Somerset NHS Foundation Trust

Yeovil District Hospital

Inspection report

Yeovil District Hospital
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Ratings

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

Our findings

Overall summary of services at Yeovil District Hospital

Requires Improvement

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 Yeovil District Hospital.

We inspected the maternity serviced at Yeovil District 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.

Yeovil District Hospital provides maternity services to the population of Yeovil in South Somerset, North and West Dorset, and the Mendips.

Maternity services include an outpatient department, maternity assessment unit, triage, maternity ward for antenatal and postnatal care (Freya Ward), delivery suite, two maternity theatres, bereavement suite, antenatal clinics and an ultrasound department. Between April 2022 to March 2023 there were 1259 births at Yeovil District Hospital.

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

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

This was the first time we inspected Yeovil District Hospital maternity services since merger of the two organisations. Our rating of this hospital went down. We rated it as requires improvement because:

- Our rating of inadequate for maternity services changed ratings for the hospital overall. We rated safe as inadequate and well-led as Inadequate.

We also inspected 2 other maternity services run by Somerset NHS Foundation Trust. Our reports are here:

- Musgrove Hospital – https://www.cqc.org.uk/location/RH5A8
- Bridgwater Community Hospital - https://www.cqc.org.uk/location/RH5K6

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited triage, the labour ward, the antenatal and postnatal wards.

We spoke with 18 staff including obstetric medical staff, midwives of different seniority, support staff and 2 women and birthing people. We received 2 responses to our give feedback on care posters which were in place during the inspection.

Our findings

We reviewed 9 patient care records, 6 observation and escalation charts and 5 medicines records.

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

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

Maternity

Inadequate

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

- Not all staff had sufficient training to recognise and understand how to protect women and birthing people from abuse and manage safety well.
- There was not enough emergency equipment to safely care for babies.
- The service did not always control infection risk well. Not all staff followed infection control principles because they were not adhering to the trust's uniform policy. Nor did all staff adhere to hand hygiene principles when entering clinical areas prior to administering care. Audits were not used to monitor hand hygiene and cleaning at the service.
- The service did not always have enough medical staff. There were gaps in rotas which were covered by locum doctors and there was only 1 consultant led ward round a day, other ward rounds were led by a registrar.
- Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service. Though staff were committed to improving services, they did not always have the skills and resources to do so.
- There was a lack of meaningful conversations and information regarding maternity services at executive board level.

However:

- The service had a safeguarding team who were available to offer support to staff when needed.
- The service acted and ordered additional emergency equipment to keep babies safe.
- The service was well maintained and visibly clean with effective signage in all areas.
- Staff worked together as a big team to cover areas where women and birthing people needed support.
- The service engaged well with women and birthing people and the community to plan and manage services.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this action as we believed a person would or may be exposed to the risk of harm if we had not done so.

Is the service safe?

Inadequate

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

Maternity

Mandatory training

The service did not ensure all staff kept up to date with all aspects of mandatory training and key skills.

Midwifery staff did not always keep up to date with all of their mandatory training nor were they always meeting the trust target of 90% compliance. For example, midwifery staff were 24% compliant with diabetes training, 25% compliant with equality and personalised care training, 61% compliant with fetal growth restriction training and 88% compliant with reduced fetal movement training. Low compliance in training rates could lead to midwives being out of date with new guidance and practices and lead to potential risks to women and birthing people and their babies. However, for other mandatory training modules such neonatal life support midwives were 92% compliant. The service provides staff with multi-professional simulated obstetric emergency training. (PROMPT) Compliance for PROMPT training ranged from 100% compliance for obstetricians and consultant anesthetists to 87% for midwives.

Following the inspection the trust advised us that the data they had supplied during the inspection was for e-learning training and did not reflect face to face training compliance. The trust said that following the trust merger they had made a decision to enhance some areas of training with face to face training and that these face to face training sessions would be completed by staff within the next 2 years, from April 2023.

There was not a process for how managers monitored mandatory training. However, staff completed training in day sessions so as not to disrupt staffing on the unit. We were told matrons would work clinically to cover staff for them to be able to complete their training and that the service tried not to pull staff off their training to work clinically.

Student midwives had access to a practice development midwife as well as a preceptorship midwife once they had qualified. The service supported a programme of international midwives who would join the service as a band 4 midwife support worker until they had successfully completed their Objective Structured Clinical Examination (OSCE's) at which point they would join newly qualified midwives on the preceptorship programme for 12 months.

Safeguarding

Staff had not received training at a level appropriate to their roles on how to recognise and report abuse. However, staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so.

We identified and the trust were already aware that staff were not trained to the correct level in safeguarding children and adults in line with national guidance. Following the inspection, the service leaders told us the named Safeguarding Midwife, supported by the Safeguarding Learning and Development Lead would urgently review training and map this to Level 3 Safeguarding adult training. We were informed that midwifery staff had been trained to level 2 safeguarding adults training. However, we did not receive compliance rates for this training. The National Safeguarding Intercollegiate Guidelines state that all staff risk assessing women and birthing people should complete training to level 3 in adult safeguarding.

Following the inspection, we received data for the staff that had completed level 2 safeguarding adults training. This data showed that 10 members of staff had never completed level 2 safeguarding training, whilst some of these staff were new to the service some had been with the service over 6 months and 1 member of staff without level 2 safeguarding adults training had been with the service since March 2022.

