Bolton NHS Foundation Trust

Royal Bolton Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Royal Bolton Hospital

Good 

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

We inspected the maternity service at Royal Bolton Hospital as part of our national maternity inspection programme. The service provides care to the populations of Bolton, Wigan, Bury and Salford. Royal Bolton Hospital has approximately 5,500 deliveries each year. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

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

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

Maternity

Requires Improvement  

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

- Shortfalls of staff lead to frequent closures of wards, which reduced birthing options available to women and birthing people and delayed patient flow through the maternity pathway. Women and birthing people could access the service when they needed it and did not have to wait too long for treatment.
- The service provided mandatory training in key skills, however, did not always ensure everyone had completed it. Staff appraisal compliance rates were below the trust's overall target.
- The service did not always manage safety incidents well as there was a backlog of incidents awaiting review.
- Staff did not consistently complete checks of specialist equipment.
- Staff surveys showed there was scope to improve the leadership support they received. Staff reported an improving leadership culture; where leaders and managers were more approachable and visible on the wards.

However:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service managed medicines well. The service used systems and processes to safely prescribe, administer, record and store medicines. The service controlled infection risk well. Staff worked together as a team to benefit women and birthing people. All staff were committed to continually learning and improving services.
- Staff supported and involved women and birthing people, families and carers to understand and make decisions about their care and treatment. Staff assessed risks to women and birthing people, acted on them and kept good care records.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- The service engaged well with women and birthing people and the community to plan and manage services

Is the service safe?

Requires Improvement  

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

Mandatory training

The service provided mandatory training in key skills to all staff but did not always ensure everyone had completed it.

Maternity

Staff did not keep up to date with their mandatory training. Completion of mandatory training across all staff groups was below the Trust's target of 85% for six consecutive months from January 2022 to June 2022, with training data showing they had achieved on average 75% training compliance rates during this period. Completion of statutory training across all staff groups was also below the Trust's target of 95% for six consecutive months from January 2022 to June 2022, with training data showing they had achieved on average 75% training compliance rates in this period.

Most staff kept up to date with their Practical Obstetric Multi Professional Training (PROMPT), which was a standardised course covering practical training scenarios such as management of obstetric emergencies. At the time of inspection, the service had an overall compliance rate of 81%, against the trust target of 90%. Midwives were 83% compliant, 94% compliance for Obstetric Consultants, 55% for other medical staff, and anaesthetic consultants and medical staff were 100%. Maternity Support workers (HSW) were 71% compliant. Following the inspection, we requested an update on overall training compliance for PROMPT. Information supplied by the trust showed overall compliance rates had improved to 86% as at 29 December 2022.

Staff did not keep up to date with their role specific mandatory training. In information provided to us post inspection we found completion rates were below the trust's overall target of 85%. For example, fetal surveillance training compliance rates were 74% overall; CTG competency test assessment rates were 23% overall; and medicines management compliance rates were at 71% for midwives. We asked the trust to supply us with information on training compliance rates for pool evacuation training of all staff, however, we were told the trust was not capturing this training data, but they were in the process of collating this information.

Although training rates were below trust targets, the programme of mandatory training provided to staff was comprehensive and met the needs of women and birthing people and staff.

The Trust recognised improvements were needed to their overall staff training compliance rates and plans were in place to address this with a target date of 1 April 2023. This included actions such as monitoring training compliance figures monthly via the trust's speciality governance meetings. Additional resources were also allocated to the trust's practice education team to maintain their local training database.

Safeguarding

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

Midwifery staff received training specific for their role on how to recognise and report abuse. Midwifery staff training compliance rates were below the trust's target of 85%, with data showing 81.5% were up to date with their safeguarding training level 3 at the time of inspection. Medical staff had also received training specific for their role on how to recognise and report abuse. The trust had met their target of 85% compliance for safeguarding training of medical staff. Data showed medical staff were 85% compliant with this training.

