspection we visited maternity services and services for children and young people.

The hospital has a consultant and midwifery day assessment unit, delivery suite with seven beds, two theatres and a 24 bedded antenatal and postnatal ward (ward 17) as well as a bereavement suite.

In relation to service for children and young people, they consist of a children's unit, with 21 inpatient beds and a level one paediatric oncology shared care unit, and an eight bedded day care unit, a six bedded assessment unit, children's outpatient department and a 10 cot neonatal unit (NNU). The neonatal unit is a level two unit, providing high dependency care and short-term intensive care.

From July 2018 to June 2019, the trust had 7,776 admissions for paediatric patients and its staff delivered 2,877 babies.

During the inspection, we visited all relevant units. We spoke with 36 staff including registered nurses, midwives, health care assistants, reception staff, medical staff, governance staff, trust board members and local and senior managers. We spoke with nine patients and their relatives. During our inspection, we reviewed 18 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We did not rate safe at this inspection as this inspection was a focused inspection. A focused inspection differs to a business as usual inspection as it is more targeted, looking at specific concerns rather than gathering a holistic view across a service

We found the following areas of good practice:

- The services provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff had training on how to recognise and report abuse, and there were processes in place to escalate concerns.
- Staff completed and updated risk assessments for each patient and took action and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The services had enough staff with the right qualifications, skills, training and experience to keep patients 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.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The services 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 patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Are services effective?

Good 

We did not rate effective at this inspection as this inspection was a focused inspection. A focused inspection differs to a business as usual inspection as it is more targeted, looking at specific concerns rather than gathering a holistic view across a service.

We found the following areas of good practice:

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

Summary of this inspection

Are services caring?

Good

We did not inspect caring at this inspection as this inspection was a focused inspection. A focused inspection differs to a business as usual inspection as it is more targeted, looking at specific concerns rather than gathering a holistic view across a service.

Are services responsive?

Requires improvement

We did not inspect responsive at this inspection as this inspection was a focused inspection. A focused inspection differs to a business as usual inspection as it is more targeted, looking at specific concerns rather than gathering a holistic view across a service.

Are services well-led?

Good

We did not rate well-led at this inspection as this inspection was a focused inspection. A focused inspection differs to a business as usual inspection as it is more targeted, looking at specific concerns rather than gathering a holistic view across a service.

We found the following areas of good practice:

- Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for women and staff.
- Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service had an open culture where women, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Local leaders used systems to manage performance effectively. Relevant risks were identified.

However,

- Leaders did not consistently operate effective governance processes throughout the service. There was a lack of visibility of senior leaders. Senior leaders including the care group leads were not consistently visible at a local level for maternity and children and young people services.
- Actions taken to mitigate risk were not always identified or actioned in a timely way.
- The services collected data and analysed it. However validated data was not easily accessible to all staff to allow them to understand performance, make decisions and improvements.

Detailed findings from this inspection

Good

Maternity

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are maternity services safe?

Good

We did not rate safe at this inspection as this inspection was a focused inspection.

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

Annual mandatory training for all staff included topics such as health and safety, basic life support, moving and handling, information governance, infection control and fire safety.

Training was accessed either via e-learning or within a classroom setting. We were told staff received reminders when mandatory training was due and compliance with mandatory training was monitored by the matron and ward manager.

During our inspection, we observed data regarding mandatory compliance for maternity staff at this hospital as:

Basic Life support (90%)

Neonatal basic life support (93%)

Fire safety (91%).

Following our inspection, we requested all mandatory training compliance for maternity staff at this location. However, the trust told us they were only able to provide overall compliance for the maternity and paediatric care group across the trust.

Data provided by the trust showed overall compliance of 94% with individual modules ranging from 87.7% (departmental fire safety awareness) to 97.7% (equality, diversity and inclusion).

Staff working within maternity services also attended maternity specific training provided over three days at another location. Staff told us they enjoyed the training and it was also an opportunity to meet staff from other sites.

During our inspection, we observed several training dates available to staff clearly visible in staff areas.

We observed in minutes of governance meetings that in October 2019, 86.5% of staff had attended mandatory training day two and 81.3% had attended day three. Data provided by the trust confirmed 88% of maternity staff at the hospital had attended day one. We did not see any data in relation to the number of staff who attended day one.

Safeguarding

Staff had training on how to recognise and report abuse, and there were processes in place to escalate concerns.

Safeguarding children's and adults were delivered as part of the mandatory training; that included child sexual exploitation. We observed compliance for maternity and paediatric services showed as of October 2019:

- Safeguarding Children and Adults (NHS Core Skills) - Level 1 (94.9%)
- Safeguarding Children and Young People (Core Skills - Level 2) E-learning (94.5%)
- Safeguarding Children (NHS Core Skills) - Level 3 (87.8%)
- Safeguarding (Level 3) Supervision (89.1%).

. Staff are aware of the named midwife for safeguarding and her role includes female genital mutilation lead along with a consultant on each site. We were told there were also safeguarding champions on the wards.

Staff told us the safeguarding team visited the ward each morning and we observed information including contact numbers for trust and local authority safeguarding teams displayed in staff areas.

