Mersey and West Lancashire Teaching Hospitals NHS Trust

Ormskirk District General Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Ormskirk District General Hospital

Inspected but not rated

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Ormskirk District General Hospital.

We inspected the maternity service at Ormskirk District General 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.

The hospital provides maternity services to the population of Mersey and West Lancashire.

Maternity services include antenatal clinics, an antenatal and a postnatal ward, triage and a consultant led delivery suite. Between April 2022 and March 2023, 2212, babies were born at Ormskirk 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 Ormskirk District Hospital maternity services since the acquisition to form Mersey and West Lancashire Teaching Hospitals Trust.

We also inspected 1 other maternity service run by Mersey and West Lancashire Teaching Hospitals NHS Trust. Our reports are here:

Whiston Hospital - https://www.cqc.org.uk/location/RBN01

How we carried out the inspection

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

We visited pregnancy assessment unit (PAU), triage, delivery suite, and the maternity ward.

We spoke with senior leaders, 3 obstetric medical staff, 9 midwives, 1 support worker, 2 women and birthing people and 2 birthing partners and/or relatives. We received 80 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 6 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 looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents, audits and action plans. We then used this information to form our judgements.

Our findings

You can find further information about how we carry out our inspections on our website:

https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement

Our rating of this service is requires improvement

- The service did not always deploy staff effectively to meet the needs of the service. Staffing levels did not always match the planned numbers. There was a risk of delays due to insufficient staffing in triage.
- Staff did not always document and use risk assessment tools effectively. There was a risk that staff would not recognise signs of deterioration.
- There was a risk that some equipment and facilities such as delivery beds and bathrooms had become old and were not fit for purpose.
- Leaders did not always operate effective governance systems. They did not consistently monitor the effectiveness of the service.

However:

- The service controlled infection risk well. The service had enough emergency equipment to keep women and birthing people safe.
- Staff were committed to improving services continually.
- Staff understood the service's vision and values, and how to apply them in their work.
- Staff were clear about their roles and accountabilities.
- Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- The service engaged well with women and birthing people and the community to plan and manage services.
- The service managed safety incidents and learned lessons from them.

Is the service safe?

Requires Improvement

We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, not all staff had completed pool evacuation training.

Midwifery staff and medical staff received and kept up-to-date with their mandatory training. Staff from all staff groups were 100% compliant with training for cardiotocography training. Cardiotocography (CTG) is used to measure the fetal heart rate and monitor contractions in the womb. All staff groups were above 90% for basic life support training (BLS). Midwives were 87% compliant with neonatal life support training, whereas all other staff groups were above 90% compliant,

The service used an online interactive eLearning tool. Data showed all staff groups had completed this training at above 99% compliance.

The service made sure that staff received multi-professional simulated obstetric emergency training.

There was a 3-year rolling training plan for multi-professional maternity emergency training, which covered 4 out of a possible 8 topics of emergency per year. We saw a training day plan which covered sepsis, eclampsia, and postpartum haemorrhage. Overall compliance across all staff groups was 88% against a target of 90% however, compliance varied across staff groups. Consultants, midwives, and support workers were all above target compliance at between 92% and 96%. However, junior doctors and specialist anaesthetists were below target at 78% and 83% compliance respectively.

Records showed 89% of staff had received initial training on emergency evacuation of the birthing pool. However, 76% of staff had not had refresher training in the previous 12 months. Some staff we spoke to during the inspection could not describe how to safely evacuate a woman or birthing person from the pool. This presented a risk that safe care would not be provided in an emergency. This was fed back to leaders during the inspection who took prompt action to put training in place. We were told following the inspection that staff were updated with a bespoke training session supported by the manual handling trainer and a live drill was undertaken on 20 December 2023.

Fetal surveillance training consisted of electronic learning modules and a face-to-face teaching session, which covered a variety of factors that impact fetal wellbeing, interpretation of results, and decision-making. Midwives and obstetric consultants were 95% and 92% compliant respectively, junior doctors were 72% compliant, which was not enough for the service to be assured clinicians were competent and had the most up-to-date training to make safe decisions about people's care.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

Safeguarding

Staff understood how to protect women and birthing people 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.