Maternity

Staff were required to complete children's safeguarding training up to level 3. At the time of the inspection, 82% of midwives had completed this training and 50% of doctors. This was below the trust target of 85%. There were no action plans shared with us to show how the service was going to improve their compliance for children's safeguarding training.

Leaders did not have effective oversight of safeguarding. Safeguarding was a quarterly agenda item at the monthly Maternity Governance meetings. We reviewed October 2023 meeting minutes where safeguarding was an agenda item and found training compliance was not discussed.

Staff we spoke with were able to demonstrate they knew how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act and understood their responsibilities to make referrals to the local authority. 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.

Staff asked women and birthing people about domestic abuse, at booking and at regular intervals during the antenatal period of care. There was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans in place with input from the safeguarding team.

The service safeguarding team had worked on joining together with the Musgrove Park Hospital safeguarding team before the merger of Somerset Partnership NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust in April 2023.

The safeguarding team was part of a trust wide safeguarding advisory services structure. There was a named midwife for safeguarding, and a deputy named midwife for safeguarding, who were part of a team of midwives who supported women and birthing people who required extra nurturing due to being identified as vulnerable or who have a range of identified social needs. These safeguarding midwives had access to support from the trust leads for safeguarding adults and children as well as a domestic abuse lead. The team held a caseload of women and birthing people as well as supporting the wider maternity team by being on call to offer safeguarding support to staff on the wards.

The named and deputy named midwife for safeguarding, offered quarterly and as and when needed safeguarding supervision to their team of midwives as well as annual safeguarding supervision to the wider midwifery team.

Staff used an electronic records system where they could place an alert on the system to make other staff aware of safeguarding concern for woman or birthing person and their babies.

There were systems and processes in place to ensure information is shared with other professionals such as GPs and health visitors.

We were told that the safeguarding team worked closely with the local authority and contributed to groups within the local authority safeguarding team and were part of the Southwest safeguarding network. They told us they were respected and listened to and that there was an escalation policy in place in case of professional disagreements.

Staff followed safe procedures for children visiting the ward.

The service had a newborn security guidelines policy which at the time of inspection was being updated. This policy had been issued in November 2018 and had been due to be reviewed in November 2020 and was therefore overdue review.

Maternity

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 and had further plans for another drill to be undertaken in January 2024.

Cleanliness, infection control and hygiene

Staff did not always use effective control measures to protect women and birthing people, themselves, and others from infection. However, they did keep equipment and the premises visibly clean.

During the inspection we observed not all staff were bare below the elbow whist in clinical areas, nor did all staff adhere to hand hygiene principles when entering clinical areas before administering care.

At the time of the inspection, the maternity service did not complete audits to monitor if staff were bare below the elbow and hand hygiene compliance audits. This meant leaders could not be assured that staff were followed infection control principles. Leaders informed us they did daily walk rounds of the service and would discuss these principles with staff that were observed not to be acting appropriately. Leaders told us there were plans to start hand hygiene and 'bare below the elbow' audits.

Maternity service areas were clean and had suitable furnishings which had been kept clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Domestic staff were available on the ward areas, and we saw them undertaking their duties. Safe colour coded cleaning equipment items were used, and waste was handled correctly.

During the inspection we asked 3 staff if they knew who in the service was the lead for infection prevention control. These 3 staff were not aware of who the lead was. Following the inspection the trust advised us that they did not have specific champions for infection prevention control and that this is the responsibility for the relevant manager of each area.

Environment and equipment

The design, maintenance and use of facilities and premises mostly kept people safe. Staff managed clinical waste well. However, not all areas of the service had sufficient emergency equipment available.

The service was accommodated over 3 floors of the women's hospital at Yeovil District Hospital. All areas of the service had clear effective signage.

Situated on the ground floor were antenatal clinics, ultrasound facilities, day care services, Consultant, and specialist midwife services. There was a separate room where staff were able to facilitate private conversations with women and birthing people, this room was furnished in a non-clinical way making for a supportive environment.

Maternity

The waiting area for antenatal clinics was shared with the gynaecology clinics. This conflicted with national guidance (Health Building Note – Maternity care facilities) where it is advised that waiting areas should be subdivided into separate waiting spaces.

The 1st floor housed an operating theatre and recovery room, used for elective caesarean sections and gynaecology procedures. The theatre was appropriately equipped, containing all equipment needed in an emergency. There were 4 slots a week for elective caesarean sections.

On the 2nd floor there was a dedicated triage service and the maternity ward (Freya ward). The triage area was for women and birthing people who presented with pregnancy related concerns. Triage consisted of 2 assessment rooms, 2 side rooms and a treatment area suitable for 2 women or birthing people and a waiting area. The waiting area had good visibility so that staff would be aware if a woman or birthing person became unwell whilst waiting to be seen or for a follow up review.

The maternity ward (Freya Ward) consisted of 3,4-bedded bay areas and 2 side rooms. Women and birthing people who required both postnatal and antenatal care were looked after on Freya Ward. As well as babies who required transitional care. Freya Ward was adjacent to the special care baby unit (SCBU). There was only 1 neonatal resuscitaire available on the 2nd floor of the service. This resuscitaire was located in the special care baby unit. The door joining SCBU to Freya ward was a locked door and meant that the resusciataire was not easily and immediately available if required. Freya Ward had some emergency equipment that could be used on a baby in an emergency, but this equipment was not stored correctly which meant there was a risk the equipment could be tampered with. There was not an appropriate alternative safe space to resuscitate a baby in the absence of a neonatal resuscitaire. In triage there was some adult and baby emergency equipment but no safe space for use or storage. This was reported to the trust who took action to ensure there was a further resuscitaire available for use across Freya Ward and the triage area.