Staff were knowledgeable and understood what to do if there were any safeguarding concerns and we observed incidents had been reported in relation to safeguarding.

Babies did not wear security tags; however, there were locked doors on the delivery suite and maternity unit, with cameras in-situ at points of entry and on the corridors. Access to the wards was via an intercom or key pad. This was used for people entering and leaving the wards, minimising any unauthorised access. Access to the units was monitored mainly by the ward administrative staff who worked during the day and by nursing staff at other times. One member of staff told us there had been some occasions of individuals tailgating others to gain access on ward 17 and they had raised this to managers. However, we did not see any incidents reported or complaints received.

The service had an infant and child abduction policy that documented that either table top exercises and/or practical testing should be performed every six months with drills included in the skills and drills programme for maternity services.

Following our inspection, we requested the date of the last abduction scenario tested on ward 17 and the delivery suite. The trust provided details of other areas in the trust that had tested the plan in collaboration with police including accident and emergency and the paediatric unit. However, we did not receive any evidence that the abduction scenario had been tested specifically within the maternity areas at the hospital.

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police including accident and emergency and the paediatric unit. However, we did not receive any evidence that the abduction scenario had been tested specifically within the maternity areas at the hospital.

Midwifery and support staff

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

The head of midwifery conducted a staffing review to review skill mix and the number of births to ensure the right staff were in the right place. The report was submitted to the chief nurse and shared with the trust board.

The national birth rate plus acuity tool was used to monitor staffing against acuity.

Ward managers we spoke to were aware of the acuity tool and the process to follow if escalation was required.

The matron confirmed that although there were no vacancies, the service still utilised four permanent bank staff if required to cover sickness or leave.

Band 5 staff told us they rotated across other maternity sites within the trust and staff we spoke to felt this had been useful and had a positive impact on breaking down any barriers.

Staff reported no concerns with staffing levels and there had been an improvement in staffing since the recruitment of new midwifes. A staffing review showed from January 2018 to December 2018, 96% of women received one to one care in labour.

Medical staffing

The service 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 and gave locum staff a full induction.

Twelve consultants worked at assigned times at the hospital but also provided cover for clinics at another trust location.

A resident consultant remained on site from Monday to Thursday with support from an on-call consultant.

From Friday to Sunday a registrar remained on site with support from an on-call consultant who lived within 30 minutes of the hospital.

Consultant contact numbers were visible and displayed within staff areas.

Doctors we spoke to confirmed staffing was good and they felt supported by their peers and senior clinicians.

Nursing staff reported they were comfortable contacting medical staff who were responsive.

Records

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

Women's records were electronic apart from those completed in the delivery suite and theatre.

We reviewed five records of women who were on the post-natal ward and we observed risk assessments had been completed. There was a clear plan of care for each woman through their pregnancy and labour.

We observed a completed surgical safety checklist for a woman who had undergone a caesarean section.

Women could access their electronic records through a dedicated portal. Women were also given information in paper form including the name of their named midwife.

Incidents

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

Good

Maternity

The trust incident policy provided guidance to staff in relation to the process of reporting, investigating and sharing of incidents.

The policy provided guidance around the types of maternity serious incidents that were required to be investigated by the Healthcare Safety Investigation Branch (HSIB) who are an independent investigation unit in England.

We were told for HSIB cases the category of harm was usually determined after the investigation was completed.

The matron told us the trust would also conduct an initial review to identify if there were any immediate concerns or issues that needed to be addressed rather than wait for the HSIB report to be concluded.

Staff were knowledgeable about the process and of the four incidents which had been escalated to HSIB.

All serious incidents that did not meet the specific criteria were investigated by the trust and reviewed at the serious incident panel attended by the governance team and signed off by either the chief nurse or medical director.

Information provided by the trust stated all incidents relating to maternity services were reviewed by the ward manager or the labour ward co-ordinator. Incidents that needed further review were sent to the matron and an obstetrician. The matron, deputy head of midwifery and head of midwifery had oversight of all maternity incidents. The matron told us rapid reviews of serious incidents were reviewed by clinicians from other locations across the trust. Data provided by the trust from December 2018 to December 2019 showed across all maternity services at the hospital there were:

- 689 incidents resulted in no or low harm
- seven incidents resulting in moderate harm
- none resulting in serious harm.

Three of the seven moderate incidents had been escalated to HSIB.

We requested the investigations completed relating to the four HSIB cases reported during November 2018 to December 2019 and we observed the service had documented they were taking actions in response to some of the issues identified; for example, reviewing and amending the induction of labour guidelines.

At the time of report writing the incidents were being investigated by HSIB.

Staff we spoke with gave examples of types of incidents they reported and there was evidence that changes had been made including ongoing measuring and recording of blood loss.

We were told staff were given the opportunity to debrief and were supported after any serious incident.

Staff confirmed lessons learned were shared back as part of the staff handover or via the three minute brief that was emailed to staff, and investigations and lessons learned following serious incidents were shared within staff areas.

The risk manager gave us examples of trends and themes that had been identified because of incidents reported, these included post-partum haemorrhage.

Staff we spoke to were aware of the principles of duty of candour and we saw evidence this had been applied; for example, we observed in governance meeting minutes there had been a delay in meeting with a family as they had been on holiday.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person).

From December 2018 to December 2019 across the women and children's care group there were 27 incidents where it was identified that duty of candour was applicable. This was completed within ten working days in 23 incidents, completed outside the ten working days in two incidents and not completed in two incidents. We addressed this with the trust and are aware that they have acted to start to address this.

Are maternity services effective?

Good

We did not rate effective at this inspection as this inspection was a focused inspection.

Competent staff

Good

Maternity

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

Staff had access to clinical educators to support learning and development.

Staff had the opportunity to discuss training needs with their line manager and were supported and given time to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance and supported staff to improve.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

Managers gave all new staff a full induction tailored to their role before they started work.

One midwife who had recently gone through their preceptorship, was very positive about the experience and had been encouraged to develop and attend additional training and conferences.

Staff told us they were supported through their competencies and once completed each competency was signed off within a handbook. During our inspection, we observed a completed example of competency assessment for IV administration.

Cardiotocography (CTG) training was included in the annual maternity mandatory training and data provided showed 89% of all maternity staff had completed the training. Cardiotocography is performed to record a foetal heartbeat and uterine contractions during pregnancy.

The service used 'fresh eyes' where another clinician would also review the CTG trace at two hourly intervals. The timings were recorded on the whiteboard against the mothers' name in the staff area.

The trust provided overall data for all staff within the women's and children's care group in relation to staff competency assessments against individual pieces of equipment. The data showed only 5,193 (35%) of 14,655 number of assessments had been completed.

The trust told us that the assessment figure was low as competency assessments on each staff members 'to do list' was based on where they worked rather than their job role. Also, if staff worked across the different sites, the equipment was added for each site, which meant the competency assessment for the same piece of equipment was logged on staff members' required competency records several times. The trust told us that staff were expected to delete competencies that were not required. We were not assured that this process was effective.

We were told staff were required to review the training needs analysis and mark any equipment that was not applicable to them.

Data observed during inspection showed appraisal rates were 88% which was below the 95% target and this was mainly due to new starters or due to cancellation because of patient acuity. The matron stated there had recently been a focus on appraisals and all outstanding staff who had not had an appraisal had a date assigned. Staff we spoke to stated they had received their annual appraisal.

Following our inspection, we requested appraisal rates for all maternity staff, including medical staff at this hospital. However, we were provided with overall data for maternity and paediatric services as the trust could not provide separate data.

Data showed the following staff had received an appraisal within the last 12 months

- 92 % medical staff
- 100 % band eight and above
- 87% band one to seven.

Are maternity services caring?

Good

We did not inspect caring at this inspection as this inspection was a focused inspection.

Are maternity services responsive?

Good

We did not inspect responsive at this inspection as this inspection was a focused inspection.

Good

Maternity

Are maternity services well-led?

Good

We did not rate well-led at this inspection as this inspection was a focused inspection.

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for women and staff.

.The clinical lead, maternity matron and clinical service manager lead the maternity service at the hospital supported by the consultant obstetricians, delivery suite manager, ward manager and antenatal manager. All supported by senior leadership team.

The senior leadership team for maternity services consisted of a head of midwifery, interim deputy head of midwifery, clinical lead and associate director of operations and performance and deputy associate director of operations and performance.

The head of midwifery, interim deputy head of midwifery and the clinical lead were all based at the hospital but worked across other sites at the trust.

We were told that the head of midwifery or deputy head of midwifery visited the matron on a weekly basis to discuss operational issues.

Local leaders and managers could explain issues and priorities within the service. However, a senior staff member could not tell us the three top risks of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service had an open culture where women, their families and staff could raise concerns without fear.

All staff we spoke to were positive about their work and the majority felt respected and valued by their peers and leaders.

Staff told us they felt comfortable in raising issues or concerns to their peers, managers and senior managers. However, most staff felt the senior leadership team and the executive team were not visible within the areas they worked, and some reported they were not engaged either.

Staff confirmed they were aware of the trust Freedom to Speak up Guardian and we observed their contact details displayed in staff areas. We noted that two concerns from maternity services had been raised with the Freedom to Speak Up Guardian.

During our inspection, we observed positive working in the areas we visited, and staff gave us examples of when staff had provided or had been provided with support.

Staff reported a positive 'no blame' culture with support and debriefs following untoward events. Staff felt well informed and received information either in newsletters, via email or at handovers. However, we observed no ward meetings had taken place across maternity services from January 2019 to October 2019.

We requested copies of the last two team meetings for both the delivery unit and ward 17 and we were provided with minutes from forum meetings and observed these were attended by senior staff including consultants, labour ward coordinators and midwifes with specific roles for example audit.

The trust provided an action tracker for meetings for band two and three staff. However, the trust reported minutes were not taken following these meetings. On review of the data provided, we saw no evidence of staff at band six to band four attending any team meetings.