Staff received training specific for their role on how to recognise and report abuse. Leaders identified that senior midwives' (band 7 and above) would be trained to safeguarding adults' level 3 and all other clinical staff would be trained to safeguarding adults' level 2. The training needs analysis had been reviewed and signed off by the integrated care board.

We found that 85% of Midwives and 86% of medical staff were compliant with safeguarding adults' level 2 training and 100% of those eligible were trained to safeguarding level 3. For safeguarding children level 3 data provided showed 90% of Midwives and 90% of medical staff were trained.

Staff we spoke with said that they had received safeguarding training and knew how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. However, given the staff were not trained to level 3 in adult safeguarding there was a risk staff would not know how to support vulnerable women and birthing people.

Maternity

Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Women and birthing people would be asked this at appropriate times during antenatal appointments. Where safeguarding concerns were identified, women and birthing people had birth plans with input from the safeguarding team and maternity services attended regular meetings with social services.

The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

The service had a named midwife for safeguarding who was supported by the trust's safeguarding lead for adult and children's safeguarding. There was a matron at the service who had safeguarding responsibilities as part of their job description and the service were in the process of implementing safeguarding champions. The service had access to 2 domestic abuse advisors.

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 a baby tagging system was used. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

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

Maternity service areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were cleaning schedules on ward notice boards. The service generally performed well for cleanliness.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. During the inspection we observed staff to be suitably bare below the elbow.

Data showed infection prevention and control audits were completed every month in all maternity areas. Since July 2023, compliance was consistently above 98%. An infection control action plan showed all actions were completed or ongoing to achieve and improve infection control compliance. During the inspection we saw hand hygiene information for the month of November displayed in the delivery suite with compliance of 100%

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.

Staff used I am clean stickers to identify that equipment had been cleaned.

Environment and equipment

The age of the facilities and equipment did not always support the needs of women and birthing people. The design and use of facilities and equipment did not always keep people safe. Staff managed clinical waste well.

The triage area was for women and birthing people over 16 weeks gestation and up to 42 days postnatal who presented with urgent pregnancy related concerns. However, we observed during the inspection and staff gave us examples of

non-urgent referrals to triage such as for raised blood pressure, gynaecology referrals for review, and scan reviews. These referrals came from medical staff within the service and midwives staffing triage were often not told of the referrals prior to the referred person arriving in the triage area. There was a risk that non-urgent referrals could put pressure on staff and the space available in triage leading to delays to urgent care. The decision for seeing gynaecology referrals for review in maternity areas did not meet national guidelines as this could cause distress for people who have or are experiencing baby loss.

The triage had 1 assessment room and a bay area with 4 beds, as well as a waiting area, situated off the bay area. There was no line of sight for staff to see women and birthing people while they were waiting. This placed women and birthing people at risk as staff may not identify a deterioration in the waiting person's condition.

There was a pregnancy assessment unit (PAU) for those with pre booked appointments, due to needing additional monitoring during their pregnancy in another 4-bedded bay area off the waiting area. However, anyone in the waiting area could easily see through to the PAU as there was not blind on the window in the door. During the inspection inspectors were able to look through the window. Staff had not drawn the curtains around a bed where women and birthing people were receiving care. This showed that staff did not always consider women and birthing people's privacy and dignity.

Some staff told us there was not enough equipment such as cardiotocography (CTG) machines in triage necessitating sharing the CTG machines with the PAU. Following the inspection, the trust informed us that an additional, 20 CTG machines were purchased in August 2023, 5 of these were for the maternity assessment unit, 3 were for the triage area and 2 for PAU.

The bereavement suite was comfortable, furnished in a non-clinical way and was sound-proofed. Women and birthing people who had experienced baby loss would give birth on the delivery suite and then be escorted back through triage and PAU. We were told that staff would need to prepare triage and PAU making these areas free from women and birthing people in order to give some privacy to those using the bereavement suite.

