Blackpool Teaching Hospitals NHS Foundation Trust

Blackpool Victoria Hospital

Inspection report

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Date of inspection visit: 21 June 2022 and 22 June 2022
Date of publication: 01/09/2022

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Inadequate**
Are services well-led?	**Inadequate**

Our findings

Overall summary of services at Blackpool Victoria Hospital

Inadequate 

Blackpool Teaching Hospitals NHS Foundation trust is situated on the west coast of Lancashire and operates within a regional health economy catchment area that spans Lancashire and South Cumbria and supports a population of 1.6 million. The trust provides a range of acute services to the 330,000 population of the Fylde coast health economy and the estimated 11 million visitors to the seaside town of Blackpool. The maternity unit delivers approximately 3,000 babies every year.

We only inspected maternity services at Blackpool Victoria Hospital and rerated this core service. This was an unannounced comprehensive inspection of Blackpool Victoria Hospital maternity services .

As a result of re-rating this core service, the ratings for the hospital location changed slightly with the safe domain changing from requires improvement to inadequate. The overall rating for the hospital location remained the same.

This inspection was partly undertaken due to the concerns raised over how the service was managing with low staffing to ensure women and babies received safe care and treatment.

The maternity services had been inspected previously; this included a comprehensive inspection carried out in 2019. The maternity services were previously rated as good overall, with all key questions rated as good.

After our inspection we sent the trust a Section 31 Letter of Intent of the Health and Social Care Act 2008. We wrote to the trust describing the serious concerns found during our inspection and requested an action plan of how the service was going to improve maternity care. Our concerns included:

1. There were ineffective processes to manage and mitigate the risks in relation to the lack of enough suitably qualified midwifery staff to care for women. This was creating and contributing to significant risks to women receiving timely and appropriate care and treatment exposing them to the risk of harm.
2. There was a lack of robust systems and processes to safely store medicines within maternity services which could expose women and babies to the risk of harm.
3. There was insufficient process to ensure staff had access to in date and safely checked equipment which exposed women and babies to a potential risk of harm.
4. There were insufficient processes in place to assess the risk of and prevent and control the spread of infections Women and babies were exposed to an increased risk of infection.
5. There was not effective systems and processes to ensure incidents were reported, reviewed, and investigated appropriately to ensure lessons were identified and shared with teams.

Following us formally raising these concerns with the trust they submitted an action plan on 11 July 2022. The trust included actions to enhance the maternity workforce and access for agency midwives. The trust had reviewed the induction of labour policy that defined delays in induction of labour as those waiting more than four hours. The trust had implemented a written risk assessment for patients waiting for induction of labour and delays over four hours must be reported. Delays in induction of labour would be reported to the trusts board as a monthly report. The trust had

Our findings

agreed that medicines in maternity theatres would be secured with keypad locking devices. The trust had checked equipment to ensure they were fit for use and were checked appropriately and the policies available for use in the department were the correct versions. We will monitor compliance of the action plan through ongoing engagement with the trust.

Details for the summary for the maternity core service inspected can be found later within the report.

Maternity

Requires Improvement 

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

- The service did not always have enough midwifery staff to care for women and keep them safe. Staff did not always have training in key skills including safeguarding and did not always manage safety well. The service did not always control infection risk well. Staff did not always assess risks to women and did not always take action to remove or minimise risks. Records were not always clear, up-to-date and were not always easily available to all staff providing care. They did not always manage medicines well. The service did not always manage safety incidents well and lessons learned were not always shared.
- Staff did not always provide effective care and treatment and did not always meet expected patient outcomes. Staff did not adequately support women to breastfeed. Managers monitored the effectiveness of the service but did not always make sure staff were competent. Midwifery staff supported women to make decisions about their care and had access to relevant information.
- The service did not always have the facilities to respect women's privacy and dignity. Staff did not always help them understand their conditions.
- The service did not always take account of women's individual needs. People could not always access the service when they needed it and did have to wait for treatment.
- Local leaders were not always visible and approachable in the service for patients and staff. The service had limited vision for what it wanted to achieve in maternity services and did not have a clear strategy to turn it into action. Not all staff were aware of the vision and strategy and how to apply it. Leaders had the systems for effective governance processes but not all risks were reported. Leaders did not always identify and escalate relevant risks and issues and did not always identify actions in a timely manner to reduce their impact. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Leaders did not always actively and openly engage with patients, staff, and the public local organisations to plan and manage services.

However:

- Staff understood how to protect women from abuse. The service had enough medical staff to provide care and treatment. Records were stored securely. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff gave women enough to eat and drink and gave them pain relief when they needed it. Staff worked well together for the benefit of women, advised them on how to lead healthier lives. Key services were available seven days a week.
- Staff treated women with compassion and kindness. Staff took account of their individual needs, and provided emotional support to women, families and carers. Women gave positive feedback about the service.
- The service planned care to meet the needs of local people and made it easy for people to give feedback.
- Leaders had the skills and abilities to run the service. Staff were focused on the needs of patients receiving care. All staff were committed to continually learning and improving services.

Maternity

Is the service safe?

Inadequate 

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

Mandatory training

The service did not always ensure staff received mandatory training in key skills and leaders did not always ensure everyone completed it.

The mandatory training programme was comprehensive and met the needs of women and staff. However, midwifery and medical staff did not receive and keep up to date with their mandatory training. The service aligned itself to the skills for health; core skills training framework's (CSFT) recommended subjects. In June 2022, each of the 11 mandatory training compliance rates for both midwifery and medical staff were below the trust's target of 95%. We requested, but did not receive, evidence of compliance for unregistered maternity support staff.

Managers monitored mandatory training but did not always ensure staff completed their training. Staff told us they did not always get protected time to complete mandatory training. Midwifery staff told us they were taken out of mandatory training to assist with staffing shortages. The divisional Quality Report for June 2022 documented that training and non-essential work was cancelled to release staff for clinical work.

The service did not always ensure all staff received up-to-date life support training. In June 2022, resuscitation level two compliance rates were 50% for midwives and 61% for medical staff. In July 2022, 79% of all midwives had up-to-date neonatal life support training. Obstetric doctors were not required to have neonatal life support training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. However, staff did not always have up to date training on how to recognise and report abuse, but they knew how to apply it.

Staff did not always receive training specific for their role on how to recognise and report abuse in adults. In June 2022, 77% of medical staff and 93% of midwifery staff had up-to-date level three safeguarding children training. Records showed that 39% of medical staff and 65% of midwifery staff had up-to-date level three safeguarding adults training. The service did not always follow their own policies to ensure 90% of eligible staff received the appropriate level of adults and children safeguarding training, which could lead to harm to women and babies. We requested, but did not receive, evidence related to compliance for unregistered midwifery support staff.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to provide examples of when adults and children were at risk of harm and could tell us the steps taken to protect the women and babies involved.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a team of safeguarding midwives, which included specialists for substance misuse and domestic abuse. The maternity safeguarding team participated in the weekly trust safeguarding meetings and fortnightly meetings with social services teams at the local council.

Maternity

Staff followed safe procedures for keeping children safe when people visited the ward. The delivery suite and ward D were kept secure with two locked doors for each area. Women and visitors could not enter or leave the ward without a staff member releasing the door lock.

Staff did not always follow the baby abduction policy and did not always participate and undertake baby abduction drills. In May 2022, the service undertook an exercise to simulate an abduction or attempted abduction. We saw that switchboard staff performed a test call to simulate a baby abduction exercise. However, there was no evidence that midwives, staff on the ward or delivery suite, midwife in charge, and appropriate managers took part in the simulation, as per policy, to practice responding to an abduction or attempted abduction. The divisional risk register showed baby abduction as a risk score of eight and the target was four. Leaders had specified control measures however, they did not always follow the trust policy. This could lead to delays in enacting the policy and cause harm to babies.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect women, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

There were insufficient processes in place to assess the risk and control the spread of infections women and babies were exposed to.

Ward areas were visibly clean; however, there was not a robust process for washable furnishings. We saw that fabric curtains were in use in some clinical areas. In addition, curtains were not dated and there was no effective system in place for curtain changes. Fabric curtains could not be wiped clean which could cause a risk of infection to mothers and babies. In response to the letter of intent, senior leaders told us that all curtains were changed as a minimum on a six-monthly rotation. The letter of intent response told us that the curtains were checked daily and changed if soiled by domestic staff but we did not see evidence of the checking process on site.