Safeguarding training included a set of learning outcomes to ensure staff were well informed and equipped with the knowledge and understanding of any potential safeguarding concerns. Learning outcomes included how to escalate concerns, identification of domestic abuse, parenting diaries and substance misuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding lead for the service was visible and staff reported this person being approachable if they had any concerns or queries. The safeguarding lead told us they helped support staff to have difficult conversations with women, birthing people and partners and supported staff to fill out safeguarding referrals and meeting reports such as case conference. The lead emphasised the responsibility of safeguarding fell to individual staff, but they were there in a supportive capacity.

The safeguarding lead told us they had good working relationships with social services, the police, local communities and drug and alcohol support services.

Cleanliness, infection control and hygiene

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

The service performed well for cleanliness. Ward areas were visibly clean, uncluttered and had suitable furnishings which were well-maintained. Apart from four mattress covers on the labour ward, furniture conformed to infection prevention and control best practice. We observed mould had started to form on the edges of two showers located in the bereavement suites. We fed back our concerns to the trust about the mattress covers and they provided assurance that immediate action was taken after the site visit to replace them. A review of information showed that mattress audits were 100% compliant for the months of August, September and October 2022.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Information supplied by the trust showed hand hygiene audits from March to September 2022 was consistently 100% against a trust target of 95%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after contact with women and birthing people and labelled equipment to show when it was last cleaned.

Data supplied by the trust showed an IPC audit undertaken in October 2022 was 87% compliant against a trust target of 90%. The audit showed that required standards were not being met on the post-natal ward for this month, with poor scoring in the general environment, safe handling and disposal of sharps and dirty utility. We reviewed action plans which had been formulated as a result of the findings from the IPC audits. These plans showed actions were being progressed in a timely manner to rectify the concerns found.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. However, improvements were required with checks to equipment.

The design of the environment followed national guidance. At the time of the inspection, the trust was providing a reduced maternity service in order safely support the volumes of women and birthing people accessing the service. The maternity services located at the Royal Bolton Hospital included a five bedded antenatal day unit; central delivery suite; a three bed maternity triage assessment area; a 22 bed ward for high-risk ante natal inpatients; a 44 bed postnatal ward; and an early pregnancy unit with six side rooms. At the time of inspection, the co-located midwifery led birth centre was closed to birthing activity and one out of the two postnatal wards was closed, reducing their postnatal bed capacity from 44 beds to 22 beds. During the inspection we observed the postnatal ward was full, which in turn, created pressures across the maternity pathway. According to information supplied post inspection, there were 11 unit closures between March and September 2022.

Maternity

The trust also provided care at the Ingleside Birth and Community Centre in Salford, a free-standing maternity unit for low risk pregnancies, with four ensuite pool rooms. At the time of inspection, the centre was not offering care during birth; instead it was being used as a community hub. We therefore did not inspect Ingleside Birth and Community Centre.

The central delivery suite consisted of 15 beds and two co-located bereavement rooms for women, birthing people and families who had experienced baby loss. The bereavement rooms were in a quieter area of the ward to provide women, birthing people and families a private and comfortable space to grieve the loss of their baby. Rooms were spacious with seating available to accommodate several visitors if needed. Each bereavement room had an ensuite bathroom and hot drinks facilities available. The lighting and decoration of each room had been adapted with the aim of creating a more therapeutic setting.

Women and birthing people benefitted from a triage service which was designed to ensure good patient flow through the service. The triage unit had a separate waiting area and a side room for initial triage. Patient areas were private and there was space for partners and relatives to sit if required. During the inspection we observed no overcrowding in the triage waiting areas.

Women and birthing people could reach call bells and staff responded quickly when called. We saw call bells available at each bed and women and birthing people told us staff responded when they used them.

The service had enough suitable equipment to help them to safely care for women, birthing people and babies. Staff carried out daily safety checks of specialist equipment. However, at inspection we observed some equipment checks were not happening daily as required by the trust's policy. In four out of the five pieces of equipment we reviewed, including resuscitaires and resuscitation equipment, there were gaps in the daily check sheet accompanying them.

The facilities department monitored when equipment was due for regular maintenance and had a schedule of work to ensure all regular maintenance was carried out.