The delivery suite had 8 delivery rooms. Rooms were spacious with full ensuite facilities, 3 of the rooms were allocated to midwifery led care, of these, 1 room had a birthing pool. The other 5 were for consultant-led care. The consultant led care rooms were also used for high-dependency women and birthing people when needed. There was an emergency theatre where emergency caesarean sections took place and a recovery room. Elective caesarean sections were undertaken in the main hospital theatres across the corridor from the delivery suite women and birthing people who gave birth in the main theatres were also recovered in these theatres and had their own recovery rooms.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

Several beds in the delivery suite were more than 10 years old. The service had recognised this as a risk. This risk was documented on the services risk register. Staff were mitigating the risk by swapping beds when they were needed. This may cause extra pressure on staff to ensure the beds had been cleaned and were ready for the next delivery. New beds had been ordered and there were trial beds. The new beds were expected to arrive at the service in January 2024. However, there was a risk that the service would not have enough suitable birthing beds available, particularly if a bed was needed urgently in an emergency. Following the inspection, the trust advised us that all new beds had been delivered in January 2024. The trust was able to assure us that there had been no patient harms or incidents were reported whilst waiting for new beds to arrive.

Maternity

The service had a maternity ward for women and birthing people who required both postnatal and antenatal care, and babies that require transitional care. The ward consisted of 21 beds, 14 were bays and 7 were single side-rooms.

The bathrooms and shower rooms on the maternity ward were 18 years old and required ongoing maintenance and repair so were frequently not in use. The service had identified this issue as a risk and planned to replace affected showers. However, there were no timescales for completion recorded in the risk register. Following the inspection, the trust confirmed that essential work had been completed in the shower and bathrooms in December 2023.

Women and birthing people who were assessed to need an induction of labour (IOL) were cared for on the maternity ward in the side rooms and partners could stay overnight. Once they were in active labour women and birthing people would be transferred to the delivery suite.

Staff had responded to concerns raised by women and birthing people who had said that the ward could sometimes be too loud. This had led to implementing a device known as a 'sound ear' on the maternity ward to measure sound levels and to encourage women, birthing people, partners and staff to keep noise at an appropriate level for the benefit of mothers and their newborn babies.

The maternity unit was fully secure with an alarmed baby tagging system which locked down all maternity services when activated.

Staff carried out daily safety checks of specialist equipment. An electronic system for equipment checking was in use so managers would be alerted if equipment checks were missed. Records showed compliance with resuscitation equipment within maternity services was 97.5 % since the introduction of this system in November 2023.

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.

The service had assessed the environment for ligature risks and acted accordingly by removing environmental risks.

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.

Women and birthing people who presented at maternity triage were assessed and given a prioritised rating of clinical urgency, either red, orange, yellow or green, using a recognised maternity triage assessment tool.

Leaders at the service audited how long women and birthing people waited for assessment and follow-up treatment. The data from these audits did not give assurances that triage was effective or able to provide safe care.

The service did not always use the same sample number for audits. For example, audit information supplied for July 2023 audit was from a sample size of 82 patients. Whereas audit information supplied for October 2023 audit was from a sample size of 31 patients. In July 2023, 100% of women and birthing people audited were seen by a midwife and triaged within 15 minutes of arrival. In October 2023, 100% of women and birthing people audited were seen by a midwife and triaged within 15 minutes of arrival. However, data from 'red flag' records (a midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing) showed there had been 13 occasions where women and birthing people experienced delays and were not assessed within 15 minutes of arrival between September and November 2023.

If a woman or birthing person had been prioritised as orange, then the policy stated they should be seen by an obstetrician within 15 minutes of the initial assessment by the midwife. In July 2023 this happened in 31% of the cases that were audited. In October 2023 this happened in 50% of the cases that were audited.

If a woman or birthing persons were assessed to have a prioritisation colour of yellow, they should be seen by an obstetrician within an hour of the initial assessment. In July 2023 this happened in 80% of cases that were audited. In October 2023 this happened in 33% of cases that were audited. This showed there was delays in women and birthing people being assessed by an obstetrician. Whilst waiting to be seen by an obstetrician woman and birthing people were re assessed at regular intervals and where there was a delay re-escalated to the obstetrician to maintain their safety.

There was no dedicated trained midwife to answer the triage phone line. This role was allocated to the midwife assessing and prioritising women and birthing people that came into triage. This meant there was not always a qualified person able to take the calls, as there were not always 2 midwives available to work in triage. A dedicated midwife solely for telephone triage is best practice and acknowledged by Royal College of Obstetricians and Gynaecologists (RCOG) (December 2023). The triage phone line is the first port of call for many women and birthing people who are concerned about their pregnancy. If the phone line is not answered this could cause delays or obstacles in women and birthing people getting the advice they needed, or in coming into the service if they need to be assessed. On the day of the inspection a midwife who was not familiar with or trained in triage was supporting by answering calls, this presented a risk women and birthing people could receive inconsistent advice.

There was no audit or oversight of call-waiting or call-abandonment rates. Leaders told us a new digital telephone system for maternity triage was being implemented in January 2024. The new telephone system incorporated ‘call waiting’ so wait times could be monitored. It was unclear how the risk was mitigated effectively in the interim period.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 6 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. Leaders completed a monthly audit of 12 records to check they were fully completed and escalated appropriately. Audits for November 2023 scored 84%. Leaders had developed an action plan and a repeat audit.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. However, the trust’s audit for December 2023 identified in 3 out of 10 case notes had missing or late observations with no reason documented for this. An action plan to increase compliance was introduced. Following the inspection, the trust told us a further review of the records undertaken by the trust confirmed that the 3 babies did have regular observations undertaken.

The service provided transitional care for babies who required additional care. There were 4 allocated beds for transitional care on the postnatal ward. Neonatal teams were involved in decision making and planning for all ‘transitional care’ babies. This enabled mothers and babies requiring additional care to be supported together on the same ward.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. For example, staff used the fresh eyes approach to carry out fetal monitoring. Leaders audited how effectively staff monitored women and birthing people having continuous cardiotocograph (CTG) during labour. We reviewed audits from July 2023, October 2023, and November 2023. In July 2023, compliance was 40%. No data was shared for the months of August or September 2023. However, in October and November 2023 compliance was 100%.

Maternity

Staff monitored compliance with ensuring there was 'a structured risk assessment completed at the onset of labour to determine method of fetal monitoring and place of birth' deteriorated. In July 2023 records audited were 94% compliant, in October 2023 90% compliant and in November 2023 only 14% compliant, which was not enough to keep women, birthing people and babies safe. Each audit had an action plan and findings were shared with staff however it had not been identified why there had been such a significant drop in staff compliance in November 2023.

Centralised CTG monitoring had recently been installed so monitors could also be checked from a central office on the delivery suite.

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. Care records were 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 (SBAR) for each person.

The service audited the compliance with SBAR use when transferring women and birthing people within areas of the maternity unit. In September 2023 the audit showed 78% compliance when transferred from the delivery suite to the maternity ward and 100% compliance from the maternity ward to the delivery suite. For the week of 6 October 2023, the audit showed 53% compliance from delivery suite to the maternity ward and 50% from the maternity ward to the delivery suite. Due to the SBAR compliance being low the service had started to audit weekly and for the week of 23 October 2023 the audit showed some improvement to 74% compliance from delivery suite to the maternity ward but a further decline to 40% compliance from the maternity ward to the delivery suite. There was therefore a risk that staff did not receive all the relevant information needed in order to provide safe care. Following the inspection, the trust informed us that staff used verbal handovers when the care of women and birthing people were transferred. However, these were not always documented using the correct electronic format.

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

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Maternity

Incident records identified a shortage of midwives had resulted in delays in women and birthing people being assessed within safe timescales and being delayed for other time-critical procedures. At times there was only 1 midwife working in triage when the service's standard operating procedure stated there should have been 2 this resulted in delays for women and birthing people.