Some areas of the bereavement suite could not be effectively cleaned. The room contained fabric blinds, fabric cushions, a fabric rocking chair and fabric lamp shades. This posed a risk of infection to women and babies. The bedding for the bereavement suite had been donated by members of the public and was washed within the delivery suite in their own washing machine to prevent being lost. In response to our letter of intent the trust told us they had removed all fabric soft furnishings.

The service did not always perform well for cleanliness. We saw that some areas were not clean. We observed a surface in the bereavement suite, where clinical equipment was stored, that had dust. Also, three cots on ward D that were in a storage area were dusty. However, we did observe that rooms were prepared and cleaned fully prior to women being admitted into the bed space.

We saw not all areas had cleaning schedules in place. In addition, the cleaning schedule in the bereavement suite had not been completed since 2015. We saw that staff were completing cleaning tasks, but this was not structured. Staff also told us that staffing levels were impacting on their ability to regularly complete important tasks like cleaning. In response to the letter of intent, the trust had informed us that cleaning schedules were in place for all rooms on the delivery suite and in the birth centre. Compliance was monitored from 04 July 2022 to 14 August 2022, four of the five weeks had 100% compliance recorded.

We saw that the daily room checks in delivery suite were not always completed. On the 22 June 2022, we saw a room check was not completed for nine days.

Staff cleaned equipment before and after patient contact and labelled equipment to show when it was last cleaned. We observed 'I am clean' stickers in use on cots and beds in both delivery suite and ward D.

The service provided a copy of the commode audit for March 2022, which showed 100% compliance within the families and integrated community care (FICC) division.

The service provided an environment audit action plan dated 28 June 2022. It contained details of peeling floors and walls, cluttered and dusty environments and spare personal protective equipment (PPE) stored in the sluice. Of the 11 issues raised, all had immediate actions and identified outcomes. The service had completed six of the 11 issues raised on the date of the action plan, including moving the PPE from a dirty area to a clean area.

Staff followed infection control principles including the use of PPE. On 21 June 2022, we observed isolation signage in use on a door on delivery suite, all staff and visitors were aware that an infectious patient was in the room. The service undertook an audit of the compliance for the use of personal protective equipment in April 2022. The compliance figures for the trust were 97%; the compliance figures were not broken down by division or specific area.

The service shared hand hygiene audits for March 2022 and June 2022, 100% of the 60 staff observed were compliant with the five moments of hand hygiene.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well.

There was insufficient process to ensure staff had access to in date and safely checked equipment which exposed women and babies to a potential risk of harm.

The design of the environment followed national guidance. Delivery suite had seven rooms and the birth centre had four rooms. Three of these rooms had a birthing pool available for use. We were told the birth centre was used minimally as the majority of women were high risk and not suitable for the birth centre. Staff told us they had practiced pool evacuation drills in the past but not recently.

Ward D had 22 bed spaces including side rooms and had a mix of post-natal and antenatal women.

The service had close access to two theatres, they were available for planned caesarean sections and emergency caesarean sections. Planned or elective caesarean sections took place on Monday, Wednesday and Friday.

The service had enough suitable equipment to help them to safely care for women and babies. However, they had ineffective systems in place for checking and maintaining equipment and associated environments. We observed out of date equipment within all the areas of maternity services. The service did not manage the stock rotation and checking of expiry dates to ensure equipment was safe to use when required. This meant that out of date equipment could be used to provide patient care which could lead to harm.

Electrical equipment tests were not always monitored and managed effectively. We observed two resuscitaires on Ward D, and one weighing scale close to the reception desk, that had passed their planned date for maintenance checks. We escalated these at the time of our inspection.

We were told that one of the resuscitaires on Ward D was broken although it was not clearly identified as being broken. Staff told us that it was being used for cannulation of babies only. However, in an emergency all staff may have been aware that the resuscitaire was not usable as all tubing was intact and bagged and looked ready for use.

Community midwives did not always ensure their equipment was calibrated and inspected within defined dates. In June 2022, the service undertook an equipment audit which showed on average 38% of community midwives' equipment was calibrated and inspected within due dates. The audit concluded that all equipment had been checked in the preceding 18 to 24 months. However, the audit did not indicate the actions of how to ensure the equipment was safely checked going forward but to re-audit in six months. This showed that the service did not always ensure equipment was safe to use, which could cause harm to patients or provide the wrong test results.

There was a lack of effective systems to check the emergency equipment. We saw that emergency trolleys and grab bags contained out of data proformas and algorithms and were not standardised. On 21 June 2022, we saw that the emergency post-partum haemorrhages (PPH) grab box had been checked on 20 occasions of the 82 days we reviewed. Staff told us that there was no standardisation for checking the equipment required in the grab boxes. In the delivery suite, we saw policies and proformas that had passed their date for review. This could lead to delays in treatments or staff not following up-to-date guidance which could cause harm to patients. We reviewed the same policies on the trust intranet and found those to be within dates for review.

On 21 June 2022, we observed that the neonatal resuscitation trolley on delivery suite was not appropriately secured with a tamper proof tag, despite staff telling us it was secure and checked. In addition, the neonatal guidelines were passed their date for review. This could lead to emergency equipment not being available when required, which could lead to harm to babies.

The monthly adult and neonatal emergency trolley checks were completed 100% of the time from 01 June 2021 to 31 May 2022. However, during our inspection we observed cardiopulmonary resuscitation policies and algorithms on trolleys that were out of date; we saw one that was 12 years out of date. In the trust's response to the letter of intent, we were told all hard copy policies and algorithms were removed from all clinical areas.

The service did not always have suitable facilities to meet the needs of women's families. On the 21 June 2022, we observed the bereavement room was unsuitable and the shower area contained a broken shower and door that was unsafe for use. Staff told us that the room was still in use and that the broken shower and broken door had been reported in February 2022. However, no action had been taken. This meant that parents who had been bereaved were being cared for in an unsuitable and unsafe environment. In response to the letter of intent, the trust told us they took immediate action to fix the shower and door.

Staff did not always dispose of clinical waste safely. Sharps bins were not always correctly labelled, assembled and temporary closure devices were not always in use as per the environment audit action plan dated 28 June 2022. Actions were taken at the time to make the sharps bins safe. The service stated in their action plan that they would make posters to remind staff of safe assembly and use of sharps bins.

Women could reach call bells and staff responded quickly when called despite being busy. We saw functioning call bells situated at each bed and within each room.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman and did not always take action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Maternity

There were ineffective processes to manage and mitigate the risks in relation to the lack of enough suitably qualified midwifery staff to care for women. This was creating and contributing to significant risks to women receiving timely and appropriate care and treatment exposing them to the risk of harm.

On the 22 June 2022, we saw eight high risk women who were waiting prolonged time periods for induction of labour. We observed one woman who waited five days for an artificial rupture of membranes (ARM) to induce labour and there was still no plan identified to undertake the ARM. Within the divisional safety huddles, we did not observe discussion of how to mitigate the potential risks associated to delayed inductions of labour and how the service was risk assessing women and their babies while they were waiting.

The service provided data which showed 89 women, 42% of all deliveries in May 2022, had an induction of labour performed. Of these, 58 women received a timely induction of labour; 21 women had delays up to 48 hours and the remaining 10 women had delays ranging from two to four days. During inspection, when reviewing women's postnatal records, we did not consistently see clearly documented risk assessment or mitigations taken to protect patients from harm.

Staff knew about but did not always deal with any specific risk issues. Leaders did not always ensure that women who had pre-labour spontaneous rupture of membranes received an induction of labour within 24 hours. We did not see that staff recognised, responded to risk and appropriately re-prioritised women who were at high risk of ascending infection which could lead to serious harm or death. We observed one woman whose waters had broken on the ward and was waiting for induction of labour for over 48 hours. This meant this patient was at a higher risk of infection, and whilst staff undertook tests to check for infections, they considered reprioritising the woman's induction of labour. However, there was no capacity on the labour ward to accommodate new labouring mothers.

Since our inspection, on the 28 June 2022, leaders updated the Induction of Labour (IOL) policy to include managing delays in the induction process. However, prior to the inspection incident reporting was not specified within the trust policy to report delays in IOL.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used the modified early obstetric warning score (MEOWS) chart to record and monitor pregnant, labouring and postnatal women's observations. During inspection, we observed that staff correctly completed MEOWS charts. From March 2022 to June 2022, the service audited 30 random patients' medical records to ensure maternal observations were undertaken, recorded at the correct frequency and calculated correctly. The service report 100% compliance.