A culture and engagement survey performed in April 2018 across maternity services showed areas where positive responses were below 45% these included team work and burn out. The trust provided an action plan with actions to be taken including conducting stress risk assessments, walk arounds and three-minute briefings.

Governance

Leaders did not consistently operate effective governance processes throughout the service. 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.

There was a governance structure within maternity services and processes were in place to ensure there was escalation and the cascading of information to and from the senior management team to frontline staff. Managers were able to describe the structure and understood their role and responsibilities and the role of others. The managers and team leaders we spoke with knew about the quality issues, priorities and challenges within the service.

Information relating to risk and performance was escalated from the services to the trust board through monthly performance reviews and meetings; for example, the quality committee was attended by the head of midwifery and executive chief nurse. However, this information was not always accurate (see information section below).

We were not assured that the overarching trust governance processes were robust as there were discrepancies in information that was held locally with centrally held trust data (see information section for more detail). This included the system regarding staff competencies relating to equipment, which highlighted a 35% compliance rate with competencies that was inaccurate.

We were told information was escalated to the trust board by the executive chief nurse who attended board meetings. We observed reports prepared by the head of midwifery and clinical governance partner were presented at board by the executive chief nurse.

Maternity services had dedicated safety champions who produced bi-monthly reports that were presented to the quality committee and shared with the board. The report included the maternity transformation programme; Better Births, Safer Maternity Care action plan, Saving Babies Lives Care Bundle, Each Baby Counts, Maternity Commissioners and Maternity Safety Champions. A recent report showed that there had been a 20% reduction in stillbirths.

Managing risks, issues and performance

Local leaders used systems to manage performance effectively. Relevant risks were identified. However, actions taken to mitigate risk were not always identified or actioned in a timely way.

Risk, issues and performance for maternity services were reported and managed within the women's and children's services care group and were discussed at key governance meetings including the care group governance and assurance meetings and clinical business unit (CBU) meetings.

We reviewed a selection of minutes provided and observed there was a set agenda with actions documented against a responsible person.

The women's and children's care service had a risk register. We reviewed the risk register and observed that each risk had a date it was identified, review date, responsible person, current risk score and actions taken to mitigate the risk.

We observed for one risk (security) there was no evidence of actions or controls taken to mitigate the concerns raised around fire doors with the overall effectiveness of controls recorded as mostly effective. We requested an update in relation to this risk and we were provided with evidence to show the risk had been reviewed in November 2019 and it was documented that the fire doors were going to be discussed with the fire officer and security. The risk had been added in March 2019 therefore we were not assured actions had been taken to address the risk in a timely manner.

We observed the risk description included a specific area at this hospital and another site.

However, following our inspection the trust told us this risk was not related to this hospital.

In addition, we saw the risk of baby abduction had been added to the risk register in 2012. This showed the actions taken to mitigate the risk, which had been completed in 2017, including review of staff awareness and abduction training and undertaking of testing in high and low risk areas.

However, the trust risk report for December 2019 showed that there was limited assurance for door access to unauthorised staff and visitors to the maternity unit or assurance that staff were trained to monitor and control

access to maternity wards ensuring that all visitors were identified before access was granted. The report also showed no assurance or control measures were in place for testing of the infant and child abduction policy.

We requested staff compliance in abduction training, but the trust did not provide this data and confirmed it was not delivered as part of the 'skills and drills' training for maternity services.

We requested, but did not receive, evidence that practical testing had been conducted across maternity services in the past 12 months. The trust provided evidence that the abduction policy was a standard item on the agenda of the labour ward co-ordinators meeting and staff had been reminded of the policy as part of a three-minute brief in April 2019.

The risk manager told us they reviewed outstanding actions on risks on a weekly basis and any issues were discussed at the care group governance and assurance meetings. However, we observed in data provided that 23.2% of mitigating actions for the care group were now beyond their review date.

Monthly quality assurance checks were completed on each ward. These included checks on medicines and the environment. Following our inspection, we were provided with a quality report dated November 2019 for Ward 17. The report showed that overall compliance was 96% with individual scores ranging from 86% (medicines management), 91% (safe environment) to 100% (patient questionnaires, safety and documentation, maternity and discharge). The data provided did not demonstrate which specific areas had been checked or include an action plan to address areas requiring improvement. We observed the report was discussed at CBU governance meetings and that staff reported actions plans were in place. However, we were not given any documented action plan to provide this assurance.

We were informed that a quality assurance check had not been submitted in November for the delivery suite due to high patient acuity.

Staff told us performance was monitored through the dashboard and audit and gave us examples of audits that had been conducted to monitor areas requiring improvement.

We were told development days were organised for band seven midwives across maternity services. This was an opportunity for peer support and for staff to raise any issues.

Monthly meetings were held for all band seven midwives across maternity services. Staff could dial into the meeting from their place of work or from home which had improved access and attendance at the meeting. Band seven staff we spoke to were positive about this way of working and said they would get their time back.

Managing information

The service collected data and analysed it. However validated data was not easily accessible to all staff to allow them to understand performance, make decisions and improvements.

The service had a maternity dashboard that was used to monitor and benchmark performance.

During inspection, we observed the electronic dashboard was accessible to all staff. However, we were told all the data did not always pull through and the midwife who was the lead on digital would add the correct data prior to sending. This meant all staff including senior leaders did not always have access to accurate data as the dashboard was not always a true reflection of current performance. In relation to training compliance, we noted that local service leads were using different data than information that the trust's central governance team held.

During our inspection, we were told the midwife lead for digital was working with the IT team to develop a new dashboard.

Following our inspection, we received a copy of the validated dashboard from October 2019. However, it did not demonstrate if data was improving or worsening and it did not document specific targets. Therefore, we were not assured how performance was being monitored.

Although the actions were RAG rated with two out of the nine green and an action point date (either September or November 2019), it was not clear when the action had been added, the date it should be completed by or the date it had been completed.

Good

Maternity

Following our inspection, we were provided with minutes from a quality committee meeting in April 2019 that documented proposals to issues associated with the way the metrics were being reported.

The women's and children's service had a dashboard that recorded staff compliance with core skills. However, we observed in the CBU meeting minutes that information recorded was not accurate as it had initially been set up incorrectly. Actions documented suggested this was going to be updated in January 2020. We were therefore not assured that data provided to the board for assurance and managing performance reflected the service's actual performance.

Good

Services for children & young people

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are services for children & young people safe?

Requires improvement

We did not rate safe at this inspection as this inspection was a focused inspection.

Mandatory training

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

The trust had a target of 95% compliance and above for annual mandatory training modules. Annual mandatory training for all staff included topics such as health and safety, basic life support, moving and handling, information governance, infection control level and fire safety. Mandatory training included early onset sepsis and neonatal sepsis training. Staff we spoke to were knowledgeable about sepsis and how to escalate concerns to medical staff.

Training was given as either e-learning or within a classroom setting. We were told staff received reminders when mandatory training was due and compliance with mandatory training was monitored by the matron and ward manager.

The mandatory training available met the safety needs of children, young people and staff.

During our inspection, we saw data regarding mandatory compliance for children and young people nursing staff at this location for basic life support (BLS) 100%, neonatal basic life support (NBLS) 90.9% and fire training 75%. The overall mandatory core skills training compliance for nursing staff was 92.9%. The paediatric medical staff mandatory training compliance was 79.8%. We were told staff had not been able to achieve the trust's target of 95% due to staffing shortages.

Post inspection the trust provided overall compliance for women and children's care group as 94%. We were told it was not possible to split the care group into maternity services and paediatrics due to the technical parameters of the training management system.

We reviewed three nursing staff's electronic training records and saw there was evidence of local workplace induction and planned training dates where needed.

Nursing and medical staff told us that they were supported to attend any training and were reminded of the need for them to remain up to date. Managers confirmed that they monitored mandatory training and alerted staff when they needed to update their training.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. This was not part of mandatory training but was included in ongoing areas of staff development.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Data for October 2019 showed safeguarding level three compliance

for nursing staff was 100% and medical staff was 85.71%. Safeguarding Children and Adults Level 1 was 94.9%, level 2 was 94.5%, Level 3 was 87.8%, Supervision Level 3 was 89.1%.

Staff gave examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. They described the support and guidance that they received.

Staff knew how to identify children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was safeguarding information accessible by staff on the trust's intranet. This included information on female genital mutilation (FGM), lessons learned from reviews, child sexual exploitation, domestic violence services, contact details for staff if they had any concerns, a referral pathway and guidelines. Staff and managers told us, and records reflected that incidents regarding safeguarding were reported and monitored. Staff described positive and supportive working with the safeguarding team.

Staff followed safe procedures for children visiting the ward. The service used physical security measures such as locked doors with swipes and access controlled by staff. There are also CCTV cameras and security officers available. Access to the wards was via an intercom, this was used for people entering and leaving the wards, minimising any unauthorised access. Access to the units was monitored during the week by the ward administrative staff, these staff were not available 24 hours a day at which time doors and CCTV were monitored by nursing staff.

An abduction policy was available that staff were aware of. This contained a flowchart and clear processes to follow. The abduction policy had been tested and lessons learned from this shared with staff. This learning was cascaded to staff by the ward manager.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks on admission. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Children's services used an early warning score tool, there were different charts for different age ranges, and they included information to assist nursing and medical staff as to the action to take in response to any indications of patient deterioration. Records reviewed showed evidence of appropriate responses to changes in scores. The ward managers informed us that the system in use was under review and they intended to move towards a new system that would include electronic records.

The neonatal unit did not use an early warning score but utilised safety huddles. Safety huddles were held three times a day and helped identify babies at risk of deterioration. Staff shared key information to keep children, young people and their families safe when handing over their care to others and during huddles. Doctors we spoke with described their handover arrangements and the medical rounds that they undertook to manage patient risk.

Staff knew about and dealt with any specific risk issues this included pathways for sepsis and the need to have all patients reviewed by a consultant within 14 hours of admission. We saw that patients were supported to return directly to the children's ward after discharge to be suitably assessed and supported.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a child or young person's mental health.