Located on the 3rd floor was the labour ward an emergency theatre and a bereavement suite. There was no theatre recovery room on the delivery suite. Women and birthing people needing care following an emergency procedure would be cared for in a birthing room.

The labour ward consisted of 6 birthing rooms all with ensuite facilities. There were 2 neonatal resuscitaire for the 6 birthing rooms. There was a risk that if all rooms were in use there would not be enough neonatal resuscitaire. Staff carried out daily safety checks of specialist equipment. There were some gaps in checks. However, the majority of checks were carried out.

Across the corridor from the labour ward was a birthing room with a birthing pool, the birthing pool was staffed when needed and available for women and birthing people who were low risk and assessed as appropriate for a water birth. There was a resuscitaire available for the room with a birthing pool.

Also across the corridor was a bereavement room. This room was furnished to be less clinical with a pull-down double bed and a sitting area. Due to location of the bereavement room women and birthing people who were using this facility did not have to go through the main labour ward and would not hear other women and birthing people who were giving birth or newborn babies crying.

Call bells in all areas of the service were accessible to women and birthing people if they needed support and staff responded quickly when called.

Call bells in shower rooms and toilets were via a red cord. These had not been risked assessed for a ligature risk and as a result, were not encased in suitable material to minimise being used for this purpose. A National Patient Safety Alert was issued around ligature and ligature point risk assessment tools and policies in March 2020. The expectation on the response to this was to ensure risk assessments were undertaken and responded to. However, the service had not taken appropriate risk assessments to ensure staff were aware of ligature risks. This was raised with the service during the inspection who agreed that risk assessments need to be put in place.

The design of the environment mostly followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. On the day of the inspection, the secure exit system was not fully working. Leaders had acted promptly and appointed security personnel outside of the labour ward.

Medical equipment was not always serviced when it should have been. Records show that compliance for equipment testing was 85.8% across maternity services at the hospital. There was a risk that equipment currently in use was not safe or working effectively.

For staff visitors and women and birthing people to move between the 3 floors of the service there were 2 lifts, both lifts were large enough to accommodate a hospital bed. On the day of the inspection one of the lifts was broken, this had been reported and was awaiting repair. We were shown the guidance for staff to follow in the case of a lift failure. However, this guidance document should have been reviewed in September 2023, 2 months before the inspection. The birth partners of women and birthing people were supported to attend the birth and provide support.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Signage in all areas of the service was clear and easy to follow. On the delivery suite we saw signage saying welcome to “labour ward” in several different languages.

During the inspection there was maintenance underway and windows in the maternity service were being replaced. Contractors were liaising with staff to ensure the privacy of women and birthing people.

Assessing and responding to risk

Staff did not always utilise tools to identify if women and birthing people were at risk of deterioration and therefore there was a risk, they would not recognise concerns or act appropriately.

The service used a nationally recognised tool to identify women and birthing people at risk of deterioration. Staff used the Modified Early Obstetric Warning Score (MEOWS) to assess women and birthing people. We reviewed 6 MEOWS records and found staff had only fully completed 2 out of the 6. At the time of the inspection, there were no audits to monitor staff compliance with completing, scoring and escalating appropriately when a MEOWS showed deterioration in a woman or birthing persons condition. This meant that the trust did not have oversight of the effectiveness of staff’s use of the tool. It also meant that women and birthing people were at risk of staff not identifying that their health was deteriorating if staff had not noticed or documented the signs of deterioration. We brought this to the attention of leaders at the trust and have been advised audits will begin in December 2023.

The service currently complete newborn assessment observation and early warning score forms (NEWS) on their electronic records system. The service did not audit the use of the NEWS tool. Following raising our concerns a

retrospective audit of NEWS on the services electronic recoding system was undertaken. This showed 49.6% compliance rate of NEWS forms. Further audits were scheduled for 2024 and findings were to be discussed at the maternity and neonatal (MatNeo) governance meeting. The service did not share if an action plan was developed and implemented to improve the compliance of NEWS observations.

Women and birthing people who presented at maternity triage were assessed using a recognised, standardised risk assessment tool and pathway. An initial assessment would determine a categorisation of red, orange, yellow, or green, which guided staff to which women and birthing people needed ongoing care immediately, their prioritisation for follow up care which could include being seen by a doctor, or if they could be discharged home.

The service had looked at their available space and moved their day assessment area to the ground floor with the antenatal clinic to create a workable triage space.

The triage service was staffed by 1 midwife and a maternity support worker (MSW) and on the day of the inspection there was also a student midwife. The midwife was expected to answer phone calls as well as assessing and monitoring women and birthing people. We were told that when the midwife was not available the calls would be answered by either the student midwife or the MSW. If the call was not answered by staff in triage, it would be transferred to a phone on the labour ward. We were told that unqualified staff did not give advice, they would take the details of the caller and the midwife would return the call. Unless it was obvious that the woman or birthing person needed to be seen immediately in which case, they would be asked to come into the unit.