The service ensured that cardiotocograph's (CTG's) were evaluated every hour and fresh eyes evaluated, as per the services policy. In January 2022, the service had initiated a fresh eyes buddy system, where two midwives would buddy-up and check each other's CTG traces every hour. In April 2022, the service undertook an audit of 27 medical records; 54% were using the CTG and fresh eyes every other hour, 37% had evidence of the buddy system fresh eyes, and 7% did not have evidence of the systematic assessments of the CTG traces. This was an improvement to the fresh eyes audits from June 2021 and December 2021 audits.

The service used the World Health Organisation (WHO) safer surgery checklist and audited the WHO checklist annually. On 20 June 2022, we observed the WHO checklist in use in theatres for women having elective caesarean sections. The process was well embedded in maternity theatres, every member of staff listened and was involved. The service used a

whiteboard in the checklist to aid in the clear understanding of the WHO checklist for staff. The WHO safer surgery checklist audit for March 2022, showed the service observed an elective caesarean section theatre list and 23 of the 68 questions were ticked as not being applicable. Two questions were below 80%, an action plan was created and actioned. The other 43 questions were 100% complaint. Therefore, the relevant questions were answered appropriately.

The service had access to specialist mental health midwife support and a perinatal mental health midwife. In the national maternity survey in 2021, a lower than national average number of women felt that midwives discussed mental health during antenatal appointments.

Staff shared key information to keep women safe when handing over their care to others. From March 2022 to June 2022, the service audited 30 random patient's medical records to ensure the Situation Background Assessment Recommendations (SBAR) handovers were documented on transfer to a new location, 96% of records included a written record of a handover. The remaining 4% recorded a verbal handover without the content of the handover documented. This was not compliant with trust policy.

However, shift changes and handovers did not always include all necessary key information to keep women and babies safe. From March 2022 to June 2022, the service audited 30 random patient's medical records to ensure the SBAR handovers were documented at shift changes, 76% of records included a written handover. The remaining 24% were verbal handovers without the content of the handover documented. Therefore, this was not compliant with trust policy. Leaders reminded staff to document all handovers in line with trust policy. Leaders would arrange another audit to check handover compliance once the new electronic patient records system was fully embedded.

Midwifery staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.

Managers could not accurately calculate and review the number and grade of midwives and midwifery assistants needed for each shift in accordance with national guidance. The service did not have enough nursing and midwifery staff to keep women and babies safe. The service had high vacancy rates. The service provided their Birthrate plus assessment in March 2021, which identified a gap of 17 whole time equivalent midwives from the current establishment, plus three midwifery vacancies. The trust received some additional national funding based on the Ockenden recommendations. As a result, there was an establishment gap of 13.5 whole time equivalent midwives. In August 2022, leaders told us they had appointed additional staff which left current vacancies at 5.60 whole time equivalent midwives.

The ward manager could not always adjust staffing levels daily according to the needs of women. Managers met twice daily to discuss the staffing levels required on shifts dependant on the needs of the women. However, the service did not always have enough staff available to cover essential services, such as delivery suite and the antenatal and postnatal ward. On 21 June 2022, the service had six out of the ten midwives required for the night shift to cover delivery suite and ward D.

During the trust daily staffing meeting, the shortages overnight were discussed, including acuity on delivery suite and ward D. The mitigation was that there were two community midwives on call overnight, but they may be required to work in the delivery suite. However, the number and length of time women were waiting for induction of labour were not discussed. This meant that leaders were not always considering priorities of the needs of the woman and to ensure birth choices were maintained.

Maternity

The number of midwives and healthcare assistants did not match the planned numbers. For the week beginning 13 June 2022, 81% of shifts on delivery suite and 67% of shifts on ward D did not have enough registered midwifery staff. In the same week, 62% of shifts did not have enough non-registered maternity support staff to cover the service. In seven of the 21 shifts reviewed over the week of the 13 June 2022, we saw nurses assisted in maternity services when staffing was short but not for all shortages we reviewed.

From January 2022 to June 2022, turnover rates were 3% for registered midwives and 5% for non-registered maternity support staff.

Sickness rates from December 2021 to May 2022 for nursing and midwifery staff within the maternity core service has steadily increased from 4% in September 2021 to 11% in March 2022. The average sickness over the six-month period was above 9%.

From January 2022 to June 2022, the maternity unit midwives collectively worked overtime on average 140 hours per month and the service required bank midwives for an average 138 hours per month. In community, over the same time period, midwives worked overtime on average 46 hours per month and the service required bank midwives on average 40 hours per month. However, this was to cover the shortfall in midwifery staff employed by the service.

Managers did not use agency staff, despite trying, because there was no availability of agency services in the local area.

Medical staffing

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

The service had enough medical staff to keep women and babies safe. The medical staff matched the planned number. From March 2022 to June 2022, the service had a greater number of obstetric medical staff, including consultants, middle grades and on call staff, working compared to the planned requirements.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

From December 2021 to May 2022, the average sickness over the six-month period was 3%.

From January 2022 to June 2022, the service used medical bank staffing on average 10 hours per month, which was equivalent to one shift a month.

The medical staffing turnover was zero between January 2022 and June 2022.

From January 2022 to June 2022, the service accessed on average six, 10-hour shifts, for obstetric and gynaecological doctors over the timeframe.

The service had access to anaesthetic support on delivery suite when required. During weekdays, from 8am to 6pm there were consultant and trainee anaesthetists on delivery suite and a separate anaesthetist covering the elective caesarean section list. Out of hours, there was a dedicated trainee anaesthetist to support maternity both on delivery suite and in emergency theatres. An anaesthetic consultant was available, out of hours, on the phone or in person within 30 minutes, 24 hours a day, seven days a week.

Maternity

Records

Staff endeavoured to keep detailed records of women's care and treatment. However, records were not always clear, up-to-date and were not always easily available to all staff providing care, but they were stored securely.

Women's notes were not always comprehensive and not all staff could access them easily. The maternity services had recently changed over to an electronic maternity system but still had some paper records. Staff told us they were worried that women's notes were not always being saved and they could not always find the notes written to check. Some staff told us that they were recording information twice, digitally and on paper. We saw that not all paper medical records were completed fully. This meant that staff were not confident that the electronic system would record all the records required.

Records were stored securely. Digital records were stored in a secure system. On Ward D, we observed the consultant ward round; the trolley was locked when staff went into the bay to see the patient. At other times, it was kept locked in the staff office. The patient board was also in the office and had a privacy flap to cover names and protect patient confidentiality.

In April 2022, the service provided a record keeping and legibility audit for obstetrics and gynaecology, the overall compliance was 83%.

Medicines

The service did not always use systems and processes to safely prescribe, administer and store medicines.

There was a lack of robust systems and processes to safely store medicines within maternity services which could expose women and babies to the risk of harm.

Staff did not always store and manage all medicines safely. We observed that medicines were not always stored securely. On the 22 June 2022, we observed medicines store cupboards and medicine fridges were accessible to staff who had access to theatres and the clean utility in delivery suite. These included anaesthetic medicines and antibiotics. The service was aware that medicines in maternity theatres were not locked and had mitigated the risk on the risk register by installing swipe card access to the theatres. However, after we wrote to the trust in the letter of intent, leaders told us they would install keypad access to the theatre cupboard to further mitigate the risks.

On the 21 June 2022, we observed that stock of medicines was not being monitored safely. We saw several medicines being stored that were out of date within the community midwives' storeroom and delivery suite clean utility, which could mean out of date medicines provided less effective treatments.

Pharmacy undertook a safe and secure handling of medicines audit in May 2021 and May 2022. Concerns found within the audits were escalated to the Quality Assurance Committee through the medicines management annual report in May 2022; the pharmacy leads had highlighted that there was a substantial gap in pharmacy cover with no dedicated pharmacist. Within the divisions risk register insufficient pharmacy provisions across the FICC division was rated as a current risk score of 15. There were limited actions and control measure to mitigate the risk within maternity services.

We saw insulin needles stored in the clean utility on delivery suite that were prescribed in 2016 to an individual patient.

We observed a large quantity of historically dispensed patients' own medicines stored within the delivery suite clean utility. Staff told us they had escalated this to pharmacy but there was no clear process to return them to pharmacy leading to unnecessary quantities of medicines being held on the delivery suite.

Maternity

We saw that the post-partum haemorrhage emergency medicines “grab box” on delivery suite, which contained medicine for use in the event of an emergency had been checked on 7 of the 31 days in May 2022 and four out of 22 days in June 2022.

We observed that the delivery suite did not always have access to in date equipment and medicines to care and treat patients with signs and symptoms of sepsis. During inspection, we observed out of date blood culture bottles and out of date policies and algorithms within the service.

Medicines on the midwifery day unit were not always stored at the correct temperatures. During inspection, on the day assessment unit, we saw medicines were stored in a room where external temperatures were exceeding 25 degrees which could lead to medicines becoming less effective and cause harm to patients if given. This had been escalated to the pharmacy team, but no actions taken to resolve. In 2022, the pharmacy undertook a safe and secure handling of medicines audit of the FICC division which showed two of the four areas had room temperatures recorded daily. It did not evidence whether the medicines room exceeded maximum temperatures or not.

In 2022, pharmacy services undertook a safe and secure handling of medicines audit the FICC division. Compliance rates showed that the delivery suite was 82% complaint, maternity theatre was 72%, maternity day unit was 96% and Ward D was 91% compliant. We were not provided with an action plan to show planned improvements for those with lower compliance rates.

Staff did not always follow systems and processes to prescribe and administer medicines safely. Within the trust’s quality assurance process, the Collaborative Organisational Accreditation System for Teams (COAST), on 16 November 2021 staff were observed not carrying out full identification checks before administering medicines. The action plan stated that staff were reminded to carry out full identification checks when administering any medicine. Managers did not always ensure that all staff had medicines management mandatory training that required it. The compliance rate in June 2022 was 70%, which was below the trust’s compliance target of 95%.

However, we did see that the service had a controlled drug audit in April 2022, over maternity services the average compliance was 97%. This had been an increase in the previous three quarters.

Incidents

Staff recognised but did not always report incidents and near misses. Managers did not always consider the risk of harm in near misses when managing safety incidents. Managers investigated incidents but lessons learned were not always shared with the whole team. However, when things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. But staff did not always raise concerns and report incidents and near misses. Staff told us incidents were not always reported due to staffing constraints. However, on 28 June 2022, the service told us there had been no significant reduction in incident reporting numbers. The service monitored incidents monthly through the quality and directorate meetings.

The service did not ensure that delays in inductions of labour were incident reported. Staff told us they did not have the capacity to complete incident forms due to lack of adequate staffing and significant pressures to keep women safe from harm. This meant that delays were not always being escalated to leaders.

Maternity

Managers investigated incidents but did not always consider the risk of harm in near misses when managing safety incident. We saw incidents of near misses which had been closed with little information on the learning identified. Staff told us that because there was not actual harm there was limited action or learning as a result of these incidents.

Staff told us that bereavement paperwork had been completed incorrectly on multiple occasions due to the complexity of the paperwork. However, these incidents were not reported and there was no identified lead to ensure lessons could be identified and shared.

In addition, we saw that over a year ago two of the Healthcare Safety Investigation Branch (HSIB) investigation reports highlighted concerns relating to induction of labour and we did not see that learning had been identified and shared. There was a risk that teams were not aware of the number of delayed inductions and the potential risks.

Managers did not always share learning incidents within the service and those that happened elsewhere with their staff. Maternity services did not have a system which evidenced a robust approach to sharing lessons from incidents and never events. We heard evidence from staff there was a lesson learnt newsletter circulated monthly, but staff did not have time to read the newsletter. We did not see that lessons learned where shared in any other format. In addition, we did not see that staff shared or discussed incidents at handovers. In response to the letter of intent, the trust told us they introduced a weekly newsletter to feedback on lessons learned, they emailed the newsletters to staff and displayed in clinical areas.

Incidents were discussed at a weekly meeting. Attendance was not mandatory, and staff were prioritising delivering of patient care. However, no minutes were taken, and staff were unable to learn about the content of the meetings they had missed.

However, staff reported serious incidents clearly and in line with trust policy. Five maternity related serious incidents were reported during the six-month period from 1 November 2021 to 30 April 2022. Two of these incidents were related to incorrect calibration of CTG machines. The service had shared learning with staff regarding how to check the speed of the CTG machines to prevent reoccurrence of the serious incidents. All staff we spoke with could explain the CTG requirements and how to check the machines.

Managers debriefed and supported staff after any serious incident. Staff told us that leaders were supportive and debriefed when incidents occurred and the service “felt like a family”.

The service had one never event reported in maternity services. In April 2021, the service had a never event regarding a retained gauze swab post normal delivery and surgical repair. Since the never event the service aligned its checking procedures to the theatre checking processes. However, during inspection we reviewed the WHO checklist in theatres and observed that the service had an effective process.

Staff understood the duty of candour (DoC). They were open and transparent and gave women and families a full explanation if and when things went wrong. The trust updated their DoC policy in March 2022, the timeframes required for DoC were described “as soon as reasonably practical”. The service provided evidence of DoC compliance from February to June 2022. The initial verbal DoC was completed on average within 16 days and initial DoC letter was completed on average within 57 days. The service completed the final DoC letters within 87 days. The others did not want to be informed of investigation findings. Since our previous inspection, the service had improved the monitoring of their DoC compliance.

Maternity

Is the service effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance.

We observed the service did not effectively manage the standardisation and version control of policies, proformas and procedures. We saw out of date printed policies and proforma in delivery suite which could lead to delays in treatments or staff not following up to date guidance which could cause harm to patients.

The service had a guideline for sepsis in pregnancy and puerperium (meaning the postnatal period up to about six weeks after childbirth), dated December 2019. It described the recognition, diagnosis and early management of sepsis in women who were pregnant, who have delivered, had a termination or fetal loss within the last six weeks. It was aligned to national guidance. In June 2022, the service undertook a sepsis audit for the entire month of June, on patient was identified within the timeframe who had sepsis. Maternity services had treated the one patient within the time frames as per policy. Leaders reviewed staff understanding and 100% of five staff spoken with could explain the risk factors of sepsis.

The service had a policy to support women who received a diagnosis during pregnancy of a fetal chromosomal or structural anomaly; however, the version reviewed during the inspection process had passed the review date of November 2021.

The service reviewed their progress regularly against Ockenden and the Saving Babies Lives outcomes and standards. The Saving Babies Lives audit in April 2022 showed that in all five areas maternity met the recommended requirements.

The service ensured that staff were monitoring growth of babies effectively to recognise babies that were small for gestational age (SFG) or had fetal growth restriction (FGR). The service undertook monitoring through an online auditing tool which used the saving babies lives care bundle algorithm for identification of increased risk pregnancies. From January to March 2022, the service achieved a detection rate of 58%, compared to the national average of 42%.

Nutrition and Hydration

Staff gave women enough food and drink to meet their needs and improve their health. But staff did not always support women with infant feeding and hydration techniques when necessary.

Staff made sure women and babies had enough to eat and drink. The service had staff designated to ensure women received adequate food and hydration. Ward D had immediate access to formula but breast pumps and storage fridges for expressed breast milk were on the neonatal unit.

Maternity

The service did not always provide enough support to mothers wanting to breast feed their babies. There was no area on ward D where expressed breast milk could be stored and there were no breast pumps located on the ward for women to use. Breast milk was stored in the neonatal intensive care unit fridge and freezer. Each woman had their own tray and each milk bottle was labelled with the expressed date and the defrosted date, where applicable. However, we observed that the lack of secure fridge storage for women on ward D could cause delays in retrieving expressed milk to feed to babies when required. Senior leaders were not sighted on the potential delays in accessing expressed milk for new mothers.

From June 2021 to May 2022, on average 63% of women started breast feeding within 48 hours of delivery. The service reported that this was high risk on the dashboard. In the national maternity survey in 2021, a lower than national average number of women felt that they could access support or advice about feeding their baby during evenings, nights or weekends. We were told about a woman who required breast feeding support overnight but was given formula bottle instead.

Although the service had access to breast feeding volunteers that supported women with advice and positioning assistance during the day, on the ward, and could support in the community following discharge. The volunteers were not permanent members of staff, so could not always be relied upon to always be there to support women. Leaders told us that the service had a breastfeeding steering group across the local integrated care system (ICS).

Pain relief

Staff assessed and monitored women regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed women's pain and gave pain relief in line with individual needs and best practice. We reviewed patient records on Ward D and appropriate pain relief was given when requested, including for women who had received a caesarean section.

Women received pain relief soon after requesting it. From June 2021 to May 2022, 85% of women who requested an epidural received one within less than 30 minutes. Out of the remaining women waiting for epidurals, 13% waited from 30 minutes to over one hour and the other 2% was not recorded.

Patient outcomes

Staff did not always consistently monitor the effectiveness of care and treatment. They did not always use the findings to make improvements in outcomes for women.