Staff disposed of clinical waste safely. Staff disposed of sharps, such as needles, correctly in appropriate containers and in line with national guidance. Posters reminding staff which clinical waste bags to use to ensure clinical waste was properly segregated were displayed in utility rooms.

Assessing and responding to patient risk

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

We reviewed 8 maternity care records. The lead clinician was confirmed in all of them. Risk factors were highlighted. For example, women and birthing people with a high body mass index, living in a deprived area, or comorbidities. All women and birthing people were allocated to the correct pathway to ensure the correct team were involved in leading and planning their care. Their risk assessments were completed at every contact and there was evidence of appropriate referral.

We saw women and birthing peoples carbon monoxide levels were monitored in all records we reviewed. This is in line with the 'Saving Babies' Lives' care bundle, which is an evidence-based bundle of care designed to reduce the numbers of stillbirth and early neonatal deaths bringing together five elements which are identified as best practice and includes reducing smoking in pregnancy.

Staff used cardiotocography (CTG) to monitor babies' heart rates. We saw this was completed in relevant records we reviewed and 'fresh eyes' checks recorded. National guidance on 'fresh eyes' checks requires a second checker to review CTGs every hour. The service audited compliance with 'fresh eyes' checks. Across the maternity service from May to October 2022 only 57% of required checks were completed.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff recorded observations using modified early obstetric warning scores (MEOWS) and we saw all were completed fully and correctly in the five relevant records we reviewed. Staff knew when to escalate women and birthing people and babies for review by the medical team in line with trust policy. In the September 2022 managers audited compliance with use of MEOWS and audits showed in records reviewed, a full set of observations were recorded electronically in a 100% of cases and women and birthing people who scored on the MOEWS the escalation was appropriate in 100% of cases. The audit showed in 88% of the cases women and birthing people had the frequency of observations undertaken as per guideline and in 62.5% of cases had a sepsis screen undertaken if MEOWS score was 1 or more. We saw findings linked to frequency of observations and sepsis screening lead to a trust action plan being implemented to improve compliance rates by December 2022.

Midwives in maternity triage followed a standard operating procedure which gave clear red, amber or green risk levels dependent on the woman's presenting concerns. Telephone calls to triage were all answered by a midwife and, if necessary, the woman given an appointment to attend maternity triage. Triage had a skilled staff team for assessing and responding to patient risk; the midwifery team included an advanced midwifery practitioner. There was also an obstetrician assigned to triage to ensure on-hand medical advice or support could be provided.

Staff shared key information to keep women and birthing people safe when handing over their care to others. They used a structured communication tool known as Situation, Background, Assessment, Recommendation (SBAR) for communication between team members. They discussed key information about women and birthing people's pregnancy, labour or postnatal information. This also included information of concern. For example, safeguarding concerns, and information about their wellbeing and support from partners and family. The results of the trust's November 2022 SBAR audit showed in 94% of patient records checked staff had completed the SBAR assessment and recommendations.

Midwifery Staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women and birthing people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The trust used the BirthRate Plus midwifery staffing establishment tool when planning staffing levels. At time of inspection, the clinical staffing establishment was 239.70 funded whole time equivalent (WTE) across the whole maternity service. This was compliant with a Birth Rate Plus assessment undertaken in 2020. However, the trust reported a staffing deficit of 39.11WTE within the Registered Midwife establishment.

The trust told us a formal Birth Rate Plus review was currently underway and due to be published in early 2023. The recommendation is to carry out this review every 3 years.

Maternity

A recommended Trust specific ratio of 1.27.5 births to 1WTE was recommended in the last Birth Rate Plus report in 2020. This ratio was calculated using a case mix and acuity data. The staffing ratio between March and June 2022 did not meet the required standard. Non-compliance with the standard had been exacerbated by a significant staffing gap during this period.

On the day of the inspection inspectors observed the postnatal ward was closed due to ensure safe staffing levels. This meant there were delays transferring women and birthing people post-delivery to an appropriate setting and tied up labour midwives with postnatal care**.**

Leaders assessed staffing levels regularly and moved staff to ensure tasks were appropriately allocated, and women and birthing people received care.