At the time of the inspection, telephone calls were taken in the clinical area by the midwife who was working on triage. This was not in line with national guidance and had led to incidents reported nationally by Healthcare Services Investigation Branch. There were plans to combine the telephone triage line with Musgrove Park Hospital’s maternity services and would ensure the telephone triage service would be staffed during high acuity hours between 7.30am and 8pm, and away from the clinical area.

In October 2023 there was an external review of triage in the maternity service. Feedback included positive feedback and where improvements could be made.

Positive feedback from their visit including, staff embracing the standardised care system, areas had been split into an excellent triage area, with an appropriate space for unscheduled attendees, good clinical oversight and the creation of a midwife-led clinic in the day assessment area away from triage for scheduled appointments and staff training.

During the inspection we found that due to staff training and competencies some scheduled appointments were still taking place in the triage area. For example, iron infusions (treatment for women and birthing people with low iron levels) were taking place in triage as the staff had the skills set and arrangements had not been made for a more appropriate place for these infusions to be administered. Additionally, the triage midwife on shift during the inspection had been called away to the outpatient clinic to give a patient a vaccine as the staff in clinic did not have the skills to do so.

The maternity triage service closed at 7.45pm, after this time women and birthing people needing the triage service wereseen on the labour ward. The service had not added additional staff on labour ward to cover triage. There was a risk that women and birthing people who use the triage service out of hours would not be seen within 15 minutes in accordance with national guidance.

Maternity

The service had not completed audits of the safety and effectiveness of the maternity triage. Leaders and staff did not have oversight and could not be assured that women and birthing people were seen within the timescales set out in the assessment tool or that all women and birthing people were all assessed and prioritised correctly.

Staff on the labour ward used the 'fresh eyes' approach to carry out fetal monitoring safely and effectively. We reviewed care records and could see that 'fresh eyes' observations were carried regularly every hour in line with national guidance and documented by labour ward staff.

We reviewed a draft report with data from July – September 2023 which was written following the inspection and mentioned CQC's review of care records during the inspection. The report stated that a review of the 'fresh eye' approach showed the 'fresh eyes' approach was used in 141 out of 145 occasions. However, this was a draft report and was not currently part of the services audit programme. The draft report stated there had been a delay in the audit due to the implementation of an electronic maternity records system and anticipation of changes to CTG guidelines. Leaders could not be assured of regular oversight of staff compliance with fetal monitoring at the service.

The service had a fetal monitoring action plan. However, this action plan did not comment on a 'fresh eyes' approach during induction of labour and was reliant on the trust updating their CTG guidelines.

Misinterpretation of intrapartum CTGs was on the service's risk register as the service had been using 3 classification tools. The mitigation for this known risk was to implement intrapartum fetal monitoring guidelines with a target date of November 2023.

The service provided transitional care for babies who required additional care.

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 women and birthing people with mental health concerns.

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

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care 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 women and birthing people and babies safe. During the inspection, we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third party organisations were informed of the discharge.

Midwifery Staffing

Maternity

Staffing levels did not always match the planned numbers and staff did not always have the right skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. The service did not always make sure all staff were competent for their roles. Not all staff had received an appraisal of their performance or support with their development.

Staff were allocated to the different areas of the service daily depending on the acuity in each area. Managers moved staff according to the needs of the service. We were told by leaders that there were currently no midwifery vacancies at the service. The chief nurse reported in the September 2023 six monthly staffing report to the trust board that 21 of the

student midwives who trained at the trust had been successfully recruited to the service with planned start dates in October 2023.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between 1 July and 20 December 2023, the service reported 21 red flag incidents. These included 10 occasions where there was more than 2 hours delay in admission for an induction of labour and the beginning of the procedure and 7 occasions where the supernumerary status of the labour ward coordinator was not achieved. Red flags were reported and discussed at trust board and Quality and Governance Assurance Board sub-committee.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers, needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in December 2021. This review recommended 67.04 whole-time equivalent (WTE) Band 3 to 8 compared to the funded staffing of 65.45 WTE, a shortfall of 1.59 WTE staff.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. They worked closely with a matron who had wider oversight of the services. Due to the occasions where it had not been possible for the labour ward coordinator to achieve supernumerary status, it was discussed at the September 2023 board meeting.

We asked the service for information regarding their use of agency and staff sickness rates. However, we did not receive this information.

The trust had specialist midwives such as a bereavement lead, safeguarding and audit midwife that covered both Musgrove Park Hospital and Yeovil District hospital. There were other specialist midwifery roles such as infant feeding, digital, governance and screening leads who were based at the service in Yeovil District hospital.

The service had recruited 2 international midwives both had passed their Objective Structured Clinical Examinations (OSCE's) and were working in Band 5 preceptorship roles.

Staff told us they worked as one big team and that senior and specialist midwives worked clinically when needed, or to cover for midwives to take their breaks and attend training. Due to the way managers allocated staff, they were all familiar with areas within the service and did not feel they were asked to work in an area they were unfamiliar with.

Band 5 preceptorship midwives told us that the service was a supportive, friendly environment. They received monthly catch ups from the preceptorship lead and benefitted from a buddy system.

The service had its own bank staff who were familiar with the service and made sure all bank and agency staff had a full induction and understood the service. shifts that needed to be covered were done so by staff from wither the continuity of carer team or by bank staff who already work at the service.