The service participated in relevant national clinical audits. Leaders had an audit schedule that planned and monitored the progress of audits. The service had started, and completed some of, the nine national audits, 13 divisional audits and 14 local audits, including cardiotocography (CTG) auditing.

The service did not ensure that all women with poor outcomes had their placenta sent for histology. The service provided evidence of placentas that were sent for pathology and histology. From November 2021 to May 2022, of the 196 births that required placental histological investigation only 50% were sent for histology. This was not aligned to the trust's labour care guidance.

Maternity

The service met the Royal College of Obstetricians and Gynaecologists (RCOG) guidance for the maternity dashboard to monitor clinical performance and governance. The dashboard included the three recommendations as per the RCOG guidance. The RCOG recommended clinical activity, clinical outcome indicators and risk incidents, complaints and patient satisfaction. However, the service did not always consistently monitor care and treatment and did not always use the findings to making improvements in outcomes for women.

The service recorded two unexpected admissions to the intensive care unit in the 12-month period from June 2021 to May 2022. For the same period, on average 4% of babies born per month had unexpected admissions to the neonatal intensive care.

The service reported low rates of third and fourth degree perinatal tears. We saw on average per month, 2.8% of women had third and fourth degree tears.

The service had a reported moderate number of post-partum haemorrhages (PPH) over 1500 millilitres. From June 2021 to May 2022, on average 4% of all women, per month, who gave birth had a PPH over 1500 millilitres.

The service had a low number of babies that had shoulder dystocia, when the baby gets stuck in the birth canal. From June 2021 to May 2022, we saw on average per month 1% of babies had shoulder dystocia.

The service did not always report Appearance, Pulse, Grimace, Activity and Respiration (Apgar) score outliers, this is the measure to check a baby's health after birth and ongoing. The service reported figures for apgars at less than seven at five-minutes after birth for five of the 12 months reported, the figures varied from one to eight babies per month.

The service initiated skin to skin contact within one hour of delivery on average for 74% of women and babies per month. This was reported as a moderate risk. Staff told us skin to skin had to be continuous unbroken skin to skin contact for one hour post delivery to count as 'skin to skin'. The national Institute for Health and Care Excellence guidance for intrapartum care quality standards [QS105] 2017, did not specify the timeframe for skin to skin but that it must be initiated within one hour. This could account for the discrepancy in reporting.

From February 2022 to May 2022, the service had 14 women return with postnatal infections within 42 days of delivery and four women returned over 42 days. No women received an emergency hysterectomy in the service within the last year.

Managers reported all still births over 24 weeks, fetal losses between 22 and 23 weeks gestational age, and neonatal and post-natal deaths of babies born after 22 weeks to Mothers and Babies: Reducing Risk though Audits and Confidential Enquiries across the UK (MBRRACE-UK). This was aligned to national guidance. The service provided from May 2021 and June 2022 data, managers ensured perinatal mortality review tools (PMRT) criteria was met in all 22 cases, the family had been informed and multidisciplinary case reviews were recorded appropriately.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance and did not always hold supervision meetings with them to provide support and development.

Managers could not always demonstrate that staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The recognise and act course was a mandatory course for registered and non-registered

nursing staff who cared for patients across the trust, which included sepsis training. A more medicalised version of recognise and act training was delivered to junior medical staff as part of their induction period. Compliance rates for the recognise and act course were not aligned to the trust's compliance rate of 95%. In June 2022, midwifery staff compliance rates were recorded as 58% and medical staff was provided as 0%.

However, maternity services told us they included sepsis training related to women during their emergency training. Compliance rates were provided for the year 2021, 40% of medical staff, 87% of all midwifery staff and 69% of non-registered maternity support staff had sepsis training related to women. All staff received neonatal sepsis training on induction. Therefore, this meant that staff were not always receiving up to date training for identifying, escalating and managing patients with signs and symptoms of suspected or confirmed sepsis.

Staff had limited opportunities to discuss training needs with their line manager and were not always supported to develop their skills and knowledge. Managers did not always support staff to develop through yearly, constructive appraisals of their work. In June 2022, 21% of midwives, 21% of non-registered support staff, 83% of consultants and 75% of medical staff had up to date appraisals. This was below the trust's compliance target of 90%. Staff told us they did not always have time during working hours to complete their appraisals and protected time was not always made available. However, senior leaders told us they had a plan to ensure staff received their yearly appraisals.

Senior midwives supported the learning and development needs of junior staff and students. Managers identified training needs for their staff but did not always give them the time and opportunity to develop their skills and knowledge. Staff told us they were not always given protected time to complete mandatory training and appraisals during work time. Managers did not always make sure staff received cardiotocography (CTG) training and did not always make sure staff completed competency assessments.

In June 2022, 76% of midwives and 50% of medical staff received the annual face to face CTG training. The average compliance figures for antenatal, intrapartum and intrapartum intermittent auscultation compliance assessments were completed by 68% of midwives and 47% of medical staff. These figures were below the services compliance target of 90% from the training needs analysis (TNA) for specialist training in the maternity services policy, updated and approved in April 2022. However, the service had identified an obstetrician and a midwife to lead on fetal monitoring. Staff told us the fetal monitoring midwife performed mobile training to staff on the wards on a Wednesday, every week, with the aim of improving compliance.

Managers did not always make sure staff attended team meetings and did not ensure staff had access to meeting notes when they could not attend. Staff told us they did not always have the time to attend team meetings due to capacity.

Managers did not always make sure staff received specialist training for their role. The service did not always ensure staff attended the annual multi-professional maternity emergency training. The training was the same programme for maternity support workers, medical staff, and community and hospital-based midwives. In June 2022, the service supplied compliance rates for skills and drills; 60% of maternity support workers, 56% of all medical staff and 52% of community based clinical midwives were compliant. This was not aligned to the services TNA for specialist training in the maternity services policy. However, hospital-based midwives did achieve higher compliance rates of 92%. This meant that eligible staff did not always get an opportunity to practice emergency situations and learn from colleagues in a safe environment.

Staff told us that they did not receive specialist training in bereavement. The service did not provide protected time to ensure bereavement was being taught appropriately and managed within maternity services. During inspection we were told of delays of a baby's funeral due to the paperwork being incorrect.

Maternity

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed good multidisciplinary working, both clinical and non-clinical, during our inspection. We observed that doctors and midwifery staff worked well together. Staff told us that there was good teamworking and good relationships through the midwifery multidisciplinary team.

Staff referred women for mental health assessments when they showed signs of mental ill health. According to the service's perinatal and infant mental health guideline, dated December 2019, midwives were able to refer to the specialist perinatal mental health midwife and other specialists including specialist health visitors and the specialist perinatal community mental health team.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. We observed a consultant ward round and we were told that the consultant attended daily including weekends.

Staff could call for support from doctors and other disciplines, 24 hours a day, seven days a week. Women had access to on call community midwives and maternity services overnight when required. However, the staffing escalation plan involved calling community midwives into labour ward when the service did not have enough staff. This would mean that women may not always be able to have the choice of a home birth if the service was short staffed.

Women had access to triage 24 hours a day, seven days a week. The triage services were run from the designated triage area by midwifery triage staff Monday to Friday for 24 hours and Saturday and Sunday 7.30am to 8pm. Outside of these times, triage was undertaken in the delivery suite. Staff had access to doctors and consultants, when required for further assessments. Sonography could be sourced when needed.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards and units. We observed that the service had leaflets to promote breast feeding during the inspection.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service did not provide additional services but could refer women to smoking cessation classes within the local community. In the maternity dashboard, from June 2021 to May 2022, the service recorded high numbers of women smoking at the time of booking and delivery. There was on average per month 19% of women smoked at the time of booking and 16% smoked at the time of delivery. This was recorded as being higher than the national average of 10.7% for both smoking at booking and delivery.

Maternity

The service offered parent education through an independent company. During the COVID-19 pandemic the classes stopped but offered appointments and online education support. However, parent education classes were due to be re-instated in July 2022, and would be offered in-person at the hospital and online classes. The classes included smoking cessation and safeguarding. We requested, but did not receive, evidence of how many women accessed parenting classes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account women's wishes, culture and traditions.

Staff made sure women consented to treatment based on all the information available.

Staff clearly recorded consent in the woman's records. In June 2022, the service reviewed 15 patient medical records, consent was gained 100% of the time for both caesarean section and perineal suturing, but 87% of the time consent was gained for instrumental delivery.

Staff received and kept up to date with training in the Mental Capacity Act.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Specialist midwives included a team of safeguarding midwives who were available to support both women and staff.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness and had the facilities to respect their privacy and dignity and took account of their individual needs.

Maternity

Women said staff treated them well and with kindness. During our inspection, all the women we spoke with were positive about the midwives, despite them being extremely busy. Women told us they felt listened to, cared for and respected. The staff were very patient focused. We observed that staff were caring and compassionate throughout our inspection and were focused on the needs of the women. Staff were putting women and babies first to ensure they received the care they needed.

In May 2022, the families and integrated community care team received 110 compliments, which included gifts, cards and letters.

We observed that staff were discreet and responsive when caring for women. They interacted with women and those close to them in a respectful and considerate way.

In the national maternity survey in 2021, a lower than national average number of women said they were given enough time to ask questions or discuss their pregnancy during their antenatal check-ups. However, in May 2022 the service launched a new electronic patient record system to enable women to submit their thoughts and questions about their antenatal care and birth plans across to their midwife between check-ups.

Staff followed policy to keep women's care and treatment confidential. In delivery suite, we were told that the privacy curtains had been removed and not replaced due to the COVID-19 pandemic. However, the delivery suite had individual rooms.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. In the national maternity survey 2021, the service performed better, when compared to the national average, for partners and those close to women being involved in the care during labour and birth.

The service had a policy and procedure to support women who have previously experienced a stillbirth, neonatal death or late miscarriage.

The service did not have a dedicated bereavement midwife at the time of inspection. There was a member of staff from the trust 'Swan' end of life team who was supporting with any administration processes. The service had policies to explain the funeral arrangements and coroners' referrals when required.

The hospital provided baby memorial services every Tuesday by the chaplaincy and spiritual care team. In May 2022 five services were held but no family members attended.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff supporting women who became upset; privacy curtains were available when needed. In the national maternity survey 2021, the service performed better when compared to the national average for the comfortable atmosphere created during labour.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. A higher number of women felt they could raise a concern during labour and be taken seriously when compared to the national average.

Maternity

Understanding and involvement of patients and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment. Women gave positive feedback about the service.

Staff made sure women and those close to them understood their care and treatment. However, women were not always kept informed of the rationale for staying in hospital or expected timeframes for induction. Some women told us this impacted their ability to see and care for their families including other young children at home.

We observed that staff supported women to make advanced decisions about their care. However, in the national maternity survey in 2021, a lower than national average number of women said that they had a choice about where their postnatal care would take place.

Women generally gave positive feedback about the service. The service provided results of the friends and family test survey for maternity services from April to June 2022. In total 82% of women said their care was good over maternity services including community, delivery suite, postnatal ward D and the birthing centre. Friends and family test results revealed the lowest percentages of good care were in community antenatal care (71%) and community postnatal care (76%). This had reduced since the previous friends and family test results from April 2021 to March 2022, 82% of friends and families said there was good community antenatal care.

The trust performed about the same as other trusts for the majority of the 50 questions in the CQC maternity survey 2021. Out of the 50 questions, four were worse and somewhat worse than expected. All of these were regarding antenatal information and care. The service scored somewhat better than expected in two questions.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service had systems to help care for women in need of additional support or specialist intervention. The service had a team of specialist midwives to support women in the local population such as mental health, complex case (women with multiple medical conditions), safeguarding, teenage pregnancy, drug and alcohol dependency and screening midwives. However, at the time of our inspection there was not a dedicated bereavement midwife.

Facilities and premises were not always appropriate for the services being delivered. The bereavement suite included a non-clinical bed and soft furnishings but also included some clinical facilities. The shower had been broken and was awaiting repair. The footprint of the service meant that the in-patient wards and day case unit were at full capacity. The day case unit included the triage area.

Maternity

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. The service coordinated care with other services and providers when they could.

Birth plans were discussed antenatally. Women assessed as low risk could choose to plan for a home birth or a hospital birth. Two community midwives were identified as on-call in the event of a home birth, however; staff told us that due to staffing shortages on the wards, community staff needed, at times, to support the hospital. This meant that if a woman was in labour and had planned a home birth, she would need to go to the hospital instead.

Staff made sure women and visitors living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had complex needs specialist midwife and mental health specialist midwives to support the care provided for women with learning disabilities and mental health problems and to support pregnant women under the age of 18. The hospital computer system prompted staff with flags if patients were known to have learning disabilities.

Staff understood the policy on meeting the information and communication needs of women with a disability, sensory loss or different spoken language. The service had information leaflets available in languages spoken by the women and local community. We observed that the service had information leaflets with differing spoken languages, including Spanish, Urdu, Arabic and Hindi. Some leaflets seen included QR codes to enable access to maternity safety information in different spoken languages. Senior leaders told us the languages varied in the area at different times, some frequent languages included Vietnamese and Romanian.

Managers told us that staff, women, loved ones and carers could get help from interpreters or signers when needed. The service had access to interpreters and the use of language line when women and visitors required an interpreter. However, staff told us they are unable to get an interpreter for the dialect Kurdish Sorani, which caused difficulties with communication.

Staff did not always have access to communication aids to help women become partners in their care and treatment. We observed that a woman was on ward D who could not speak English. Staff told us this caused challenges with communication with the woman. We did not see any other communication aids such as pictures to aid in communication difficulties. This meant that staff could not always ensure women were involved and understood their care and treatment.

Midwives did not always have access to aromatherapy for women who wanted to use it during labour. The aromatherapy policy was in date but the oil in the policy was not available for staff to use with women during labour. We saw that aromatherapy oils within delivery suite were locked away, but the orange and jasmine oils were past their expiry dates. We observed two unidentified oils that were not covered within the guidance to use for women in labour. Midwives we spoke with told us they had not received training in the use of aromatherapy.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Managers monitored waiting times but did not always make sure women could access services when needed and received treatment within agreed timeframes and national targets.

Maternity

From May 2021 to April 2022, 90% of women were booked into the service by 12 weeks' gestation. However, this figure reduced in May 2022 to 55%. Leaders told us the booking delays were due to the introduction of the new electronic patient record system and support was in place to make improvements.

On inspection we observed that eight women were waiting prolonged time periods for induction of labour.

Managers did not always work to keep the number of cancelled appointments to a minimum due to the management of the on call rota. When women had their appointments cancelled at the last minute, managers did not always make sure they rearranged clinic appointments as soon as possible and within national targets and guidance. On 22 June 2022, community midwives had cancelled two booking clinics last minute and rearranged community visits to support in other midwifery clinics. This was due to two community midwives being called to a home birth overnight.

From February 2022 to April 2022, out of the 94 women booked in late, 48% had their late booking appointment within two weeks of referral. Women were defined as booking in late when they were booked in after reaching 12 weeks and six days of pregnancy. In the four-month period from February 2022 to May 2022, the service recorded 185 women who did not receive antenatal bookings by 12 weeks and six days. We received figures from the same time period, of the 48 recorded 6% of women had bookings delayed due to maternity influencing factors, which included the midwife being unaware and delays in scans. The rest were women's influencing factors such as concealed pregnancies.

Managers monitored waiting times but did not always make sure women could access emergency services when needed to. Women did not always receive treatment within agreed timeframes and national targets. From June 2021 to June 2022, nine incidents were identified where there were delays in transfer to the chosen place of birth due to capacity or staffing issues.

Managers monitored that patient moves between wards were kept to a minimum. Depending on length of stay, women were either discharged directly from the delivery suite or from the postnatal ward if transferred there. Managers and staff worked to make sure postnatal women did not stay longer than they needed to.

The service moved women only when there was a clear medical reason or in their best interest. For women who had experienced a bereavement, they remained in the delivery suite until discharge.

Managers and staff started planning each woman's discharge as early as possible. Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Specialist midwives supported women dependent on their individual need as necessary.

Staff supported women and babies when they were referred or transferred between services. From January 2021 to May 22, 25 women had planned home births, three women were transferred from home to the hospital delivery suite. In addition, there were 11 unplanned home births, six women were transferred from home to the hospital delivery suite following the birth.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them but did not always shared lessons learned with all staff. It was not clear if the service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. We observed during our inspection information was clearly displayed how to feedback to the service. We saw QR codes being used to assist in gaining feedback.

Maternity

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The trust policy, dated 2019, defined that complaints should be responded to within an average of 25 working days and up to 40 days for complex complaints. Of the nine complaints received from June 2021 to June 2022, seven complaints had been responded to. The average complaint response time was 23 days, with complex complaint response time averaging 47 days.

