

Liverpool Women's NHS Foundation Trust

Liverpool Women's Hospital

Inspection report

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Ratings

Overall rating for this location

Inspected but not rated ●

Are services safe?

Inspected but not rated ●

Are services well-led?

Inspected but not rated ●

Our findings

Overall summary of services at Liverpool Women's Hospital

Inspected but not rated ●

Liverpool Women's NHS Foundation Trust is a specialist trust that specialises in the health of women, babies, and their families. It is one of only two specialist trusts in the UK and the largest women's hospital in Europe. As a tertiary centre the hospital provides care for a significant proportion of patients with high levels of complexity and clinical risk, as well as serving a local population with significant deprivation. The hospital teams deliver around 8,000 babies each year. The maternity team cares for women and their babies from conception to birth supported by the neonatal team who provide around the clock care for premature and new-born babies needing specialist care.

The trust also delivers neonatal, end of life care, outpatients, gynaecology, fertility and termination of pregnancy services but these were not included in this inspection.

In January and February 2023, we carried out a focused inspection of maternity services as part of the CQC national maternity inspection programme which looked only at the safe and well led questions. We also inspected the well-led key question for the trust overall. Following the inspection, we issued a Warning Notice to the trust in accordance with Section 29A of the Health and Social Care Act 2008.

We undertook this focused inspection to follow up the Warning Notice and did not cover all of the safe and well-led domain, therefore the ratings remain unchanged. We found:

- Staff routinely carried out checks of emergency equipment.
- Staff completed and updated risk assessments for each woman and took action to remove or minimise risks.
- The service had enough staff to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- There were leadership structures in place to maintain oversight of the service.

However:

- We found out of date items on emergency trollies and the system used to carry out checks of emergency equipment was not always fit for purpose.
- Staff did not always use the Modified Early Obstetric Warning Score (MEOWS) tool effectively to identify women at risk of deterioration.
- Performance data was not always accurate.

Following this inspection, we determined the Section 29A Warning Notice that we issued to the trust in February 2023 had been complied with.

Maternity (inpatient services)

Inspected but not rated ●

Is the service safe?

Inspected but not rated ●

We inspected but did not rate this service.

Environment and equipment

Staff routinely carried out checks of emergency equipment, but these checks were not always effective.

We reviewed the contents of 3 emergency trollies across the maternity service. All emergency trollies were secured with numbered tags. Staff carried out and recorded daily and weekly checks of emergency trollies. However, we found out of date items in all 3 trollies. When we raised this with staff, it was immediately addressed.

We reviewed the system used to carry out stock checks of emergency trollies and found it did not always support staff to carry out their role. For example, some discontinued items remained on the system, and it did not always allow for expiry dates to be entered as a prompt.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. However, staff did not always utilise the MEOWS tool effectively to identify women at risk of deterioration.

We observed that there was improved oversight of women within the Maternity Assessment Unit (MAU) when compared to our last inspection. An interactive whiteboard displaying live performance data had been installed in MAU and on the corridor outside of the executive leaders' offices. This whiteboard meant that staff and leaders had real time oversight of women in the department waiting to be triaged or for a medical review. Staff had access to robust escalation procedures to follow when the service was busy. Staff reported that processes in MAU were much improved since our last inspection and that escalation processes were effective.

The national best practice guidelines state that women should be triaged within 15 minutes of arrival at the unit. Performance had significantly improved since our last inspection. Between May and November 2023, the percentage of women triaged within 15 minutes of arrival remained above 95%, except for October 2023 when performance was 92%. The percentage of women triaged within 30 minutes of arrival remained above 99%. Any triage breaches were reviewed for learning.

During our inspection, we observed that women were being appropriately prioritised and received timely medical reviews. Staff were appropriately escalating any delays. However, time to medical review data, provided by the trust prior to our inspection, showed inconsistent performance. We discussed this with leaders who said that work was ongoing to ensure that data was accurate. We saw evidence of actions which had been identified to improve data quality.

The service had completed an audit of time to medical review from July to December 2023. The audit showed that 73% of women were seen within the recommended time frame. Women who attended MAU were colour coded dependent on their clinical presentation in line with the Birmingham Symptom-Specific Obstetric Triage System (BSOTS) categories,

Maternity (inpatient services)

with 'red' being the most urgent cases. The audit showed that 100% of 'red' cases received immediate ongoing care and subsequent review by a medical team. There had been no episodes of patient harm reported because of delays in medical review. However, audit results were gathered through review of case notes and therefore, the data was not readily available to leaders. In addition, in 7% of cases the information recorded in the patient records was incomplete, so performance was unable to be confirmed. Information provided by the trust highlighted that delays in medical review were likely caused by an absence of Advanced Clinical Practitioners (ACPs), reduced medical cover out of hours or short-term sickness. Leaders told us of plans to increase the number of ACPs within MAU to support timely medical reviews.