The service did not always make sure all staff were competent for their roles. Not all staff had received an appraisal of their performance or support with their development.

Staff told us they felt supported by their managers. However, when we reviewed data on the number of staff that had received an appraisal only 50.5 % of midwives had received an annual appraisal within the last 12 months prior to our inspection.

The service had a practice development lead and a practice development midwife who supported staff with training. The practice development team had won an award for their work around 'Implicit Bias' in maternity care 2022. This award was around their approach of treatment and recognising signs of deterioration in babies of all skin colours and was won after they entered a competition to gain funding for resuscitation dummies in different skin colours to support staff's understanding of monitoring vital signs.

Medical staffing

There was not always enough medical staff with the right qualifications, skills, training, and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. However, recruitment had been on going. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service always had a consultant on call during evenings and weekends. We were told by medical staff that there was not always a consultant present for the 2nd ward round each day, where there were gaps the ward round was led by a registrar. This was not in line with Ockenden recommendations made in February 2021, which recommended that there must be a minimum of twice daily consultant led ward rounds. This meant the service did not always have a good skill mix and availability of medical staff on each shift. Following the inspection the trust shared data regarding consultant presents at ward rounds. This showed there were some gaps. However, the majority of times when the ward round was not in full attendance this was due to none attendance of anesthetist. The trust also shared a consultant obstetrician job plan which stated the consultant coved the 2nd ward round as part of their hot week duties.

The service had vacancies for medical staff. There were 3 vacant registrar posts of which 2 posts had been filled put the post holders had not yet started at the service. Medical staff we spoke to said gaps in the rota were covered by locum doctors.

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

The service had an induction handbook for doctors on rotation at the service covering maternity and gynaecology. As well as a locum induction checklist, that was to be completed on the first shift for any new locums working at the service.

Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Junior doctors told us that they knew who to escalate concerns to.

Maternity

Records

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

The service had started using an electronic recording system specifically designed for use in maternity services in February 2023. Some staff were still getting used to the system. We reviewed 9 electronic records. Most women and birthing people's notes were comprehensive, and all staff could access them easily. However, we found that not all records were fully completed. It was not always recorded where additional risk factors in pregnancy were identified as high risk and required additional monitoring. These risk factors varied from high body mass index to social factors. The lack of documentation of these risks put women and birthing people at risk of not receiving the correct treatment.

Leaders had not audited the use of the electronic recording system in the time since it was implemented in February 2023. This meant that leaders could not be assured of the quality of recording. We were told that there were plans to audit the electronic records in March 2024.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

The service had a digital midwife who was able to support staff when needed with any issues relating to the electronic records system.

The trust had previously used a different patient administration system (PAS) and it had been identified that when transferring data from PAS to the maternity electronic records system, that women and birthing people's ethnicity was not being accurately recorded. This had led to a project by the digital team to review and implement changes.

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. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 7 prescription charts and found staff had correctly completed them.

Staff reviewed medicines regularly and provided advice to women 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. 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. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct

temperature. The temperature of the clinic room where medicines were stored was monitored by the pharmacy team. To Take Out (TTO'S) in the medicines cupboard on Freya ward were dated the month before the inspection. These medicines were given to staff who returned to the pharmacy Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services.

Staff completed e learning courses on medicine management. The trust did not monitor staff's ongoing competencies around medicines management.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents; Incidents were not always correctly categorised. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. However, there was not effective systems in place to ensured that actions from safety alerts and lessons learned 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 could describe what incidents were reportable and how to use the electronic reporting system. The service had an incident reporting and management policy for staff to follow which set out actions staff must take along with roles and responsibilities.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. The governance lead for midwifery had oversight of daily incidents and serious incidents. Incidents were discussed at weekly maternity governance meetings, and monthly at Maternity and Neonatal (MatNEO) governance meetings. However, the grading of incidents had not been minuted at these meetings.

We reviewed 115 incidents reported in the 3 months before inspection. The leaders could not be assured all were fully reviewed to promote investigation and improvement such as for obstetric haemorrhage. However, those graded as serious incidents did have a thorough investigation with a 72 hour review and were also discussed at the trust serious incident review group. We reviewed 2 such incident review reports. These reports showed involvement and views of the women, birthing people and the families in the incidents. Managers shared duty of candour and draft reports with the families for comment. However, actions from reviews were not always clear or had an assigned owner to carry out any actions.

Learning was shared with staff by email on a learning from incident review forms. Staff met to discuss the feedback and look at improvements to the care of women and birthing people as part of their perinatal meetings for all staff, at Band 6/7 meetings as well as using governance boards across the service. However, there was often a delay between the completion of the audits and creating an action plan to make improvements. Any action staff were asked to undertake was not followed up with an audit therefore leaders could not be assured that staff were making changes or that the proposed changes had been effective.

There were 2 'never events' at the service in the 3 months prior to the inspection, in maternity theatres. 'Never events' are incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

These events had been investigated and action taken to improve systems in the maternity theatres. These actions included improvements made to the use of World Health Organisation (WHO) surgical safety check list and procedures used to trigger action in cases of massive obstetric haemorrhage (MOH). However, there had been no audits undertaken on how effective these changes had been.

We did not identify any evidence that managers reviewed incidents potentially related to health inequalities.