Managers investigated complaints and identified themes. From January to March 2022, the FICC division, which was not broken down by speciality, received 30 informal complaints and 21 formal complaints. In the same quarter, 60% of the formal complaints received were responded to within the timeframes set by the trust policy. Over the last year, one complaint in the FICC division had been referred to the parliamentary health service ombudsman.

From June 2021 to June 2022, maternity services received nine formal complaints, seven of these related to treatment concerns, the remaining two related to a hospital acquired infection and an administration concern.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Women received the response in writing and included an apology, explanation and answers to specific questions raised and what to do if the woman was unhappy with the complaint.

Complaint responses involved discussions with individual staff members. However, it did not evidence that learning was always shared across maternity services to prevent similar events.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced when raised. Local leaders were not always visible and approachable in the service for patients and staff.

The service had an executive director as a lead for the maternity services since 2019.

The board had identified a non-executive director for maternity services who took over the role during the COVID-19 pandemic in 2021. They had been a non-executive director within the trust since January 2019.

The triumvirate leadership team included the head of midwifery, the divisional director and the divisional director of operations. A new director of midwifery had been appointed and was due to commence in post later this year. The triumvirate were passionate about the service and sighted on much of the issues highlighted particularly the staffing challenges.

Maternity

Senior leaders participated in walkarounds through the department at least on a monthly basis. This included the non-executive director from April 2022. However, staff we spoke with told us that they did not always see senior leaders and were unable to name the non-executive director for maternity services.

During the inspection, staff we spoke with told us that ward managers and matrons were visible in clinical areas on a regular basis.

At the time of inspection the trust had appointed additional leaders for the service; however, interim arrangements were in place until taking up posts.

We identified that the matrons, clinical heads of department and divisional triumvirate leads understood most of the challenges facing the services and had implemented some improvement measures. We observed a disconnect between leaders and staff in maternity services; some challenges were not always being reported effectively which meant leaders were not always sighted on risks. However, the actions taken to address issues or reduce their impact did not always result in effective and timely improvements across the services.

The service had invested in developing midwives into the professional midwifery advocates (PMA). This followed the NHS England's advocating for education and quality improvement (A-EQUIP) which was a model for clinical midwifery supervision. Staff who had undertaken their PMA training were required to undertake the role on top of their current workload. Staff told us that PMA's were not given protected time to undertake the advocacy roles effectively. We were told PMA's undertook the role on an impromptu basis and many supervision conversations were informal. This meant that clinical supervision was not always made available and documented appropriately.

Vision and Strategy

The service had a limited vision for what it wanted to achieve in maternity services and did not have a clear strategy to turn it into action. Not all staff were aware of the vision and strategy and how to apply it.

The trust had a five-year plan, Our strategy 2022-2027. The strategy stated its aim was 'to improve the lives of people who live, work and volunteer on the Fylde Coast and beyond.' The strategy focus was 'working with our partners to provide high-quality services, whilst recognising that giving staff more power to create change is key to improvement.'

The trust's strategy was broken down into three elements; our people, our population and our responsibility. The strategy provided by the trust was for the Families and Integrated Community Care division. The first year's priority was to concentrate on recruitment in maternity services and developing new roles such as nurse consultants. They had plans to develop integrated neighbourhood teams which would allow primary care services, education and family hubs to work together. The trust were going to prioritise the delivery of Ockenden two, the CNST and continuity of care. There was limited detail in the strategy specifically related to maternity services.

The trust had introduced their updated strategy in April 2022, and posters were displayed with the trust vision. Senior leaders told us that engagement sessions were held with all staff to discuss various topics, including the trust strategy. However, staff we spoke with were not able to articulate the strategy.

The service had discussed the progress of introducing the new strategy during the families divisional board meeting in May 2022. However, the trust strategy was in the socialising and embedding stage and had been launched to all senior leaders on 15 June 2022.

Maternity

Culture

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

During our inspection, we spoke with maternity staff across a variety of roles and grades. All staff we met were friendly and welcoming.

Staff told us they were proud and happy to work at the trust. We were told that staff who had left the organisation often returned after a period elsewhere because of the positive culture in the service. The NHS Staff Survey showed 56% of staff said there were opportunities for them to develop their career in the organisation.

The staff worked well as a team. This included all staff - doctors, midwives, maternity support staff, and non-clinical staff including ward clerks, housekeeping and domestics.

Staff on the wards supported each other; however, they frequently missed their breaks due to low staffing numbers. We observed staff collectively having refreshments, in the office, while continuing their duties. Staff had escalated concerns to leaders; however, they did not always feel listened to.

All staff we spoke with, of different grades, were open and welcoming to CQC inspectors as well as other staff and patients.

Staff were committed to providing an excellent service for women and their families. Staff told us they had worked past their finish times and missed breaks to ensure women received the care they needed.

Staff told us they were exhausted. They were visibly emotional when discussing the staffing problems within the department and did not feel that they were able to do all they could to keep women and babies safe from harm. Staff told us they were not sleeping well when at home due to worrying about the previous shifts worked. Staff told us they felt there was a disconnect between staff on the wards and senior leaders about the level of safety on maternity wards and departments.

The trust had subscribed to a wellbeing and engagement app for all maternity staff. The app was a workforce engagement tool which worked towards unifying workforce culture, behaviours, engagement and performance management. It was designed to improve workforce communication and help staff feel more engaged. This was due to be launched in October 2022. A wellbeing officer had been appointed to support the delivery of the new app. They would also identify wellbeing needs of the staff.

Governance

Leaders had the systems for effective governance processes but not all risks were reported to allow oversight. Not all staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service but staff did not have the availability to attend meetings.

Staff did not always report all risks effectively which meant that leaders did not always have oversight of some risks, such as induction of labour delays and issues with bereavement paperwork. However, the key risks and performance issues that were reported on were routinely discussed at departmental and divisional governance meetings. The FICC

division held monthly governance, quality and clinical effectiveness meetings and an operations women's health directorate meeting. These fed into bi-monthly divisional board meetings. We found the governance and reporting processes enabled divisional leaders to understand the key risks and challenges that had been reported and the identification of improvement actions required.

During meeting minutes, we observed evidence of constructive challenge from attendees to the meetings recorded in meeting minutes. However, the actions taken to address key issues or reduce their impact did not always result in effective and timely improvements in the management of risks, issues and performance across the services.

Senior leaders reported to board on a quarterly basis to provide assurance on maternity services and the progress on the Ockenden action plans, Morecambe Bay (Kirkup Report), Clinical Negligence Scheme for Trusts (CNST); the maternity incentive scheme, HSIB and MBRRACE.

The trust had created an implementation plan following the Ockenden report recommendations. The trust addressed each of the 15 Immediate and Essential Actions (IEAs) and produced an updated report in April 2022 detailing progress made. One of the resulting actions detailed the need for a workforce action plan to recruit and retain midwives. Another noted the requirement to review the pathways for induction of labour, (IOL): to ensure it had a clear mechanism to describe safe pathways for IOL if delays occurred due to high activity or short staffing.

In the April 2022 report to the board, the service outlined the progress to achieving the maternity incentive scheme. The service were assured that they were on track to achieve nine of the 10 safety actions specified, except the safety action related to training. The report described the challenges the service faced with cancelling training and confirmed that training was on the risk register.

During our inspection, we saw five printed copies of proformas, algorithms and guidelines that were out of date, two of these were dated 2015. We alerted the trust of this, and they acted promptly to remove out-of-date information. We saw in the women's health directorate meeting in June 2022, the service had highlighted that the division had 75 overdue procedural documents. This was reflected on the risk register with a current risk score of eight which was double the target risk score. The control measures were the ongoing review of out of date policies but there were no open actions noted.

Senior leaders told us that the trust had updated their standard operating procedure for incident reporting, and this had been shared with staff across the trust. The updated process included a weekly meeting to discuss all reported incidents and themes identified. Midwives were invited to attend these meetings. The process stated learning would be shared with staff via a newsletter. However, staff told us that they did not have the time to attend the weekly meetings due to staffing pressures, nor did they have the time to read the newsletters.

Our review of notifiable incidents revealed discrepancies in the risk and harm stratification used; for example, we saw varied ratings for post-partum haemorrhage (PPH). This means it was not possible to be assured of the correct level of review for these incidents.

Staff told us that there were no specific team meetings held, but they had regular five-minute huddles in the office. There was no process in place for disseminating information to staff in a face-to-face structured format.