Birth Rate Plus advises a registered/non-registered skill mix of 90:10 ratio within defined clinical areas such as the postnatal ward to support the delivery of care with unregistered staff. The trust skill mix calculation is integrated in the overall Birth Rate Plus establishment recommendations. The service, at time of inspection, had a 95:5 distribution of clinical to non-clinical ratio in defined settings. The trust told us an adjustment of the staffing allocations will be undertaken following publication of the upcoming revised Birth Rate Plus report early in 2023.

Oversight of acuity and demand was undertaken by the Matron during working hours and the Delivery Suite Co-ordinator out of hours. The trust told us staffing figures and acuity levels within the maternity intrapartum areas are input into an electronic Birth Rate Plus acuity tool and a weekly summary of compliance with the required standard is calculated. A review of all staffing levels is also undertaken at twice daily huddle meetings and any actions taken to redeploy staff are documented for future reference.

The sickness absence data for the period January to June 2022 showed a decreasing trend in sickness absence reported within the maternity service. Matrons were supported by workforce partners to monitor absence and support staff members during their absence and following their return to work. The sickness absence rates at the time of inspection were 6.39%, which was consistent with national trends.

The service had a vacancy rate of 18.9%, with most vacancies occurring amongst midwives. The trust had a 5-year recruitment and retention plan to ensure optimal maternity staffing and appropriate skill mix in line with Birth Rate plus recommendations.

The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 ‘Safe midwifery staffing for maternity settings'. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. There were 329 red flag incidents in the previous 6 months. Eighty-six percent were due to a delay between admission and starting the induction of labour process. No red flags were due to a delay in an emergency caesarean section.

Data provided by the trust showed a significant number of cases are delayed each month during the induction of labour process. The trust highlighted this as a red flag attributable due to low staffing numbers. In between February and June 2022, there were 616 incidences of a delay of 24 hours in accessing the central delivery suite (CDS) for continuation of induction of labour once identified as ready for transfer. The trust told us an audit of outcomes would be undertaken to seek whether any harm occurred, however, we were not made aware of when this would be completed.

Medical staffing

Maternity

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep women, birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

With the exception of the service's theatre provision, there was enough medical staff to keep women, birthing people and babies safe. The data supplied by the trust showed that the establishment included 19 WTE permanent consultants, 5.8 WTE permanent speciality doctors, 6 fixed term doctors and 25 trainee doctors (grades ST1 to ST7). The delivery suite had a dedicated anaesthetist Monday to Thursday, during the hours of 8.00am to 10.00pm. Outside of these times delivery suite anaesthetist cover was shared with the theatres located at the service. The trust recognised due to staffing constraints not being able to open a second maternity theatre was a serious risk. A business case was approved on 1 November 2022 to establish a multidisciplinary team to support the opening of second maternity theatre as required.

The sickness rate for medical staff within the maternity core service had steadily decreased from 3.2% in September 2021 to 0.3% in March 2022. An increase to 4.5% in June 2022 was followed by a decrease to 2.2% in July 2022.

The service had a good skill mix of medical staff on each shift and managers reviewed this regularly. The consultants ensured an on-call rota for junior doctors was completed for each shift.

Most medical staff were supported to develop through regular, constructive clinical supervision of their work. Information supplied post inspection showed the overall appraisal rate for November 2022 was 71.24%, which was below the trust's minimum target of 75%. It was unclear from the information provided by the trust whether this figure included medical staff.

Junior doctors told us they felt supported by the senior team, they could discuss their work and individual cases and had opportunities for development. Trainees in a GMC approved training post in the UK complete a survey ever year regarding the quality of training received, support and wellbeing. Results from the 2022 General Medical Council National Trainee Survey showed their overall satisfaction levels were within the top and bottom quartiles of the benchmark group, so neither good or bad. In the 2022 survey, the score for 'clinical supervision out of hours', 'handover' and 'supportive environment' was significantly below (worse than) the national aggregate.

The maternity service multidisciplinary team (MDT) worked together with external multi professionals such as social workers, GPs and health visitors and hospitals to improve patient care and outcomes. Doctors, midwives, midwifery support workers, safeguarding midwives, perinatal mental health midwives and other healthcare professionals supported each other and were involved in assessing, planning and delivering women and birthing people's care and treatment.

Staff held regular and effective multidisciplinary meetings to discuss and improve the provision of care to women and birthing people using the service. Daily safety huddles, ward rounds and handover meetings took place to update staff on plans for women, birthing people and babies.

MDT staff spoke highly of each other and the focus on collaborative care to improve care and patient outcomes.

Records

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

Maternity

Women and birthing people's care records were comprehensive, and all staff could access them easily. The service used a nationally recognised software programme to record information relevant to women and birthing people. We reviewed 8 records for women and birthing people at different stages of the maternity pathway and found records were comprehensive, all risk assessments and clinical assessment were documented such as VTE, fetal movement, high or low risk pregnancy, safeguarding questions and MEOWS.

Information supplied by the trust showed a number of audits being undertaken monthly, bi-monthly and annually relating to patient records. A review of the latest audits showed full compliance against agreed standards set by the trust. For example, in October 2022 the overall record keeping score was over 95% across all maternity wards.

Records were stored securely. All computers and tablets were password protected and staff closed screens when computers were not in use. Paper records were stored in filing cabinets in secure areas of the ward. During the inspection we observed these were kept closed when not in use.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The training compliance rate in maternity for medicines management was 85%, which was within trust target as at October 2022. Midwives used midwife exemptions to administer some medicines and this was clearly recorded on medicines charts we reviewed. Pharmacy staff provided support to the wards and units daily.

Staff completed medicines records accurately and kept them up to date. We reviewed 5 prescription charts for women and birthing people on the wards and found that these were, in the main, accurate and up to date. All prescriptions were signed and dated with legible writing used throughout.

Staff stored and managed all medicines and prescribing documents safely. A sample check of medicines held showed these were in date, labelled and stored safely. On the central delivery suite, we saw one occurrence where medicines had not been consistently stored safely. The daily record sheet accompanying a medicines fridge showed five occasions in November 2022 where the fridge temperature had exceeded the optimal storage conditions for refrigerated medicines. There was no record of follow up action taken.

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

Staff learned from safety alerts and incidents to improve practice. Staff understood how to report a medicine incident or safety concerns following the trust incident reporting policy. Staff told us they received updates about errors or incidents.

Incidents

The service did not manage safety incidents well. However, staff knew how to recognise and report incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Maternity

Incidents were not always reviewed in a timely manner, which delayed potential opportunities for learning or taking action to improve the safety of services provided. Data supplied by the trust showed 238 incidents reported by the maternity department had remained open for a period of over 60 days as at 27 November 2022 and were still awaiting a full review. Incidents had received initial grading according to level of harm sustained, so they could be prioritised by the trust accordingly. Out of the 238 open incidents there had been; 23 near miss incidents, 150 no harm incidents, 64 low harm incidents and 1 moderate harm incident. The trust told us the 1 moderate harm incident was undergoing divisional review and due for completion in December 2022. The trust were aware improvements were needed to ensure all incidents were reviewed in a timely manner and we saw steps already being taken to address the backlog.

Despite our concerns around the timeliness of incident reviews, staff knew what incidents to report and how to report them. There was a clear process which all staff we spoke with understood and followed. In completed incident records we looked at, we saw actions the trust had taken to minimise, reduce or eliminate reoccurrence. This included providing workshops and learning sessions to staff, bulletins, and newsletters to highlight specific issues and changes to policy and practice.

Staff received feedback following incident investigations and themes and learning from incidents were shared. For example, themes from incidents, learning identified, and good practice was highlighted in staff handovers, staff forums, emails and one to one meeting with a line manager.

Managers debriefed and supported staff after any serious incident. Staff told us they felt well supported by colleagues, managers and the wider team when they were involved in an incident.

The maternity service had not reported any never events in the past 12 months. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

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. They were visible and approachable in the service for women, birthing people and staff. They supported staff to develop their skills and take on more senior roles.

There was a clearly defined management and leadership structure in place. The maternity leadership structure from September 2022 was revised to improve stability, capacity and oversight of the service. The leadership team consisted of the director of midwifery, interim head of midwifery, two assistant divisional directors, maternity matrons and specialist leads. Shortly before we came to inspect, approval had been provided to increase the number of maternity matrons from two to five. There was also a newly appointed chief nurse from April 2022, who was involved in the development and implementation of the maternity service's transformation strategy.

Maternity

At the inspection, staff reflected that the changes to the leadership structure were positive and we heard numerous reports of a much more visible and approachable leadership team. There were 5 safety champions for maternity services. They completed regular walk-rounds of clinical areas and spoke to staff for feedback. One midwife told us they felt inspired and motivated by the leadership team's ambition to establish Bolton as an excellent provider of women's services

The trust also had a non-executive director (NED) with responsibility as maternity safety champion. The purpose of this role was to highlight issues and concerns relating to maternity to the board and to formulate an understanding of the issues facing maternity on a strategic level, with some oversight nationally as well as issues specific to the trust. We spoke with the NED who appeared well-informed of the issues in the service, particularly recruitment and retention and ensuring the voices of women and birthing people were promoted.

We spoke with members of the senior leadership team about the leadership and current state of their maternity service. They were candid about the key challenges the service had faced through the covid-19 pandemic and how the national shortage of midwives was impacting their service. They also recognised instabilities in leadership had impacted aspects of the service but felt under the revised structure were now on an improvement journey.

Members of the senior management team met formally each week to discuss the service and were based together, which allowed for more informal, ad hoc communication. Local leaders also met regularly through a variety of forums including daily safety huddles and weekly quality and safety meetings. Managers told us they felt supported by leaders and leaders and managers worked well together.

Senior leaders were visible within the department, staff knew who they were and told us members of the senior management team were present on the department often. The non-executive and executive director maternity safety champions conducted regular walk arounds of the department and posters were displayed throughout the service telling staff who the maternity safety champions were and how to contact them.

We saw examples of staff being promoted internally and given opportunities to develop leadership skills. The service also used experienced staff in part time roles to support newly promoted staff to develop into a managerial or leadership role.

Vision and Strategy

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

In the spring of 2019, staff, patients, the public, and partners across Bolton were invited to engage in the development of the trust's 2019-24 strategy, "For a better Bolton". Within the trust's strategy they set out six ambitions which at its core, demonstrated the trust's aspirations to be recognised by the people of Bolton as an excellent provider of health and care services, and a great place to work. Staffing was recognised as a key ambition in the trust's strategy with plans to make it the best place to work; to retain, attract and recruit high calibre, skilled staff.

There was a further trust wide strategy for 2022 – 2025 to integrate digital technologies and the data the trust collects to improve the care they provide to the people of Bolton. The vision was to be a 'digital trust' and included plans to empower patients to self-manage their care using technology. We saw the trust had already begun to implement electronic patient records (EPR) as part of their ongoing digital strategy.

To ensure the trust was delivering on their strategies, the Strategic Operations Committee's was formed to oversee performance against the trust's strategic ambitions and objectives and ensure that the strategic programme was aligned and responsive to operational priorities. The committee reported to the board and was chaired by a non-executive director. Minutes of committee meetings showed these discussions maintained focus on the progress and delivery of transformational programmes.

Culture

Staff did not always feel respected, supported and valued. Despite this, staff remained focused on the needs of women and birthing people receiving care.

Staff were mostly happy working for the trust. The most recent staff survey carried out in 2021 showed 80% of participants in the family division felt the people they worked with were polite and treated each other with respect and 79% felt valued by their team. A further 92% of staff felt that their role makes a difference to patients and service. Although the staff survey predominantly reflected the trust was a good place to work compared to other NHS organisations, it also demonstrated that there was scope to improve the working culture at the trust. For example, 44% of staff felt the trust valued their work and only 25% felt there was enough staff for them to do their job properly.

The trust provided evidence which showed they had received several concerns from various sources regarding a poor culture within the maternity leadership teams. As a result the trust commissioned an organisation development review by an external provider to further understand the generalised concerns about leadership behaviours and their potential impact on staff, teams and turnover rates. The full outcome of the review, findings and recommendations was expected on 31 December 2022.

We spoke to staff across most grades and disciplines. Staff told us they were proud to provide care to promote women and birthing people's health. Staff also reported an improving leadership culture and that multidisciplinary teams worked closely, respected each other, and were united to improve outcomes for women and their babies.

The trust had a freedom to speak up guardian. Staff told us they knew who their freedom to speak up guardian was, and they would be confident to raise a concern with their managers.

Information supplied by the trust showed there had been 6 formal complaints raised from August to November 2022. Trend analysis showed a common theme around decisions made about clinical treatment. We saw each complaint had been investigated and a response provided. However, the trust's maternity dashboard between March and September 2022 showed they were not always responding to complaints within 30 days; in April 2022 they responded to 0% of received complaints within 30 days; and in July 2022 they responded to 28% of received complaints within 30 days. The months March, May, June, August and September 2022 had incomplete data.

The maternity safety champion told us about a new process called '3 steps to the exec', which created a clear pathway for women and birthing people to speak directly to an executive if after two attempts to resolve the issue they remain dissatisfied. The maternity safety champion said 3 steps to exec had proven effective at resolving patient concerns more quickly and averting the need to go through a formal complaints process.

Maternity

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Most staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Since the last inspection the trust highlighted several areas of concern where certain governance processes were not operated effectively. As referenced earlier in the report under the key question safe, there was a backlog of incidents at the time of inspection. The trust told us the backlog was caused, in part, by a lapse in oversight following changes in leadership. There were other examples where governance processes had not been managed effectively; systems to record and monitor staff training had not been effective at meeting the trust's compliance targets; the trust's BCG vaccination processes had not always been effective and there was a backlog of approximately 700 babies to be vaccinated as at 28 November 2022. In all areas of concern highlighted by the trust, there was a clear plan of actions in place.

The service measured performance against national schemes and reports and reported this to board through the governance structures. This included the Clinical Negligence Scheme for Trusts (CNST) and Ockenden reports (2019, 2022) were presented to the board. CNST is a scheme which applies all trust maternity services in which there is a financial incentive to meet 10 key safety standards. The Ockenden reports proposed immediate and essential actions to improve care and safety in maternity services across England. The trust's CNST quarterly report dated 16 November 2022 showed the trust were not meeting all 10 safety standards at that time. There was an action plan in place however the board recognised they were unlikely to fulfil all 10 standards by the final submission date of 2 February 2023. The trust's Ockenden action plan dated 25 November 2022 showed further action was needed to promote patient safety; with all 15 essential actions recorded as partially met.

The service had clear governance and reporting structures which outlined key meetings and committees and lines of reporting through directorate, divisional and trust wide structures. This ensured information flowed from floor to board and then back to floor. A monthly governance report was presented to the trust board.

With the exception of incidents where oversight was historically inconsistent, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Managers held a divisional briefings regularly with matrons and ward managers to ensure feedback was provided both from staff and to staff. Each area held a staff forum to share information about performance and learn from any incidents or feedback.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. The service displayed information on policy and guideline updates in staff areas to remind them to access and read them. The service followed trust policy on the implementation of National Institute for Health and Care Excellence (NICE) guidance and quality standards which set out a process for receiving, reviewing and updating staff of all new and updated NICE guidance and Quality Standards.

Management of risk, issues and performance

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

Maternity

Service leads were fully aware of the risks across the service and had plans in place to address them. Risks and performance were being managed in line with service improvement plans and informed decisions regarding pathways and developments. The main area of concern was staffing and additional risks were largely linked to the improvement of patient pathways.

Outcomes for women and birthing people were mostly positive, consistent and met expectations, such as national standards. Data from the maternity dashboard was submitted to the local maternity system and compared with other trusts to see if they were an outlier for any outcome. According to the trust's maternity dashboard, the 12 month rolling average of the number of women and birthing people who had a 3rd/4th degree tears from March to September 2022 was above the trust's target. The trust had taken steps to reduce such risks, which included delivering focussed teaching to staff and ensuring staff had access to the support from a senior staff member during delivery.

The service participated in relevant national clinical audits. The service reported outcomes to the NHS Digital Maternity dashboard, the National Neonatal Audit Programme, the National Maternity and Perinatal Audit and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiry).

Information Management

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

Arrangements were in place to ensure confidentiality of maternity patient records was robust. We found the trolleys and filing cabinets where patient records were stored at the midwives' station and were lockable. Computer screens were closed when not attended. Staff had password access to electronic systems.

Data or notifications were submitted to external organisations as required. The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical area KPIs. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK). This enabled the service to benchmark performance against other providers and national outcomes.

Engagement

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

The service engaged well with the stakeholders and was actively involved with their local Maternity System group (LMS). A representative from the trust attended the meetings. The meeting was attended by other trusts and clinical commissioning groups as well as any other relevant stakeholders such as local GPs, NHS England and local authority representatives.

There were systems in place to engage with staff. The senior leadership team told us the wellbeing of all staff was prioritised by senior leaders.

Maternity

The maternity voices partnership (MVP) worked with maternity services to bridge any gaps with women and birthing people that could be harder to reach. They used social media platforms to connect with women and birthing people, raise awareness, and act as their advocate. The trust valued their partnership working with the MVP and monitored their engagement.

The service undertook the NHS Friends and Family Test (FFT) with inpatients. All inpatients were asked how likely they were to recommend the ward to friends and family. The feedback from the FFT question for maternity services, on average, did not meet the trust's target of 95%. Data provided post-inspection showed that the target was not met once in a 7-month period from March to September 2022, indicating not every person who undertook the test was positive about their experience. The response rate for the FTT in the same period showed they had met the trust's target of 20% in 2 out of the 7 months, 4 months were satisfactory and 1 month was flagged for a poor response rate.

The safeguarding midwife told us they engaged with several external organisations when providing care to women and birthing people with complex needs. When the woman went into labour, the external organisations provided support to existing children to ensure the families remained safe.

The service had an equality and diversity midwife who linked with local groups representing people from black and minority ethnic communities to ensure services met their needs. The service had processes in place to ensure information was accessible in different languages in all clinics to enable them to share information with women and birthing people.

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.

Leaders described how they used the actions from governance meetings such as complaints to identify themes to highlight areas for improvement. These were communicated with staff through various mechanisms, such as newsletter and staff huddles. Staff were also informed about research and improvement projects through notice boards in staff areas and team meetings.

Outstanding practice

We found the following outstanding practice:

- Junior doctors were able to discuss and agree learning objectives for the shift they were due to work during medical handovers.
- Smart boards were used on the antenatal ward, thereby enabling effective coordination and planning of people's care.
- The design, layout and staffing of the triage ward supported excellent patient flow. Separate patient waiting areas reduced the risk of overcrowding. There was a highly skilled staff team; with an on-call obstetrician assigned to support triage when needed and an advanced midwifery practitioner working alongside the staff team.

Maternity

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons to safely care for women and birthing people. Regulation 18(1)
- The trust must ensure staff complete mandatory training in line with the trust's own target. Regulation 12(1)(2)(a)(c).
- The trust must ensure equipment is checked in line with trust policy and documented clearly. Regulation 15 (1)(2)(c)(d)(e)
- The trust must ensure incidents and complaints are handled in a timely way and in line with trust policy. Regulation 17 (1)(a)
- The trust must ensure staffing, waiting times and other key metrics are in line with national standards. Regulation 12(2)(b); 17(1)(2)(e)
- The trust must ensure staff receive such appropriate support and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(1)(2)(a)

Our inspection team

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

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.

Regulated activity	Regulation