Managers debriefed and supported staff after any serious incident. We were told debriefs looked at what went well as well as where things could be improved and supporting staff.

Is the service well-led?

Inadequate

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

Leadership

There was a newly established leadership team in maternity services. The maternity leadership team for the trust was formed as part of the trust merger in April 2023. Some leaders had been in post for only 2 weeks before the inspection. Leaders had not prioritised audits to ensure the quality of the service. Some leaders were more visible than others. Executive leaders did not always understand and manage the priorities and issues the service faced.

Maternity services at the trust were managed as part of the service group for children, young people, and families. This included services such as child and adolescent mental health services (CAMHS) women's sexual health and maternity services.

The structure of the senior leadership team did not support effective clinical oversight of maternity services. The service group had a quadrumvirate that consisted of the director of midwifery (DOM), an associate director of patient care for the service group, the associate medical director for obstetrics and gynaecology, sexual health and dental, who was a vascular surgeon and a paediatric and neonatal doctor. There was not a dedicated triumvirate/quadrumvirate for maternity services.

Actions from senior leadership team meetings were not tracked effectively. The quadrumvirate leadership team told us they met every 2 weeks. There were no minutes to these meetings, but they kept an action tracker of actions agreed. This tracker showed all items as completed. However, not all items had a date that they were completed and 1 item marked as green stated it needed further action.

The associate director of patient care for the service group and the director of midwifery (DOM) reported to the safety champions twice a month. There were 3 board level safety champions, which were the chief nurse and 2 non-executive directors. The safety champions then reported up to the board. The DOM informed us that they attended board level quality and safety meetings where they presented maternity information, and that they attended board meetings 3-4 times a year. However, on review of the public board meetings for the year of 2023 the DOM was not listed as attending, we did not receive minutes for the quality and safety meetings.

Maternity

We reviewed the maternity safety champion meeting minutes for the last 5 meetings and found that there was poor attendance from the Trust board level safety champions. From meetings held in May 2023, July 2023, August 2023, September 2023, and October 2023 there was only 1 occasion out of 5 when 2 safety champions and the DOM were present. This at times led to the meeting not being quorate, which was minute but led to no improvement in attendance. We also saw that the effectiveness of the meetings was questioned, attendees noted improvements were needed around learning shared at the meeting, but this led to no evidenced improvements in this area. Those in attendance were unable at times to progress actions due to lack of attendance from key members. We also spoke with the 3 board safety champions. They were consistently positive about the assurance they received about the service and did not demonstrate an awareness of the challenges in the service. The service could therefore not be assured of the effectiveness in the board safety champions being cited on maternity issues and driving quality and safety improvements.

We saw maternity briefing reports for the quality and governance assurance committee (Q&GAC) which was a subcommittee to the board. Areas of concern would then be highlighted for escalation and discussion at the public board meeting. It was not clear from the Q&GAC briefing minutes provided who attended those meetings, or if there was an overarching action plan to track progress. The reports were discussed at board level and staffing within maternity was included as part of overall staffing discussions. We also saw that the board had reviewed the risk register which included risks over 15 which also sat on the corporate risk register, this included risks around theatres and estates with maternity. The board could not be properly cited on issues around audits, poor attendance at meetings (which impacted compliance with the maternity incentive scheme) and poor compliance with training and appraisals as these were not included in the Q&GAC meetings and the service had poor oversite of the issues faced.

The figures presented to the board did not match up with data we received around incidents for the service or from the data supplied from the combined maternity and neonatal (MatNeo) governance meetings. In the board papers, figures showed that there had been no babies born in an unexpected poor condition between the months of October 2022 and September 2023. The combined MatNeo governance meeting showed data from August 2022 to September 2023 where there had been 5 occasions where therapeutic cooling of babies was needed, on 4 of these occasions' babies needed to be transferred to a specialist unit in another hospital trust. There was also a missed opportunity to provide the board with regular key safety performance information such as delayed induction of labour and meeting national guidance for emergency caesarean sections. Following the inspection the trust advised us that at the time of the inspection the MatNeo governance meeting was not covering both hospital sites. This meeting did not cover Yeovil District hospitals maternity service. This was not clear when reviewing the documentation, nor was it clear from the board papers if the executive board had oversight of the maternity service at both hospitals.

Executive leaders were not always visible in maternity services. Staff told us the head of maternity was visible and approachable in the service for women and birthing people and staff. However, when asked about visibility of the director of midwifery, who covering both Yeovil District Hospital and Musgrove Park Hospital, and the executive leadership team not all staff felt they were as visible. However, staff told us they were well supported by their line managers, ward managers and matrons.

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.

Maternity

There was a systems strategy, combining maternity and neonates' The strategy had been written in 2023 after the recommendations from the Ockenden 2020 and 2022 reports. Also, with the merger between Somerset Foundation Trust and Yeovil District Hospital in mind. They had a vision for what they wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Staff could explain the vision and what it meant for women and birthing people and babies. The progress and oversight of the strategy was monitored at a systems level.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, it was not clear that leaders and staff understood and knew how to apply processes in the strategy and there were no systems in place to monitor progress.

Culture

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

We received mixed feedback on how well staff were supported. Most staff felt respected, supported, and valued and said that there was a good working relationship between staff groups. However, some staff told us that they felt more could be done to support junior staff, that the culture at the service could be hierarchical and that consultants were felt on occasions to be dismissive during professional disagreements. Most staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff at the service said that they benefitted from working across the service as one big team. Most staff, but not all said that the merger with Musgrove Park Hospital had been a positive move.

The service had recognised culture at the service to be of concern. Poor culture had been added to the risk register. The risk register stated that there was an action plan in place with a target date of January 2024. Leaders were planning to monitor staff feedback from a range of sources such as exit interviews, freedom to speck up and reviews of incidents.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' 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.

The trust had an equality and impact assessment tool that was used when creating and reviewing policies and procedures. This assessment tool had been discussed at board meetings where the outcome had been, more should be done to ensure that the tool is used to assess reports prior to them going to board. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women 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. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints, 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. We reviewed the trusts responses to the last three complaints and found complainants questions were responded to in detail and a full apology given. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

We did not see evidence of leaders exploring and understanding how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. There was no evidence that incidents were reviewed in relation to whether ethnicity or health inequalities may have impacted outcomes.

Governance

Leaders did not operate effective governance processes throughout the service. Leaders did not have clear oversight of the service. However, leaders made referrals to partner organisations when this was required.

The service did not have an effective program of regular local audits to ensure the safety and quality of the service was monitored and processes to learn from incidents were not effective.

The service did not have effective governance processes. The governance structure did not always support the flow of information from front line staff to senior leaders and vice versa. Governance and safety champion meetings took place but were not always well attended by senior leaders. We saw discrepancies in information about key safety and performance metrics at a service level to information and key safety and performance metrics discussed at executive board level.

We reviewed the last three meeting minutes of the governance meetings and the combined maternity and neonatal governance meetings. We found that the number and type of incidents were broken down, the risk register was discussed, and issues such as complaints, training, acuity, guidelines, and safeguarding were also discussed. However, there was a lack of clear action and accountability from these meetings to drive improvement.

Data and key performance metrics discussed at governance meetings was often a year old and therefore we were not assured any themes and trends were actioned or responded to quickly.

Maternity quality surveillance data reviewed at this meeting was minimal and only included raw data of the numbers of PPH incidents, shoulder dystocia, 3rd and 4th degree tears rather than statistical process charts to map trends over time. Further work was needed to make the information presented more meaningful and provide context.

Governance meetings were not always attended by the head of midwifery or the director of midwifery. It was unclear if this meant that actions could not be decided upon as some items had actions whereas others did not.

The service did not have effective systems in place to ensure staff received regular supervision and appraisals. Required staff training had not been completed by all staff. Ineffective systems had led to staff not being asked to complete safeguarding level 3 adults training, due to a lack of oversight of the training mapping. Systems for ensuring the safety, oversight, maintenance, and monitoring of equipment were not effective.

Maternity

Leaders at the service had not recognised the need and their responsibility to ensure the oversight of quality at the service. As well as not ensuring an effective audit programme was in place, there was no effective process for reviewing and updating policies and guidelines. Senior leaders were not always present at governance meetings or invited to present information regarding the service at executive board meetings. Following the inspection, we were advised that the trust had devolved responsibility for oversight on maternity governance issues to the Quality and Governance Assurance Committee. We were told senior leaders were always present to discuss the reports in detail at these meetings. However, the data we received for these meetings did not state who was present at the meetings or what escalation the Quality and Governance Assurance Committee would follow regarding information of concern.

The maternity safety champions covered maternity and neonatal services on both Yeovil District Hospital and Musgrove Park Hospital sites. However, the visit to Yeovil District Hospital was not regular with the last recorded visit as July 2023 with 2 safety walk rounds of the maternity services. However, there was a safety champions' board displayed in the service advising staff of who the safety champions were as well as information on the next walk round.

The director of midwifery (DOM) reported to the safety champions twice a month. There were 3 board level safety champions, which included the chief nurse and 2 non-executive directors. The safety champions then reported up to the board. We were told that the DOM attended board level quality and safety meetings where they presented at board meetings 3-4 times a year.

Maternity safety champions were not effective in their role in improving 'floor to board' communication. We reviewed 5 notes and actions from maternity safety champion meetings between May and October 2023. There was only 1 occasion out of 5 when 2 safety champions and the DOM were present.

We raised our concerns about the governance of the service following the inspection. Leaders told us they would review their systems for oversight within maternity to ensure oversight of the training and appraisal position improved and staff were clear on their accountabilities.

Management of risk, issues, and performance

Leaders and teams did not used effective systems to manage performance. They did not always identify and escalated relevant risks and issues or take actions in a timely manner to reduce their impact.

The service did not have an effective program of regular local audits to ensure the safety and quality of the service was monitored and processes to learn from incidents were not effective.

There were significant failures in audit systems and processes. Audits we would expect a service to undertake for leaders to have oversight of key safety and performance metrics were not being regularly undertaken. For example, the service had not audited the use of Modified Early Obstetric Warning Score (MEOWS), newborn assessment observation and early warning score forms (NEWS), triage, handover tool Situation Background Assessment (SBAR), World Health Organisation theatre checklist (WHO) or the electronic records system.

When improvements had been made at the service, they were not monitored to ensure they were fully implemented or that best practice were being followed. For example, a maternity electronic record system was implemented in February 2023. However, there had been no audits of the system to ensure staff were using the system effectively. In governance meetings leaders could not assure themselves that a drop in reporting was not down to poor record keeping. In September 2023 and in October 2023, it was recognised in the maternity governance meeting minutes that staff may not always be recording information correctly on the electronic patient record system and that audits may be pulling the

information from several places. However, despite the electronic patent record system being in place since February 2023 there had been no audit of how well the system had been implemented or the quality of the record keeping. We discussed this with the service during the inspection process and were advised that the trust's governance team would support the maternity governance team to develop a more coordinated approach to auditing.

Risks were not always identified by leaders through the service's incident management systems. When risks were identified the service did not always act promptly to take action. The service had not recognised safety risks that were identified on inspection. For example, leaders at the service had not recognised that the service had insufficient resuscitaires to meet the needs of the service based on number of birthing rooms, nor had they completed risk assessments for areas of the service that did not have immediate access to a resuscitaire. Following the inspection and our feedback, the service acted by ordering more resuscitaires and putting risk assessments in place.

The service had a risk register which identified a risk score, risk lead and owner. Risks were reviewed. However, the register did not state when the risk had first been added which meant we were not able to assess how well the service managed these risks. Following the inspection the trust told us that their risk register does include the dates that risks are added to the register. However, this information was not shared with us.

The service took part in national audits. Data was obtained and reported at trust level to the National Maternity Dashboard. Results across all metrics were within expected limits and so the trust was not considered an outlier. For example, the rolling 6-month average rate for perineal trauma (also referred to as 3rd and 4th degree tears) in March 2023 was 37.2 per 1,000 births across the trust against the national average of 27 per 1,000 births. The rolling 6-month average rate in March 2023 of post-partum haemorrhage of 1500 mls or above, was 44 per 1,000 births across the trust, against the national average of 29 per 1,000 births. The rate on a rolling 6-month basis in March 2023 for the number of pre-term babies born per 1000 births was 54.7 which is lower than the national average of 63 per 1000 births.

Information Management

The service collected reliable data. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. However, service did not always analyse it in a timely manner.

The service collected reliable data, but there was not always evidence that the service leaders had analysed the data in a timely manner. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Staff could find the data they needed.

The information systems were integrated and secure.

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff engaged with women and birthing people. They collaborated with partner organisations to help improve services for women and birthing people.

Maternity

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The MNVP told us they felt embedded into the service, that leaders at the service were approachable and that they felt listened to. They told us that they had worked with the trust on 2 main projects. These projects were on personalised care and bereavement care.

The service made available interpreting services for women and birthing people. Staff were able to tell us of times when interpreting services had been used. However, it was mainly a telephone service that was utilised.

Leaders understood the needs of the local population. They were able to inform us of their local demographic and had continuity of carer teams in postcode areas where they were most needed.

We received 2 responses to our give feedback on care posters which were in place during the inspection. Of these responses we had a mixed response 1 both positive and mixed response.

Learning, continuous improvement and innovation

Learning from incidents was shared with staff. Improvements needed to be made to the way in which leaders at the service recognised and encouraged staff to use quality improvement methods and to participate in research.

When things went wrong the service looked at incidents and identified learning on how they could improve and added situations from the incidents to their training programme. There was a learning board in the labour ward office where information on the emergency of the month was shared. Information on learning was also shared by email to all staff.

We were given details of a local maternity and neonatal systems (LMNS) funded project that had supported staff with empowering, resolving problems and improving access to support. We did not however see any evidence of quality improvement meetings where those involved would look at ways in which they could improve their service through quality improvement methodologies.

The service did not have a quality improvement champion to coordinate and develop quality improvement initiatives. For example, an improvement at the service was where leaders had put in place white boards to ensure a live count of swabs used during birth in birthing rooms and theatres. However, this had not been followed up with an audit of how effective this new process was or if staff were using the process correctly. Additionally, this new way of working had not been shared with or taken on by Musgrove Park Hospital, another maternity service within the same trust. Following the inspection, we were advised that these improvements had been embedded at Musgrove Park Hospital. However, we observed to not be the case during our inspection.

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

Outstanding practice

We found the following areas of outstanding practice:

The service had won an Award for the introduction of ‘Implicit Bias’ and training recognising signs of babies being unwell by using resuscitation dummies of different skin colour.

Maternity

Areas for improvement

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

Action the trust MUST take to improve:
Maternity

- The service must ensure staff are up to date with maternity mandatory training modules, including adult and children's safeguarding training at level 3. Regulation 12 (1) (2) (c)
- The service must ensure staff accurately complete, and document modified early obstetric warning scores and newborn assessment observation and early warning score forms in order to identify and escalate women and birthing people and babies at risk of deterioration. Regulation 12 (2) (a) (b)
- The service must ensure effective risk and governance systems are implemented which supports safety and quality care. Regulation 17 (1) (2)
- The service must ensure that policies are up to date and reviewed in accordance with the review date. Regulation 17 (1) (2)
- The service should ensure all staff must receive annual appraisals. Regulation 18 (2) (a)
- The service must ensure electrical equipment is properly maintained. Regulation 15 (1) (e)

Action the trust SHOULD take to improve:

- The service should ensure that all staff adhere to the uniform policy to maintain effective infection prevention control.
- The service should consider a review of arrangements for twice daily consultant led ward round to comply with national guidance.
- The service should consider monitoring incidents by ethnicity to evaluate incidents and clinical outcomes to ensure equality in maternity care.

Our inspection team

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