Maternity

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They did not always identify and escalate relevant risks and issues and did not always identify actions in a timely manner to reduce their impact. They had plans to cope with unexpected events but they were not effective.

Risks and incidents were monitored by senior leaders during the monthly women's health directorate meetings. This was the trust's monthly governance meetings, which reviewed incident reporting, serious incidents, HSIB reports, and the risk register within maternity services. The monthly governance report was shared at the divisional quality meeting. In the June 2022 meeting minutes, we saw that "the division had 326 risks on the risk register with 68 being divisional risks".

However, when we reviewed the maternity services risk register there were 104 risks on the risk register; 78 of these met the target risk scores but were still on the risk register. The remaining 26 had a higher current risk score than the target set; four of these had no control measure in place and five had no open actions. This meant that the service did not always have oversight of all the risks and did not always have actions or controls in place to reduce the maternity risks.

At the time of our inspection, the service had a maternity dashboard. The dashboard enabled clinical teams to compare their performance against National Maternity Indicators (NMIs) and Clinical Quality Improvement Metrics (CQIMs) in order to identify areas for local clinical quality improvement. However, the dashboard appeared to contain inaccurate information and was not fully completed. The service did not always report all figures consistently, we saw five of the 12 months reported apgars at less than seven at five-minutes after birth, the other seven months showed no data or figures. From April 2021 to March 2022, we saw that the service had on average 84 inductions of labour per month. But for the month of November 2021, the service recorded no inductions of labour.

Senior leaders told us their top risks were midwifery staffing numbers, smoking rates, uptake of breast feeding and lack of pharmacy oversight from a dedicated medicines team. However, we did not always see appropriate actions had been taken to mitigate these risks.

There was a lack of a robust escalation plan to managing staffing shortages. The escalation policy and flowchart showed some plans to managing staffing. However, not all appropriate actions were included to manage the risk to women and babies. Staff also told us that the escalation plan was not effective to manage and mitigate the risks. Staff told us that the lack of staffing was impacting their ability to provide safe care and treatment for women and their babies.

Leaders had recognised that mandatory and specialist training was a risk to women and babies and had two risk register entries regarding mandatory training risks. One was scored as a current risk of six and the other was scored at nine. The control measures included monitoring the mandatory training compliance. We were told this was reported quarterly to the governance meeting. We saw that mandatory training was reported for children's services in the May 2022 meeting minutes but this did not include maternity services. This meant that mandatory training was not always monitored as the risk registered stated in the control measures.

Information Management

The service did not always collect reliable data and analyse it. Leaders could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated but there was a security risk being managed by the integrated care system (ICS). Data or notifications were consistently submitted to external organisations as required.

Maternity

The service had introduced a new maternity digital record in May 2022. This was a full end to end electronic digital record throughout the pregnancy, birth and postnatal care. Also, there was the functionality for digital maternal notes known as Badgernotes. Women could see their plan for their pregnancy, add in comments, birth plans, and queries to their team, and see the outcome from visits.

The new maternity digital record system was in line with other trusts in the integrated care system (ICS). At the time of inspection, not all staff had received training although superusers were available from the trust and the ICS. Senior leaders told us they were pleased with how the system had been implemented and was being utilised. The trust had been made aware of a potential cyber threat, but this was being managed in the ICS.

However, there was a disconnect between the senior leaders and the staff on the wards. Staff expressed concerns that connectivity was not consistent throughout the department and they needed to use multiple processes to ensure they completed contemporaneous records. Staff told us that they could not always find the information recorded on the digital record system so staff were completing records on paper as well. This meant staff were not confident with the recording systems and were concerned about maintaining good quality and comprehensive records.

We observed there had been incidents when women were booked on multiple systems meaning staff were not clear about what appointments had been booked.

We saw an incident where there was a delay in generating a baby's hospital number when an investigation was required prior to the first feed. The decision was taken to allow the baby to feed to prevent any detrimental effects for the baby. However, this meant that the investigation was not completed as per policy due to technological delays.

Engagement

Leaders did not always actively and openly engage with patients, staff, and the public local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Senior leaders told us they engaged well with staff and staff survey results were positive when compared to other areas of the trust. The results for the service showed that 67% of staff would recommend the organisation as a place to work. Over 70% of staff would be happy with the standard of care provided by the organisation if a friend or relative required treatment. In addition, 83% of staff said the care of patients was the organisations top priority.

There were weekly Facebook live events for the public during the COVID 19 pandemic. The matron took over the Facebook page for one hour every Friday and answered users' questions in real time. There was also an option to send in questions beforehand. This was an example of using innovative solutions to engage with the public in different ways.

Staff we spoke with told us they received maternity services updates via email. However, they were not able to access information in a timely manner due to staffing issues. They told us they often needed to review information in their own time.

There was a maternity voices partnership (MVP), although senior leaders told us it was not utilised as effectively as it could be. They had identified another trust in the integrated care system that may be able to support and provide advice.

Maternity

The MVP chair for the Fylde coast attended the project groups and perinatal surveillance group to support in the co-production and involvement in maternity areas. They had also undertaken the 15 Steps Challenge (this was a toolkit to explore healthcare settings through the eyes of patients) and attended with users to gain independent feedback from service users.

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.

The trust had participated in developing a pathway for Born into Care with the local council. The trust was selected as a pilot site for HOPE (Hold On Pain Eases) boxes designed to help mothers capture important memories prior to separation. The aim was to promote ongoing connection between them and their baby post-separation whilst court proceedings were considering the longer-term plans for the baby. They also helped mothers grieve their immediate loss and acknowledge their parental identity.

The service had devised a virtual pre op assessment clinic prior to elective caesarean section. This reduced the need for women to come into hospital and have their appointment from the comfort of their home.

In June 2022, maternity services were fully compliant with year three of the maternity incentive scheme.

Outstanding practice

We found the following outstanding practice:

- The deputy head of midwifery and matron hold hour-long Facebook Live events where women and their families can ask questions and any worries can be addressed. This was implemented during the COVID-19 pandemic when face-to-face appointments were limited.
- Born into care and Hold On Pain Eases (HOPE) boxes – emotional support, mechanisms and communications going forward to support mothers and father post-separation from baby.

Areas for improvement

MUSTS

Maternity

- The service must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experiences persons, to include resuscitation and safeguarding training. (Regulation 18 (1)).
- The service must ensure that persons employed receive appropriate support, training, professional development, supervisions and appraisals to carry out the duties they are employed to perform. The trust must ensure there is sufficient capacity for clinical supervision to be delivered effectively by utilising the PMA roles or equivalent (Regulation 18 (2)(a)).

Maternity

- The service must ensure that they suitably assess and communicate the risks to the health and safety of service users receiving care and treatment and do all that is reasonably practicable to mitigate any such risk. (Regulation 12 (1) and (2) (a) and (b)).
- The service must ensure that the premises used by the service are safe for their intended purpose and used in a safe way (Regulation 12 (2) (d)).
- The service must ensure that the equipment used by the service for providing care and treatment is safe for use (Regulation 12 (2) (e)).
- The service must ensure there is proper and safe management of medicines to include the storage of medicines and safe disposal of medicines no longer required (Regulation 12 (2) (g)).
- The service must ensure that they assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. This must include ensuring appropriate cleaning schedules and cleaning is undertaken (Regulation 12 (2) (h)).
- The service must ensure the care and treatment of service users must be appropriate, meet women and babies needs and reflect women's preferences, including to support women and babies with breast feeding and ensuring available access to expressed milk. (Regulation 9 (1)).
- The service must ensure that they assess, monitor and improve the quality and safety of the services provided in carrying on of the regulated activity (Regulation 17 (2) (a)).
- The service must ensure that they assess, monitor and mitigate the risks related to the health, safety and welfare or service users and others who may be at risk which arise from the carry on of the regulated activity (Regulation 17 (2) (b)).

SHOULDS

Maternity

- The trust should ensure that women are fully informed about the reason for remaining in hospital ahead of an induction.
- The trust should consider utilising the trained professional midwifery advocates to support in professional development and supervisions.
- The trust should consider involving all staff in baby abduction drills as per the providers policy.

Our inspection team

During our inspection, we spoke with a variety of staff including consultants, junior and senior doctors, junior and senior midwifery staff, maternity support workers and healthcare support workers, divisional operations manager, deputy director of nursing and midwifery, divisional medical director, the non-executive directors for maternity services and executive director for maternity services. We visited the maternity services and held focus groups with different grades of midwifery staff. We reviewed patients records, national data and other information provided by the trust.

You can find 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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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