Staff completed risk assessments for each child and young person on admission using a recognised tool, and reviewed this regularly, including after any incident. Appropriate arrangements were made for psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide.

Children and young people requiring transfer to intensive care were stabilised on the ward where there were two high dependency cubicles. A regional paediatric transport service was used to transfer the children to other hospitals with paediatric intensive care facilities. There were clear pathways in place to support these transfers.

To support neonatal care, the service had recently developed and put into place a transition service. This was in place on the maternity unit for recently born babies. It was staffed for 14 hours by paediatric nurses and

monitored overnight by midwives with direct access to paediatric nursing staff. If needed this allowed the service to make sure specific interventions such as intravenous antibiotics (IV) could be carried out by paediatric nurses maintaining patient safety and reducing the need for admission to the neonatal unit.

To support neonatal care, the service had worked with the maternity service as part of the maternity and neonatal safety collaborative to develop and put in place a transitional care service. This service was provided on the postnatal ward for recent born babies. It was staffed for 12 hours by neonatal nursing staff and monitored overnight by midwives with direct access to paediatric medical staff. If needed this allowed the service to make sure specific interventions such as intravenous antibiotics could be carried out by neonatal nurses maintaining patient safety and reducing the need for admission to the neonatal unit.

Band 6 nursing staff were trained in advanced paediatric life support (APLS), this meant there was always an APLS trained member of staff on duty to maintain patient safety and respond appropriately in an emergency.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families 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.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance and adjusted the staffing levels as needed. A safety huddle with a proforma record was completed up to three times a day and discussions included patient acuity and staffing needs. This was used to make sure that there was enough staff available to safely meet the needs of patients.

Staffing levels were monitored against the RCN document 'Defining staffing levels for children and young people's services' and the neonatal unit used British Association for Perinatal Medicine (BAPM) guidelines for staffing. Staff and records reflected that these guidelines and the acuity determined by huddles was consistently met. When the service identified that staffing levels could be compromised particularly overnight, arrangements were made to divert new patients not already admitted to other children's wards at different hospitals. Prior to our inspection this had happened over the weekend. A patient had attended Accident and Emergency overnight however due to unforeseen circumstances the patient was unable to be transferred, as soon as the day staff arrived on the children's ward increasing the available number of staff the patient was transferred directly to the ward.

An escalation policy was in place for when staffing numbers were not met. Staff could be moved between the neonatal unit and children's ward and cross site to cover for vacancies. To maintain patient safety consideration was made as to the specific skills of the staff member. As an example, if neonatal staff transferred to children's ward they were exclusively allocated to support babies.

The service had low vacancy rates with a full complement of staff.

Medical staffing

The service had medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment.

The risk register identified two risks from 2017 that suggested there were not sufficient consultants to;

- meet the facing the future standards requiring patients to be seen by a consultant within 14 hours of admission
- to deliver the required standards in cardiac and allergy specialist services in paediatric outpatients.

However, medical staff reported that there was no vacancies and that consultant support was available as needed. Records viewed reflected that newly admitted patients were reviewed by an allocated paediatric consultant within 14 hours of admission. The service employed 11.52 whole time equivalent consultant there was a 0.11 of a consultant vacancy. We were therefore unclear why the risks remained as active risks on the risk register.

Medical cover was provided by consultants, middle grades and intermediate grades. There was always a minimum of

two doctors on site, one middle grade and one intermediate grade. Consultants worked a rotation with one week on the paediatric ward and one week on the neonatal unit

Cover for the assessment unit was provided by the medical staff covering the inpatient ward. The service had recently changed how assessments were managed, this meant that there was a separate assessment room that medical staff could utilise. This had reduced the length of time that patients waited to be assessed. Patients and their parents spoken with were complimentary and did not feel that they had waited a long time.

Medical staff took part in handovers and huddles which assisted them to adjust staffing levels and prioritise patients as needed. Nursing staff reported that medical staff were supportive and available.

The trusts policy regarding when patients were no longer paediatric patients was different to other services. As such patients could be on the paediatric ward if they were a day under their 17th birthday but allocated a consultant from a different adult speciality because they were over 16. This had resulted in patients over 16 experiencing delays in seeing the specific consultant. Incidents when this happened were recorded. Staff spoken with said it was a rare event as they were aware of this difference and tried to make sure that they contacted appropriate consultants as needed.

Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. Medical locum staff spoken with spoke positively about their induction and the support they had received.

Records

Staff kept detailed records of children and young people's care and treatment. Records were stored securely. Records were easily available.

There was a mix of electronic and paper records. Ongoing care and treatment were recorded in the electronic system. However, observations used to form a risk approach for potential deterioration were paper based. The ward manager stated that they were reviewing the inclusion of electronic observation charts to maintain easy access.

The electronic patient administration system used a flag system to indicate if a patient had specific needs such as communication, child protection, special needs or mental health that would require additional awareness and support from staff.

We viewed 14 patient notes, the majority were comprehensively completed. However, we saw in two sets of records dates, times and signatures were missing leaving an incomplete record of care and treatment delivered. The trust told us they did not undertake a specific standalone audit of patient care records/documentation, these were monitored through; matrons audits (a review of selection of patient records are part of this audit), quality assurance accreditation scheme audits (a review of a selection of patient records are part of these audits), corporate quality reviews (a small number of patients records systematically reviewed by the clinical nurse specialists in electronic patient record team) and targeted paediatric clinical audits which reviewed relevant sections of the patient's care records.

We observed staff transcribe patient observations from a piece of paper to the early warning system forms. This practice ran the risk of observations being transcribed incorrectly, lost or forgotten.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Electronic records required individual password access and paper records were kept securely in locked trolleys

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learnt.

Staff knew what incidents to report and how to report them. Staff told us they were confident that they frequently reported all concerns and received feedback for any incidents they had reported. Staff saw reporting safety incidents as a learning and quality development opportunity.

Staff raised concerns and reported incidents and near misses in line with provider policy. We looked at how

incidents were graded. Incidents were graded from no harm to catastrophic. The grading guidance did not include an element of potential risk of harm but was graded on outcome.

Local managers we spoke with told us that they reviewed all incidents checking the grading and referring to higher management if needed. The risk and governance team for children's and young people's services also reviewed incidents and grading requesting further investigation as appropriate.

Staff met to discuss the feedback from incidents and to look at improvements to children and young people's care at local team meetings. There was evidence that changes had been made because of feedback. Examples of this included the development of the transitional care service located within maternity.

Staff received feedback from investigation of incidents, both internal and external to the service. This was undertaken in newsletters, information available in staff rooms, at handovers and huddles.

Managers shared learning with their staff about never events that happened elsewhere. There was several minuted meetings that took place to review incidents and to look at the safety of patients as an ongoing theme. These included meetings at ward level, weekly patient safety summit, monthly governance and assurance group with items escalated to the health and safety Committee as needed.

A review of incident records showed that staff reported incidents clearly and in line with the trust policy. Safeguarding incidents were reported on an electronic system and staff and managers said these were the main themes. Managers said they were well supported by the risk and governance team who monitored incidents looking for specific themes to be escalated to the care group team as needed.

Staff spoken with understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation when things went wrong. It was not always clear in the 27 incident records viewed that where an incident was graded as moderate or above that the appropriate duty of candour letter in some cases had been sent within the recommended timescale.

Are services for children & young people effective?

Good

We did not rate effective at this inspection as this inspection was a focused inspection.

Competent staff

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

The clinical educators supported the learning and development needs of staff. Staff had different monthly training available that they could attend should they choose. Monthly teaching sessions covered a different topic each time, staff were encouraged to identify areas they would like input on.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Staff spoken with were complimentary about the paediatric and neonate development away day (PANDA). PANDA 1 covered mandatory training PANDA 2 contained more specific training such as breast feeding. Each shift included a competent band 6 nurse for advanced paediatric life support (APLS).

Managers made sure that all new staff had a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. The trust sent information following the inspection, but this did not separate maternity services from paediatrics. The data showed that leadership appraisals rates were 100%, band 1-7 appraisals were 87% and medical staff were 92%. Staff spoken with told us that they found appraisals of benefit.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes were made available. Staff commented that they received a significant number of newsletters and did not always have time to read the information. Managers printed out copies and made them available to staff with copies in a file in the manager's office and the staff break room.

Good

Services for children & young people

Managers spoken with identified any training needs with their staff and monitored staff individual training. Staff said they had the time and opportunity to develop their skills and knowledge. Where staff were unable to attend training, they were rescheduled as soon as possible.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that they developed their personal development plans following appraisal with their managers.

Managers and staff told us that there were opportunities for them to apply for training that was not specifically within their role. Staff reported that they were supported to attend this training after the application was approved.

Staff were not specifically trained to meet the needs of children and young people with mental health needs. However, there were opportunities for them to receive training such as self-harm. Staff spoke about the support they received from staff within the trust with specific roles such as a safeguarding, mental health and special needs and their availability to provide support and guidance.

Are services for children & young people caring?

Good

We did not inspect caring at this inspection as this inspection was a focused inspection.

Are services for children & young people responsive?

Good

We did not inspect responsive at this inspection as this inspection was a focused inspection.

Are services for children & young people well-led?

Good

We did not rate well-led at this inspection as this inspection was a focused inspection.

Leadership

Local 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 patients and staff. However, there was a lack of visibility of senior leaders. Senior leaders including the care group leads were not consistently visible at a local level.

Most staff we spoke with said that the care group leads were not visible. Staff we spoke with knew who the chief executive and the board for the trust were, but most said they did not see the executive team. Staff received a weekly bulletin from the chief executive.

Ward managers and matrons spoken with were enthusiastic about their roles. They had development plans for the services. Staff told us they understood what local leaders' ambitions were and how they could support improved quality.

Children's ward staff and neonatal staff said that there had been various improvements in the service over the last few years. Staff were particularly complimentary regarding their managers as there had been several changes over the last few years and the stability of local leaders was important to them.

Leadership development opportunities were available, including opportunities for staff. Individual development for leadership opportunities was discussed with staff at appraisals with development plans implemented to assist in succession planning.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The

service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff spoken with felt respected, supported and valued. They told us that the implementation of a behavioural standards framework had a positive impact. We saw displays on the wards outlying positive phrases such as "be proud of the role you do and how this contributes to patient care".

Staff felt positive and proud about working for their team. Recent social events had been attended by most of the team contributing to a positive teamworking approach.

Staff were aware of success by staff awards and through feedback. There was a display within the hospital that highlighted staff who had won awards in each area and what the award was for. Staff received an award pin to attach to their identification when they won an award.

Staff told us that they felt able to raise concerns without fear of retribution. They knew how to use the whistle-blowing process and about the role of the Freedom to Speak up Guardian. We saw information displayed as to how to contact the Freedom to Speak up Guardian if staff had concerns that they wished to share.

The leaders took appropriate learning and action because of concerns raised. We were provided with examples where this had occurred.

All staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff and volunteers.

Staff had access to support for their own physical and emotional health needs through occupational health.

Teams had positive relationships, worked well together and addressed any conflict appropriately. Relationships between nursing staff and medical staff were good, staff told us they felt able to challenge in a positive supportive team.

Governance

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

Local leaders had effective structures, systems and processes in place to support the delivery of its strategy. Leaders regularly reviewed these structures. These were supported by a risk and governance team for the service who reviewed incidents and fed into the governance arrangements to enable learning and changes in the service.

A clear framework set out the structure of ward and care group.. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed.

Staff at all levels of the service understood their roles and responsibilities and what to escalate to a more senior person.

Care group governance meetings were held monthly. Discussions included incidents, audits, complaints and risks. Care group performance reports were presented to the board.

A governance newsletter was produced to keep staff informed about governance issues.

A weekly patient safety summit was held to discuss incidents and look at any root cause analysis (RCA). Managers and staff said that shared learning within different services and hospitals of the trust were not always clear. Staff told us that they were reluctant to work in other hospitals of the trust. Managers tried to work with their peers in other hospitals but that this was not easily accomplished due to the distance between hospitals.

Following our inspection, we were informed the purpose of the weekly patient summit was to ensure staff were able to hear and share any learning throughout the organisation.

Local leaders produced quality assurance reports monthly. They did regular audits such as hand hygiene. Results of these were shared with staff. The trust submitted a copy of the children and young person's dashboard for December 2019. This monitored areas such as timeliness of patient assessment by consultant, access to children and young person's unit and return for treatment times (RTT). The system flagged when performance was trending below

target and this was discussed at relevant meetings to increase performance. The dashboards showed overall that where risks were identified action was taken and performance improved.

Managing risks, 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.

Managers reviewed and improved the processes to manage current and future performance. The service had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The care group team regularly reviewed the systems in meetings attended by local leaders and the learning made available to improve the service.

Local leaders were satisfied that clinical and internal audits were enough to provide assurance to care group managers.

Staff had access to the risk register and were able to escalate concerns as needed. The care group had a risk register in place and local managers were aware of risks relevant to their service. Risks were discussed with staff and their input utilised to add or remove risks on the risk register.

The risk manager told us they reviewed outstanding actions on risks on a weekly basis and any issues were discussed at the care group governance and assurance meetings. However, we observed in data provided that 23.2% of mitigating actions for the care group were now beyond their review date.

Managers monitored changes for potential impact on quality and sustainability.

Managing information

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.

Leaders used meeting agendas to address quality and sustainability. Staff said they had access to all necessary information and were encouraged to challenge its reliability.

Local leaders were assured of performance using key performance indicators and other metrics. Managers said they monitored the data they received, and variance used to inform performance.

Ward managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing, staff training, appraisals and patient care. Managers informed us that they were able to utilise this information at a ward level. However, when requested training and appraisal data from the trust they were unable to extrapolate this to ward level.

Systems were in place to collect data from wards and service teams and this was not over burdensome for front line staff.

Staff had access to the IT equipment and systems needed to do their work. IT systems were working, and they helped to improve the quality of care. Staff reported that there was consideration to make all patient records electronic.

Information governance systems were in place including confidentiality of patient records.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure all risks are assessed, monitored and actions taken to mitigate them are effective and timely. (Regulation 17)
- The trust must ensure that systems to collect and analyse data are effective. Such as the maternity dashboard accurately reflects current data or performance. That validated data is easily accessible to staff to allow them to understand performance, make decisions and improvements. (Regulation 17)
- The trust must ensure that it has appropriate arrangements in place to assure itself around staff competencies regarding equipment. (Regulation 18)

Action the provider SHOULD take to improve

- The trust should ensure all equipment is appropriately located for the purpose for which they are being used. (Regulation 15)
- The trust should ensure that incident records clearly evidence that duty of candour has been completed. (Regulation 20)
- The trust should ensure staff have access to child abduction and awareness training. (Regulation 18)
- The trust should consider increasing the visibility of senior leaders across maternity and children and young person services.

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 17 HSCA (RA) Regulations 2014 Good governance Providers must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Providers must ensure that systems to collect and analyse data are effective.

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure they can meet people's care and treatment needs.