We saw that leaders had oversight of women waiting transfer from MAU to other clinical areas. There was a shift leader in MAU 24 hours per day and 7 days per week who maintained oversight of all women and escalated any concerns with delays or staffing. Staff told us processes for escalation were effective and gave examples of when staff had been moved from other areas to support acuity in MAU.

Since our last inspection, the telephone triage service had been moved to a separate room in line with BSOTS recommendations. There was a system in place to contact any woman who did not attend for assessment or who needed a follow up call. At the time of our inspection, there was no call waiting facility on the triage line, but we were told that this was soon to be installed.

Staff and managers told us breaches in 1:1 care in labour were rare. Performance data provided by the trust prior to our inspection was conflicting. However, from September to November 2023, over 98% of women had received 1:1 care in labour.

We reviewed 5 MEOWS records and found that not all records were fully completed or completed at the correct frequency. We saw that 1 set of observations had not been completed until 2.5 hours after the woman's admission to the Midwifery Led Unit (MLU).

An audit of MEOWS completed by the trust in October 2023 showed that the required frequency of observations was only recorded in 12.5% of records. We did not see that any actions had been identified to improve this and this remained an issue when we carried out our inspection. We reviewed MEOWS records and found that the required frequency of observations or decisions to deviate from policy recommended timescales were not always recorded.

We saw records of women in active labour and saw that staff did not use the MEOWS chart to record observations. Incomplete sets of observations were recorded on the cardiotocograph (CTG). A CTG is used during pregnancy to monitor fetal heart rate and uterine contractions. This meant there was a risk that staff may not identify a deterioration in condition. The trust's Maternity Early Warning Score Guideline outlined that MEOWS charts may not be used in the intrapartum period. However, it did say that in the event of any 'amber' flags for sepsis, a MEOWS chart must be used. As staff were not completing and appropriately recording full sets of observations, there was a risk that signs of sepsis or deterioration might not be identified.

The trust Maternity Early Warning Score Guideline was due for review in December 2023. We were told that the review of this policy had been delayed due to cancellation of the December 2023 Maternity Clinical Divisional Ratification Meeting due to staff absence. The policy was scheduled to be reviewed at the end of January 2024.

Risk assessments were completed in a timely way for women who were being cared for on MLU. We saw that there was a process for risk assessments displayed in MLU office.

Maternity (inpatient services)

Women who attended for induction of labour had a full set of observations and CTG monitoring repeated every 6 hours until they progressed to the next stage of labour. This was in line with the trust Induction of Labour policy and national best practice guidelines.

There was a system in place for hourly 'fresh eyes' of CTG in labour. 'Fresh eyes' is a system where the CTG is regularly reviewed by a senior midwife or obstetrician. However, staff told us it was often challenging to complete this due to the staff skill mix on the labour ward. We reviewed 4 records and saw some delays in the completion of 'fresh eyes'. An audit completed at the trust from October to December 2023 showed that compliance with fresh eyes had deteriorated. The audit included a review of 10 patient records each month. In October 2023, 100% compliance was seen in 6 records, in November 2023, only 4 records were 100% compliant and in December 2023, only 1 record was 100% compliant. Actions had been identified to improve compliance.

We observed the staff handovers on delivery suite and the ante and post-natal ward known as matbase. The handover on delivery suite was comprehensive, followed the SBAR (situation, background, assessment, recommendation) format and included all relevant staff. However, although the shift lead handover on mat base did follow the SBAR format, the midwives were often interrupted and completing other necessary tasks throughout. Staff told us that the shift lead handover was often rushed due to time pressures and the number of beds on the unit, and that staff were often required to stay after their shift to complete this. When we discussed this with leaders, they told us that additional management support had been put in place since our last inspection, which staff agreed had been helpful. However, leaders told us that they were looking at the configuration and staffing of matbase to see if any improvements could be made.

Safety briefs took place twice daily to assess the safety of the maternity service and included discussions about acuity, activity and staffing. We reviewed records of the safety briefs that took place in the week prior to our inspection. We saw that representatives from all departments did not always attend. Of the 13 safety brief records that we reviewed, anesthetic staff were not present on 4 occasions, staff from the fetal medicine unit were not present on 4 occasions and 1 safety brief had no representation from MAU or MLU. It is not clear from the safety brief records if any risks or challenges in these non-represented areas were considered, escalated or mitigated.

There was a baby abduction policy in place and staff undertook baby abduction drills. The ward areas were secure, and doors were monitored. All babies wore an electronic tag which set off an alarm if the baby was taken off the ward and hospital doors automatically locked when the alarm was activated. However, we saw that staff did not always respond appropriately to an activated alarm. Staff told us the alarms often falsely activated and therefore they didn't always respond.