On the day of inspection, midwifery staffing should have been 11 midwives plus 1 supernumerary coordinator but there were 9 midwives plus 1 supernumerary coordinator. Staff told us although the workload could be very busy, they worked well together as a team. Some staff said vacancy and sickness rate were an ongoing issue.

As well as the service not always having the planned amount of midwifery staff, staff were not always deployed effectively. The service did not have a dedicated qualified staff member to answer the triage phone line. There was a risk women and birthing people were not able to access timely telephone advice by an experienced, qualified midwife when they called triage as this was not a dedicated role.

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 June 2023 and November 2023 there were 25 red flag incidents, the majority of which related to delays in women and birthing people being assessed within 15 minutes of arrival in triage. Other delays were around admission to the delivery suite during induction of their labour (IOL) and when artificial rupture of membranes (ARM) was required.

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. They completed a maternity safe staffing workforce review in line with national guidance in January 2022. This review recommended 111.63 whole-time equivalent (WTE) midwives Band 3 to 8. There was a shortfall of 12.78 WTE. Recruitment was ongoing and where possible shortfalls were covered by bank or agency staff known to maternity services.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Leaders reported 100% compliance for 1-1 care in labour and a supernumerary shift coordinator for July to November 2023.

Staff told us they felt well supported by managers and senior leaders.

Not all staff had received an appraisal of their work and performance. Of midwifes working on triage and pregnancy assessment centre 78% had received an appraisal, 80% of midwifes working on the delivery suite and 81% of midwifes working on the maternity ward had received an appraisal. However, 94% of doctors had received an appraisal of their work.

A practice development team supported midwives. The team included 1 practice development lead midwives and 1 preceptorship lead midwife.

Medical staffing

The service usually had 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Maternity

The service had 15 whole time equivalent (WTE) consultant doctors, 3 specialist and associate specialist doctors, and a number of doctors in training. The service maintained 7 days a week obstetric consultant presence on site and facilitated twice daily consultant led ward rounds in line with national guidance. Consultant attendance was required for certain clinical situations, and this was known and understood by medical and midwifery staff.

On the day of the inspection, staff told us there was no allocated doctor for the triage area. Midwives told us at times there could be delays for medical review in triage, in particular after 5pm. There were 12 obstetric consultants employed.

Leaders acknowledged there were at times gaps in the trainee doctor and middle grade doctor rota but said the obstetric team were usually able to provide cover.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Improvements had been made to the support and supervision provided to junior doctors.

The service had a check list to ensure suitability and full induction of locum doctors who worked at the service. This checklist was audited in December 2023 and showed 100% compliance with all areas on the checklist.

When on-call, consultants have the option to use accommodation on site.

Records

The service used electronic and paper records to record women and birthing people's care. Which led to potentially incomplete records over multiple locations. Staff did not always record risk assessments. Records were stored securely and easily available to all staff providing care.

Staff were recording care in both electronic and paper records. This meant staff had to document care given in multiple places and could lead to information being inconsistent or not recorded. The service used an electronic records system (ERS). However, there was not a facility for women and birthing people to access their own records electronically, therefore information that needed to be accessible had to be written in the handheld notes. If women and birthing people were out of area the ERS was not always compatible with neighbouring services which meant staff had to write in the handheld notes for access of the community midwife. Following the inspection, we were informed that the service has plans to introduce a maternity specific records system that women and birthing people will have access to. This should be in place by quarter 3 of 2024.

Staff in triage told us that they had to record care on the electronic system, on the triage proforma, as well as in the paper records. We were told during busy periods staff would prioritise the paper records of women and birthing people who were out of area so that their community midwife would be able to see the care that had been given.

We reviewed 6 paper records and 6 electronic records and found records were not always complete. 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.

Medicines

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

Maternity

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their stay. We reviewed 5 prescription charts and found staff had correctly completed them.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team attended the wards daily to support the service and reviewed medicines prescribed.

Staff completed medicines records accurately and kept them up to date. However, there were no records of discarded medicine used for epidurals, this meant there was no clear audit trail for this medicine which is a controlled drug. This was fed back to leaders during the inspection. Following the inspection, we were advised that leaders had acted to make changes immediately after the inspection to ensure that all epidural waste was recorded.

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. Staff checked controlled drug stocks daily. Medicines were in date and mostly stored at the correct temperature. Staff monitored and recorded fridge temperatures and knew to act if there was variation. However, records showed that the temperature had on occasion been above the recommended temperature. Staff made the pharmacy team aware.

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

Staff learned from safety alerts and incidents to improve practice.

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 and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed incidents reported in the 3 months before inspection and found them to be reported correctly.

The service used an 'incident management framework' to support effective identification, reporting, investigation, and learning. Managers reviewed incidents on a regular basis to identify potential immediate actions.

Staff reported serious incidents clearly and in line with trust policy. Serious incident review meetings ensured root cause analysis was carried out and learning could be shared. Five-day rapid reviews took place for incidents graded as a moderate or a higher level of harm. Moderate and serious incidents were reported to the board level maternity safety champions and the Local Maternity and Neonatal System (LMNS) monthly.

Maternity

Data from the maternity service showed 172 incidents remained open after 60 days and therefore not all incidents had been reviewed in a timely way. There were no incidents between July and September 2023 which met the criteria for reporting to the maternity and newborn safety investigations programme (MNSI, formerly HSIB). MNSI undertake independent investigations into incidents within maternity services which fall under a defined criteria that includes maternal deaths, stillbirths and babies that require cooling.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. Managers reviewed incidents potentially related to health inequalities.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning with staff. 'Lessons learned' newsletters reminded staff about current risks and safety actions and encouraged an open reporting culture.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed. Managers debriefed and supported staff after any serious incident.

Is the service well-led?

Good

Leadership

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

On the 1 July 2023 Southport and Ormskirk Hospital NHS Trust was dissolved and its staff, property, services, and liabilities were transferred to St Helens and Knowsley Teaching Hospitals NHS Trust. At this time, the trust's name was changed to Mersey and West Lancashire Teaching Hospitals NHS Trust. Maternity services for the new trust are at the Ormskirk Hospital and Whiston Hospital sites.

The director of nursing, midwifery and governance, supported the maternity leadership across both Ormskirk Hospital and Whiston Hospital sites and visited the Ormskirk Hospital maternity services at least 3 times a week. At Ormskirk Hospital, maternity services came under the Specialist Services Clinical Business Unit. The associate director of midwifery, nursing and allied health professionals (AHP's) was supported by an associate director of operations as well as a consultant midwife, 2 matrons, a risk midwife, a quality and audit midwife, a practice development midwife, a preceptorship lead midwife and other specialist midwives.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

Maternity

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service was supported by the director of nursing, midwifery and governance and a non-executive directors as maternity safety champions. The maternity safety champions did regular walk rounds of the service talking to both staff and women and birthing people.

Vision and Strategy

The service did not have its own vision and strategy. There was however a joint strategy with nursing. This vision and strategy was focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Leaders had not made steps towards a maternity specific strategy following the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services.

Prior to the recent merger of the 2 trusts, both trusts had developed nursing and midwifery strategies for 2022 – 2025. The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed in consultation with members of the trust workforce. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

Following the inspection, the trust advised us that there were plans for a creation of a maternity specific strategy for the trust follow the implementation of the new management arrangements for the Women's and Children's Division on 1st April 2024.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply the vision and monitor progress.

The new trust had developed their trust objectives for 2023 and 2024. There were 5 trust objectives: around care, safety, pathways, communication and systems. In addition to these objectives there were trust priorities which included further improving the experience for women and birthing people and their families using maternity services.

Culture

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.

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

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.

Maternity

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. The service had a continuity of carer team who supported women and birthing people in deprived areas.

The service had an action plan to address known inequalities of outcome for Black and Asian women using maternity services. This included early identification of women and birthing people at risk and the opportunity to receive care from a specific team of midwives.

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

The service shared with us complaints from the last 3 months. There had been 2 complaints raised. Managers investigated these complaints and shared feedback with staff. Learning from these was used to improve the service. Complaints were acted on in a timely manner keeping the complainants informed and involved. Staff could give examples of how they used women and birthing people's feedback to improve daily practice. For example, the hearing ear on the maternity ward which monitored noise on the ward.

Governance

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

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

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

The service had introduced governance boards in areas such as maternity theatres. These boards highlighted top risks, incidents and themes around complaints, lessons learnt and safety messages of the week.

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

We noted the service risk register stated that there were overdue and outdated guidelines on the intranet.

We reviewed several policies, which were up to date However, the regional maternity escalation policy and operational pressures was past its review date but was confirmed by the LMNS to still be applicable for use.

A consultant midwife and a consultant obstetrician were overseeing a process for review and completion of guidelines and policies. The risk register acknowledged that there was a lack of dedicated staff to undertake the role of managing the guidelines and harmonising the process.

The directorate clinical governance and quality meeting was held monthly. We looked at minutes of the last 3 meetings and saw there was a set agenda which covered all key aspects of performance and safety including risks, incidents and the maternity safety dashboard.

Oversight of safety in maternity services was reported to the board quarterly. We reviewed the maternity services update to the quality committee for July to September 2023. It provided an update on progress towards MIS year 5 safety actions, reportable deaths, serious incidents, Saving Babies Lives Care Bundle v3, complaints and claim and maternity staffing.

The maternity dashboard was reviewed at the monthly directorate clinical governance and quality group and reported from this to the trust quality committee.

Students were invited to governance meetings to give them an understanding of the importance of these meetings.

Management of risk, issues, and performance

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

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

The service had undertaken a gap analysis and collation of evidence of compliance to Saving Babies Lives version 3 (SBLv3) and met with the local maternity and neonatal system (LMNS) to assess compliance with the care bundle. In November 2023, the service self-assessed it was fully compliant with 2 elements and had partially implemented 4 elements 3 of which were above 80% compliant. The service planned to provide further evidence to the LMNS including audits which would improve compliance.

Managers and staff carried out a programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. However, audit samples and methodology were not always consistent. We did not receive all the data we requested as part of the inspection. For example, the triage audit for data collected in July 2023 had a sample size of 82 patients, whereas the audit for data collected in October 2023 had a sample size of only 31 patients. It was not clear from the methodology why the service had used a smaller sample size. We did not receive data for August 2023 or September 2023. The July 2023 audit methodology stated that they had excluded data where a priority level had not been documented, which was an intrinsic part of the audit to show whether appropriate care had been given, therefore audit results were not reliable as a performance indicator.

The service had an audit plan for all maternity guidelines, policies and standard operating procedures, which was last updated in November 2023. This included audit leads and a rating system to show if audits were completed, on track or overdue.

Maternity

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

The service had a risk register. We reviewed the risk register and saw there were 14 risks initially rated as high and 1 as low. There was no risk rated as moderate. The high risks related to the triage phoneline, maternity staffing, facilities such as bath and shower rooms and delivery beds, and medical staff not routinely reviewing outstanding medical reviews on the system. Mitigating actions and controls had been put in place for most of these high risks. However, the service had recognised that there was no consultant lead for the service and that job lists for medics needed to be reviewed. This had been identified in December 2022 and remained a risk in November 2023 despite having been reviewed monthly, which demonstrated a slow and ineffective response to this risk. Following the inspection, the trust informed us that this risk had now been closed as there was a dedicated clinical lead for maternity services.

The risk register was reviewed and updated at the monthly directorate clinical governance and quality group and actions noted to mitigate risks.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

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

The service collected data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. Key information from the dashboard, scorecards, audits and performance data were displayed across the service for staff, women, birthing people and public to access.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff used electronic patient records to access all the information they needed, including screening results and safeguarding information.

The information systems were integrated and secure**.**

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

Engagement

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

Maternity

Leaders worked closely with the local Maternity Neonatal Voices Partnership (MVNP) to contribute to decisions about care in maternity services. As part of the inspection, we spoke with the MVNP chair. They told us that the service was very approachable. They are invited to safety champion meetings and safety walk-arounds of the service. The MVNP chair had found it difficult to commit to walk-arounds at the times and dates suggested by the service due to their other commitments and the service was happy for them to arrange times that suited their schedule.

The service and the MVNP had organised a listening event in a family wellbeing centre in Jully 2023 which they are planning to repeat yearly. The event was call “World Cafe event” The aim of the event had been to engage with all pregnant women and birthing people in the area as well as women and birthing people who had already used the maternity services. The MVNP chair shared that the event had been a huge success where they had been able to hear the views of 100 families. A report was written with recommendations for each of the 4 themes discussed during the event.

The MVNP and the service produced a monthly dashboard where women and birthing people are able to view at-a-glance information about the service, this included information such as how many births, how many attendances at triage, and how many inductions of labour. This information was for the trust and covered maternity services at Ormskirk and Whiston hospitals.

The service always made available interpreting services for women and birthing people and collected data on ethnicity.

Leaders understood the needs of the local population.

We received 230 give feedback on care forms through our website. Feedback received indicated more women and birthing people had positive experience than negative experience and that some women had a mixed experience depending upon the area of the maternity services. Feedback included concerns about not receiving pain relief and staff attitude. Many women and birthing people were unhappy their partners were not able to stay on the maternity ward overnight and did not feel they received the support they required following the birth of their babies. Seventy-seven women and birthing people gave negative feedback about their experience. One hundred and fifty women and birthing people told us they had positive experiences and described the support they had. Following the inspection, the service told us that the MNVP Chair was undertaking a survey of women’s and birthing people's views of women’s and birthing people’s partners staying overnight.

Leaders feedback to staff information such as audit outcomes in the weekly staff newsletter.

Learning, continuous improvement and innovation

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

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. The service had fortnightly maternity improvement meetings where they would discuss all matters relating to improvement at the service. We reviewed 3 maternity improvement meetings minutes and saw quality improvement (QI) projects included escalation, where Junior doctors, preceptorship midwives and student midwives were asked to be escalation champions. These meeting minutes also praise the work of a midwife who had done a QI project on the use of a fetal surveillance board on delivery suite.

Maternity

All ward areas had their own individual improvement plans. These plans covered actions such as training and environmental issues and gave the ward leader and matron oversight of their responsibilities.

The service had several ways in which they ensured information about lessons learned were fed back to staff. These included team meetings, newsletters, and lessons learned newsletters.

The service collaborated with regional universities and charities to support research studies. For example, leaders encouraged innovation and participation in research studies for high blood pressure in pregnancy and group B streptococcus screening.

Outstanding practice

We found the following areas of outstanding practice:

- A device known as a 'sound ear' was used on the maternity ward to measure sound levels to encourage women, birthing people and staff to keep noise at an appropriate level for the benefit of mothers and their newborn babies.
- The service had worked closely with the Maternity Neonatal Voices Partnership (MNVP) in running a successful listening event called "World café event" where they had heard the views of 100 families from the local area.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure all staff are up to date with mandatory training including but not limited to pool evacuation. Regulation 12(1)(2)(c)
- The service must ensure staff accurately complete, and document modified early obstetric warning scores and newborn risk assessments, record CTG assessments and fresh eyes in order to identify and escalate women, birthing people and babies at risk of deterioration. Regulation 12 (2) (a) (b)
- The service must ensure there are sufficient numbers of staff deployed to keep women, birthing people and babies safe. Regulation 18 (1)

Action the trust SHOULD take to improve:

- The service should ensure that records are maintained for all discarded medicine used for epidurals.
- The service should ensure all staff receive supervision and annual appraisals.
- The service should consider making electronic records accessible to women and birthing people.

Maternity

- The service should ensure incidents are reviewed in a timely manner.
- The service should develop a maternity-specific strategy and vision.

Our inspection team

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