Staffing

The service had enough staff to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Medical staffing on MAU had been reviewed since our last inspection and amended to ensure dedicated cover at peak times. Staff told us that there had been some gaps in the registrar rota, but that these were being covered. We reviewed the registrar rota for the MAU in December 2023 and January 2024 and found that 97% of shifts were filled.

ACPs were also utilised in MAU to support with patient assessments and treatment during periods of high acuity. Leaders told us of their plans to recruit and train more ACPs.

The telephone triage service in MAU was staffed 24 hours per day and 7 days per week, and the unit also had ward clerk support. The telephone triage line had been consistently staffed and maintained since July 2023.

Maternity (inpatient services)

The staffing model on MLU had been reviewed since our last inspection and there had been no unit closures. This meant that women booked for MLU care could present directly there or be immediately redirected from MAU.

Staff told us that the shift lead on matbase was not always supernumerary. Following our inspection we asked for the number of times that the shift lead not being supernumerary had been reported. Data provided by the trust showed that between December 2023 and January 2024 (up to our inspection date), there had been no reported incidents of the shift lead not being supernumerary. During our inspection, despite the shift leader being supernumerary, we did observe that the role was very demanding due to the size of the unit. Leaders told us that this was under review.

Staff told us that staff skill mix was impacting their ability to complete some tasks in a timely way, such as 'fresh eyes'. However, data provided prior to our inspection showed that 38 whole time equivalent (WTE) midwives were due to complete their preceptorship in January 2024 and move from Band 5 to Band 6. In addition, the trust had recruited an additional Fetal Surveillance Midwife to support training, education and auditing.

The trust had recently introduced a new midwifery bleep holder role 24 hours per day, 7 days per week. This supernumerary midwife carried out walkarounds throughout the day and night, and they maintained oversight of the maternity service, including any staffing challenges and delays in care. They also attended the twice daily safety huddles.

Leaders reported that the maternity service had no midwifery vacancies at the time of our inspection. The matbase midwife day staffing rate for December 2023 was 87.24%. Information provided by the trust showed that this was reduced due to high short term sickness rates (12.8%). Bank staff were requested to fill staffing gaps and the maternity bleep holder redeployed staff from other areas to maintain safety. On the day of our inspection, there were staffing gaps on matbase but acuity was low and there were enough staff to maintain safety according to the acuity of the unit.

Is the service well-led?

Inspected but not rated



We inspected but did not rate this service.

Management of risk, issues and performance

Performance data was not always complete or accurate and therefore, leaders could not always monitor performance effectively.

Information provided by the trust showed that time to medical review performance data was not always accurate or complete. In addition, we were also sent conflicting data for 1:1 care in labour performance. We spoke with leaders about the accuracy of the data they used to monitor performance and safety. They acknowledged that there were issues with the time to medical review data and they were working to improve this.

We spoke with leaders about the shift leader role on matbase. They acknowledged that change was needed and had put additional management support in place whilst they were reviewing more long-term options for the reconfiguration of matbase.

Maternity (inpatient services)

Since our last inspection, the matrons' portfolios had been reviewed to ensure that all areas had matron oversight and that the safety and flow through the whole maternity service was monitored.

Leaders carried out deep dives for any cases where 1:1 care in labour has not provided to ascertain if there has been any harm and to learn lessons.

An interactive whiteboard had been installed on the corridor of the executive leaders' offices. This whiteboard displayed live performance and safety data which allowed leaders to maintain real time oversight of demand and the safety of the service.

Areas for improvement

MUSTS

- The trust must ensure that staff complete and record full sets of observations in the intrapartum period and effectively monitor for deterioration. Regulation 12 (2)(a)
- The trust must ensure that clinical decision making in relation to the frequency of observations is recorded. Regulation 17 (2)(c)
- The trust must ensure that there are sufficient shift leadership on matbase to keep women, babies and staff safe. Regulation 18 (1)

SHOULD

- The trust should ensure that systems and processes are in place to accurately collect data to assess and monitor performance in relation to time to medical review and 1:1 care in labour.
- The trust should ensure that all departments are represented at twice daily safety briefs to effectively identify, escalate and mitigate risks.
- The trust should ensure that staff respond appropriately to activated baby alarms.
- The trust should consider reviewing the systems and processes used for checks of emergency equipment.

Our inspection team

On 15 January 2024 we carried out an unannounced focused inspection to review the areas of concerns highlighted in the warning notice.

The inspection was carried out by two inspectors, supported by an inspector and operations manager offsite. During our inspection, we spoke with 20 members of staff, including midwives and doctors, maternity support workers, and midwifery matrons, as well as senior leaders. We reviewed 5 patient records.

Due to our inspection findings, we determined that the trust has complied with the S29A Warning Notice that we issued in relation to Maternity Services in February 2023.

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

Maternity and midwifery services

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Maternity and midwifery services

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Maternity and midwifery services

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing