Mid Cheshire Hospitals NHS Foundation Trust

Leighton Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Leighton Hospital

Requires Improvement 

Pages 1 to 2 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Leighton Hospital.

We inspected the maternity service at Leighton Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

The Leighton Hospital provides maternity services to the population of Crewe and Mid Cheshire.

Maternity services include a triage, labour ward, midwifery led unit, obstetric theatres, a mixed antenatal/postnatal ward, and transitional care. Between April 2021 and March 2022, there were 3,080 babies were born at Leighton Hospital.

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

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

Our rating of this hospital went down. We rated it as Requires Improvement because:

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

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.We visited maternity assessment (Triage), Labour ward / Delivery Suite, the mixed antenatal and postnatal ward, the midwifery led unit and obstetric theatres.

We spoke with approximately 12 midwives, 2 support workers, and 5 doctors. We reviewed 3 medicines records during the inspection.

We received 81 responses to our give feedback on care posters which were in place during the inspection.

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

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

Maternity

Requires Improvement 

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

- Not all staff had completed mandatory training, including safeguarding training.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Not all staff had received training in how to use equipment safely.
- Staff did not always complete and update risk assessments or take action to remove or minimise risks. Staff did not always identify and quickly act upon women and birthing people at risk of deterioration.
- Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- The service did not always have enough medical staff with the right qualifications, skills, training, and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep detailed records of women and birthing people's care and treatment. Records were stored securely, but not always easily available to staff providing care.
- The service used systems and processes to safely prescribe and record medicines but did not always store medicines correctly.
- The service did not always manage safety incidents well.
- Leaders did not always understand and manage the priorities and issues the service faced.
- Staff did not always feel respected, supported, and valued. However, they were focused on the needs of women and birthing people receiving care.
- Leaders did not always operate effective governance processes.
- Leaders and teams had systems to manage performance, but these were not always effective. They did not always identify and escalate relevant risks and issues nor identify actions to reduce their impact.
- The service did not always collect reliable data and analyse it. The information systems were not integrated. Data or notifications were not always submitted to external organisations as required.
- There was an understanding of quality improvement methods, but improvement was not always timely or effective.

However:

- Staff we spoke with understood how to protect women and birthing people from abuse, and the service worked with other agencies to do so.
- Staff used equipment and control measures to protect women and birthing people, themselves, and others from infection. They mostly kept equipment and the premises visibly clean. Staff generally managed clinical waste safely.
- Junior doctors were positive about their training and support.
- When things went wrong, staff apologised and gave women and birthing people suitable support.
- Leaders were generally visible and approachable in the service for women and birthing people and staff.

Maternity

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with 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 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.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

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

Not all midwifery staff were up-to-date with their mandatory training. Due to the way in which the data was provided we were unable to identify an overall training compliance figure for obstetric mandatory training. Fetal surveillance training was divided into 2 parts, face to face surveillance training and device training. Overall compliance with the fetal surveillance training day was 85% but ranged between 76% to 100%. Overall compliance for cardiotocograph (CTG) device training was 87% overall but ranged between 67% to 100%. Evidence showed training compliance with documenting intrapartum, fetal physiology and cord gases on the electronic records system was low and ranged between 45% to 51%.

Compliance with adult basic life support ranged from 67% to 100% across the different midwifery staff groups, with neonatal basic life support being 84% overall (60% for community midwives).

Compliance with perinatal mental health training was 89% overall for midwives and ranged between 70% to 100%.

As of September 2023, most medical staff had not completed their mandatory training. Compliance with the fetal surveillance training day was 43%, and with fetal physiology and CTG assessment was 43% and 46% respectively. Compliances with E-learning chapters covering intrapartum, fetal physiology and cord gases ranged from 14% to 18%. The trust later submitted data which showed that as of February 2024, compliances for fetal physiology and CTG assessment had improved to 93% (86% for junior doctors, 100% for consultants). Data showed 70% of medical staff had completed perinatal mental health training, ranging between 58% for obstetric consultants and 80% for junior doctors.

The service did not always make sure that all staff received multi-professional simulated obstetric emergency training (PROMPT). Compliance for midwifery staff groups ranged between 76% to 100%. Data showed overall compliance with PROMPT training for anaesthetic doctors, including consultants, was 37%, and for obstetric doctors, including consultants, was 75%. This meant the service could not be assured it met the recommendations for multidisciplinary training to improve safety. This was below the recommended training compliance levels of 80% identified by NHS

Resolution and the maternity incentive scheme year 4. The trust later submitted information that the overall compliance for PROMPT across all midwifery and medical staff groups had improved from 82% as of September 2023 to 91% by the end of March 2024, and the service had passed CNST 5. However, we do not know the breakdown of compliances for the midwifery and medical staff groups within this overall compliance figure.

The service did not always make sure staff were competent for their roles; for example not all staff had completed the obstetric training requirements. Staff told us that following their initial training, there were no further obstetric competency assessments. Other competencies were assessed through face to face or e-learning training, and for example, medical device competencies were self-assessed and declared as competent on an annual basis following initial training.

Compliance with pool evacuation training for midwifery staff groups ranged between 50% to 75%. This meant the service could not be assured of the competence of staff to evacuate a woman or birthing person from the pool in an emergency.

There was 1 room on labour ward with a birthing pool, and staff told us this was allocated as a room for high-risk women and birthing people. However, there had not been any pool evacuation drills in this room to confirm that pool evacuation could be conducted safely and effectively.

Managers monitored mandatory training but did not always make sure staff completed and updated their training.

Safeguarding

Staff did not always complete mandatory safeguarding training. However, staff we spoke with understood how to protect women and birthing people from abuse, and the service worked with other agencies to do so.

Not all staff had received training specific for their role on how to recognise and report abuse. Compliance with safeguarding level 3 for maternity staff was 85% overall, however, ranged between 50% to 100%. Evidence showed safeguarding training compliance for midwives was 90%, for maternity support workers (MSWs) was 79%, and for healthcare assistants (HCAs) was 87%. Training compliance for medical staff was 65% overall and ranged between 67% compliance for consultants and speciality doctors, and 64% for specialty trainees.

The safeguarding level 3 training also included level 3 domestic abuse training. The service had an Independent Domestic Violence Advisor (IDVA) who could advise staff, and they used a secure computer system not accessible to staff to protect confidential information about people using the service.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff we spoke with were able to explain safeguarding concerns. Staff told us ‘Cause for Concern’ forms were completed for safeguarding concerns identified and contained the details of the plan for that individual. These were stored on the electronic record system and filed in the person’s notes.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to explain that for new safeguarding referrals not previously identified during the antenatal period, and therefore without a plan in place, they would contact the safeguarding team who would look into this. Staff told us they were always available to answer questions. Staff explained that for out of hours safeguarding concerns staff would contact the local authority safeguarding team and would also alert them to the birth of babies with safeguarding plans.

Maternity

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect women and birthing people, themselves, and others from infection. They mostly kept equipment and the premises visibly clean. Staff generally managed clinical waste safely.

Maternity service areas were mostly clean and had suitable furnishings which were clean and maintained, but we noted some dusty areas in the triage assessment rooms. Cleaning audit results from June to August 2023 showed 86-97% compliance in the antenatal and postnatal areas. When cleaning audit results highlighted areas for improvement, there were action plans for improvement.

The service provided cleaning audits for June to August 2023, which showed monthly overall scores of over 93.4% for ward 23, over 94.5% for ward 26, and 86.5% - 97.9% for the antenatal clinic. We also saw completed actions for the items which had failed on the audits. We also received the results of environmental audits and action plans by the IPC team designed to provide gap analysis and improvement plans for wards 26, 23 and the antenatal clinic from April 2022, September 2023, and June 2023 respectively. The current progress ratings shown for the improvement plans for ward 26 and antenatal clinic were all either 90-99% or 100% adherence. Adherence for actions on the ward 23 audit, which was more recent being in September 2023, ranged from less than 79% to 100%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Results of monthly hand hygiene audits for June to August 2023 were 100% for Ward 23, and results for July to August 2023 for Ward 26 were 100%.

Staff cleaned equipment after contact with women and birthing people. Equipment we saw was visibly clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Not all staff had received training in how to use equipment safely. Staff generally managed clinical waste safely.

The design of the environment did not always follow national guidance. The triage waiting area was located in the main labour ward reception area, which was physically removed from the main triage assessment area. This meant triage staff did not have direct and continuous oversight of women and pregnant people waiting, should any deterioration in condition occur. There was a receptionist during the day from 7.30am to 7.30pm except for Saturday, and outside of these hours a labour ward health care assistant (HCA) covered reception. However, the HCA covered other duties overnight as well, meaning people waiting would not always be overseen. The trust board had approved further funding for 24/7 reception cover. Staff told us for women and birthing people waiting a long time for triage in the labour ward reception, triage staff would check them as they came back and forth to the assessment room. There was a camera in triage showing the reception area, however staff did not actively monitor this. The maternity triage area had 2 assessment rooms, and this lack of space meant there could be delays in assessing women and birthing people when both rooms were occupied.

The service did not always have enough suitable equipment to help them to safely care for women and birthing people and babies. There was only 1 pool evacuation net for the 2 birthing pools available for women and birthing people to use. The pool evacuation net which was located on the midwifery-led unit (MLU), had not been serviced in line with the manufacturer's instructions and also did not state a maximum weight. This meant at the time of our inspection there

was no suitable equipment to facilitate the emergency evacuation of either of the birthing pools. We raised concerns about this during our inspection, and following our onsite inspection, the service provided assurance that 4 new pool evacuation nets had been purchased. Records for monitoring of women and birthing people's temperature and the birthing pool water temperature showed these checks were not always completed. Monthly audits of 10 records for June to August 2023 showed compliance with checking the temperature of the pool water and maternal temperature hourly for people using the birthing pool was inconsistent. Evidence provided showed the recording of pool and maternal temperatures was 100% in 2 months but 0% in 1 month for labour ward. For MLU compliance was 100% in 1 month but only 60% and 67% in the other 2 months.

Rooms on the labour ward had new floor standing resuscitaires, however the wall mounted resuscitaires remained in situ, which reduced the amount of space in the rooms. We also saw there were new computers on wheels, however the previous wall mounted computer cupboards remained, which further impacted upon space in labour rooms. Leaders told us they had planned to remove the old equipment and furniture when the ward was relocated elsewhere for the required work on the reinforced autoclaved aerated concrete (RAAC), to minimise disruption. The impact of surplus equipment and furniture on space was particularly significant in the high-risk labour room containing the birthing pool, as high-risk women and birthing people were more likely to need intervention. There had been no emergency pool evacuation drill in this room, therefore the service could not be assured staff could get the bed alongside the pool and fit the required number of staff around the pool in an emergency. We escalated this during the inspection and the service provided assurance following the inspection that this had been conducted.

Not all staff had received training on how to access blood from the fridge, despite a recent incident concerning obtaining blood for delivery suite. The trust later provided information that 85% of staff eligible to access the blood fridge had received blood fridge training at the time of the inspection. The morning safety huddle included a prompt to check which members of staff on shift in each inpatient area were trained to access the blood fridge, and we saw the list of staff on shift in the office on labour ward indicated who had been trained for this.

The service had completed environmental ligature risk assessments for maternity in 2018. However at the inspection, staff were not aware. We raised this concern with managers at the inspection and a few days following the inspection, ligature risk assessments were re-completed and the risk entered on the risk register as immediate assurance. However, this meant there had been a gap of about 5 years between the previous assessments and the latest ones.

One of the resuscitaires on labour ward had a service due date of July 2023, but was not possible to service due to old equipment connections. This had remained in service due to lack of suitable space for the new mobile resuscitaire in this room. Staff and maintenance were aware of this but there had been no risk assessment for continued use. This was requested at inspection and conducted afterwards.

There was only 1 emergency resuscitation trolley and defibrillator for 4 different maternity areas (labour ward, MLU, triage and theatres and recovery). When we raised this the service entered this onto the risk register and added a risk control stating that a timed simulation showed it took 55 seconds to respond to an emergency bell, collect the emergency trolley storing the defibrillator and deliver it to the room furthest away from the trolley (triage room 1). They planned to conduct a peer review of this risk by October 2023. The trust has since confirmed they are satisfied with the safety level the single emergency resuscitation trolley provides.

Staff did not always conduct daily safety checks of specialist equipment. There was no daily checklist for August 2023 for the resuscitaire in theatre, and we also saw gaps in daily checks for the resuscitaire on the antenatal/postnatal ward.

There was no evidence of daily or weekly checks of the neonatal emergency trolley on antenatal/postnatal ward. We found some out-of-date equipment on triage.

Equipment was not always tested when it should be. For example, on Wards 23 and 26 we saw the last annual checks were conducted in July 2022. However, we saw some evidence of planned preventative maintenance (PPM) for equipment on Ward 26, showing both equipment with PPM due dates later in 2023 and 2024 and equipment with completed PPM from earlier in 2023 up to the time of inspection. We did not see evidence of PPM for any other areas of the maternity service, except for the maternity theatres ventilation system, for which we saw evidence of the annual inspection and Health Technical Memorandum (HTM) verification of the maternity theatre suite ventilation system in October 2022.

We noted some oxygen cylinders that were not secured appropriately which was not in line with national guidance.

The telephone triage area was physically distanced from main triage in a different part of the labour ward. This was in line with national guidance which recommends that the triage phone line is located and staffed in a separate area to triage, so that advice to attend is not influenced by workload, and to ensure that all calls are answered promptly. The triage line had 6 options to filter calls, including an emergency option which would divert to labour ward. There was a call waiting service so the number of calls could be monitored. The number of calls in 24 hours was logged and staff told us those phoning 3 times would be asked to come in.

The telephone triage service relied upon bank staff to fill 8am-8pm day shifts, which had been implemented in May 2023. Therefore, if bank staff did not fill the day shift, there was no protected staffing to conduct telephone triage. This meant staff conducting in person assessments would also need to manage the telephone triage service. Staff told us that most of the time there was no separate telephone triage midwife during day shifts. When this happened, calls diverted to the main triage and were managed by midwives covering triage. Leaders told us call activity and in person attendance to maternity triage overnight had been analysed and deemed to be manageable without a separate telephone triage midwife, therefore a separate telephone triage was not funded overnight.

The building housing the maternity service had some reinforced autoclaved aerated concrete (RAAC). The service was planning to relocate the induction of labour (IOL) bay and MLU upstairs to address this. Staff told us this would mean they would not be able to use staff or the escalation policy in the same way.

Staff had access to a portable ultrasound scanner, cardiotocograph (CTG) machines and observation monitoring equipment. CTGs were centralised on labour ward so each room could be viewed centrally. CTG machines had a battery operated function so could run continuously if moving between areas, for example moving to theatre in an emergency.

There was a 4 bedded induction of labour (IOL) bay which meant the service could take a maximum of 4 women or birthing people for induction at any one time. Once allocated, these beds would stay allocated even if the person continued their IOL at home.

The bereavement suite was separate from the main maternity unit and had a private entrance from outside so people using this facility could enter and exit without having to walk through the hospital or maternity unit. There was a private outdoor space which was part of the suite and a parking space next to the suite. The facility had been designed and decorated based on consultation with maternity service users.

The main maternity unit and antenatal/postnatal ward had a secure entry system.

Staff disposed of clinical waste safely, but waste areas were not always secured. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste into different bins. However, at the inspection the lockable door to the room where the placenta freezer was located was propped open and therefore not secure. We told service leaders about this at the time of inspection.

Assessing and responding to risk

Staff did not always complete and update risk assessments or take action to remove or minimise risks. Staff did not always identify and quickly act upon women and birthing people at risk of deterioration.

Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people, but they did not always complete the observation chart fully to identify women and birthing people at risk of deterioration. The service conducted documentation audits of 10 records a month for each area of the service. The labour ward audits conducted between June and August 2023 showed MEOWS completion ranged between 70% to 100% on admission, and of those completed, 100% were calculated correctly. Following birth, we saw MEOWS completion ranged between 80% to 100% of those completed, and 100% of completed MEOWS were calculated correctly.

Documentation audits for midwifery-led unit (MLU) conducted between June and August 2023 showed MEOWS completion ranged between 50% to 80% on admission, and of those completed, between 67% and 100% were calculated correctly. Following birth, we saw MEOWS completion ranged between 80% to 90%, and of those completed, between 78% and 100% were calculated correctly.

Intrapartum documentation audits also showed that blood pressure, maternal pulse, bladder care and temperature were not always documented in specified time limits. Compliance with these measurements ranged from 70% to 100% for June to August 2023 on labour ward and MLU.

Postnatal documentation audits between June and August 2023 showed MEOWS was completed between 90% to 100% of the time. Of those completed, between 90% and 100% were calculated correctly. Compliance with completing observations at the correct time intervals ranged from 80% to 100%.

We cannot tell from the MEOWS audits whether or not elevated MEOWS scores were escalated appropriately as this was not reviewed by the audits.

Leaders monitored waiting times for women and birthing people accessing triage to check they received treatment within agreed time limits. Evidence provided showed between May and July 2023 there was 100% compliance for red category cases (requiring immediate treatment). Compliance with the initial 15-minute assessment and other prioritisation categories (orange, yellow, green) was over 90%.

Although triage midwives used a set of nationally recognised algorithms to aid the standardisation of assessment and prioritisation, the electronic system used for triage documentation did not have purpose made triage proformas mapped to the risk assessment and prioritisation process. Instead, a generic entry form for an antenatal outpatient assessment was used. This meant the documentation of the triage risk assessment and prioritisation process was not standardised, and it could not be confirmed from records that all midwives followed the same process, or how they arrived at their conclusion about priority. The service was planning to implement a new electronic system which would be compatible with a full electronic triage process in February 2025.

Maternity

Staff did not always complete and escalate newborn risk assessments appropriately. The baby early warning scores (BEWS) audit in June 2023 showed 100% of babies requiring observations had observations performed. However, compliance with recording all the required parameters, including the date, frequency of observations and escalation of babies requiring additional support was poor. Compliance ranged between 50% to 74%. In addition, the audit showed 50% were not escalated appropriately. We did not see a robust action plan with allocated actions and time limits for improving compliance with BEWS, and re-audit was not planned to take place until 2024/2025, which is a significant gap considering the level of compliance.

Staff did not always use a 'fresh eyes' approach for checking cardiotocography (CTG), a tool used to objectively assess fetal well-being hourly. Intrapartum documentation audits showed between June and August 2023 compliance with fresh eyes in the 1st stage of labour was 90 to 100%. However, CTG audits between June and August 2023 showed compliance with hourly fresh eyes ranged from 70% to 80%. In addition, where a reason had been documented for missing fresh eyes, this was due to the level of acuity. We were told the service had recently introduced twice weekly CTG teaching sessions.

Staff did not always conduct initial labour assessments. Evidence showed between June and August 2023 initial assessments in labour were conducted on labour ward in 60% to 80% of records reviewed; on the MLU initial assessments were completed in 50% to 89% of the records reviewed. We asked for and received minimal data for the completion of postpartum haemorrhage risk assessments; no data was provided for labour ward, however, we did receive data for the MLU which ranged between 60% and 100% completion between June and August 2023. We saw postnatal documentation audits between June and August 2023 showed postnatal risk assessments were completed in 70% to 80% of the records reviewed.

Staff did not always document deep vein thrombosis risk assessments (VTE). We saw between June and August 2023 100% of records had a VTE assessment documented, however on the MLU this was 60% to 90% of the records reviewed. The trust later provided additional information following review of this data that patients who were reported as not having a VTE assessment were either exempt due to an attendance of less than 7 hours duration, or had an assessment but this had not been added to PCS (45 out of 98 with apparent lack of VTE assessment), which is the route by which the DQSG has visibility of VTE risk assessment compliance. However, this raised concerns around why the audit compliance results had not been investigated further before. During the factual accuracy checking process, the trust provided new information for March 2023 to February 2024 that compliances with VTE risk assessment for those eligible were 98.8% and 99% for MLU and labour ward respectively.

Response times for emergency caesarean sections were not always met in line with national guidance. Category 1 is the most urgent emergency section, requiring delivery within 30 minutes of the decision to deliver because there is an immediate threat to the life of the mother or birthing person or fetus, and category 2 within 75 minutes due to maternal or fetal compromise. Failure to meet these response times risks fatality or compromising mother or baby. From September 2022 to August 2023, compliance with the category 1 response time varied from 67% to 100%, and compliance with the category 2 varied from 62% to 92%. We requested additional information following our inspection, and the service advised a number of caesarean sections had been miscategorised retrospectively. However, this does not mitigate that the category time limit at the time was not met and could result in a poor outcome.

We found a high number of the delays in category 1 and 2 sections were due to maternity theatre being unavailable, staff being unavailable and delay in transfer to theatre. Problems around theatre and staff availability and getting a second theatre opened for emergencies happening at the same time were also evident in incidents. We saw incidents which identified delays in emergency caesarean sections which resulted in a poor outcome. The service had identified the need for a second theatre opening SOP, but by the time of inspection still had not produced this.

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During the inspection, we observed, and found staff were not engaged with, the surgical safety checklists in line with national guidance from the World Health Origination (WHO). For example, we saw the physical checking of wristbands and consent was not conducted. We reviewed WHO surgical safety checklist audits between June and August 2023 and found completion varied between 50% and 100% of the checklists reviewed. Considering our observations during the inspection we were not assured actions to improve compliance were effective.

Staff told us women and birthing people requiring induction of labour were risk assessed and prioritised through discussion between the midwifery and medical team. There was local guidance on factors to be considered as part of the risk assessment and prioritisation process to aid decision making when the number of inductions exceeded capacity, or there was an anticipated delay in continuing an induction process. However ultimately this was a clinical decision by the clinicians, rather than a standardised prioritisation process.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. There was a perinatal mental health team for people identified as having mental health conditions during the antenatal period. Staff completed a form for this which was also stored on the electronic record. Those already under the care of a mental health team in the community would have a plan and contact details for their main team. For new acute mental health concerns staff could access the psychiatry service in and out of hours.

Shift changes and handovers included the expected information to keep women and birthing people and babies safe. Staff used a handover process based on 'situation, background, assessment and recommendation' (SBAR) to ensure all relevant information was handed over. During the inspection, we attended the morning medical handover on the labour ward and found it was attended by the expected staff and content was as expected. We saw that medical staff used a printed handover sheet to pass on information from night to day shift staff.

Evidence provided showed between June and August 2023 90% to 100% of records reviewed had a full SBAR handover documented on labour ward; in the MLU we found between 80% and 100% had a full SBAR handover documented. On the postnatal ward we found between 60% and 70% of records reviewed had a SBAR handover documented.

The service provided a transitional care service for babies who required additional care. This was not a full transitional care service (as it did not include tube feeding) at the time of the inspection. However, the service had a transitional care improvement plan, part of which involved becoming fully British Association of Perinatal Medicine (BAPM) compliant. This included providing tube feeding, and documents submitted after the inspection showed the improvement action of staff training in tube feeding had been delivered as of March 2024. A new SOP for transitional care for babies had been approved in January 2024.

Midwifery Staffing

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

Staffing levels did not always match the planned numbers, and planned numbers were not always adequate, putting the safety of women and birthing people and babies at risk. The service had completed a baseline minimum safe staffing requirements review using a nationally recognised acuity tool in October 2021. This had recommended 83.4 whole time equivalent (WTE) hospital based midwifery staff, and as of September 2023, actual funded establishment was 83.5 WTE.

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The service had recently conducted an internal staffing review which showed that as of September 2023 there were 9.2 WTE midwifery vacancies. Leaders told us additional investment was being made to meet new staffing requirements identified by the staffing review. We were told all of the vacancies had been recruited to with newly qualified midwives who required a 12-month preceptorship programme starting in Autumn 2023. We found a high maternity leave rate resulting in 11 WTE temporary vacancies, compared to the average 5WTE, which was expected to improve in Autumn 2023.

The service monitored sickness absence rate, and we found between September 2022 and August 2023, the sickness absence rate for midwifery staff ranged between 0.4% and 8.2%. The overall sickness absence rate for all staff groups was 6.7%.

The service did not always report maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between March 2023 and August 2023 there were 77 red flag incidents reported. Seventy nine percent (n59) of these were delay between admission and starting IOL. The service did not record delays in the continuation of the IOL process once started. The delayed activity, specifically emergency caesarean sections , was 21% (n16). Data for March to August 2023 contained only 16 red flags for delayed caesarean sections, but we counted 38 delayed category 1 and 2 sections during this time. The service told us this was because any delays outside of the live data entry, which is done 4 hourly, would not be captured via the acuity tool. This meant the number of red flags for delays to, for example, emergency sections, could not be relied upon as accurate.

The service did not record delays during the induction of labour process, although these would qualify to be reported as delayed activity or care red flags. This meant the service did not capture red flag information on delays once induction started.

Staff told us staffing levels caused difficulties with IOL, and that delayed starts over 2 hours were reported as red flags, whereas delays over 4 hours once started were reported as incidents. We were told there had been some emergency IOLs the day before the inspection which had caused delays to elective caesarean sections.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance, but staffing did not always meet the activity requirements. For example, the intrapartum acuity tool showed staffing met acuity between 74% and 80% of the time in June and July 2023. Further data submitted at factual accuracy checking showed that during this period there were instances of staff being redeployed from training, unable to take allocated breaks, staying beyond rostered hours, and specialist midwives and manager/matron working clinically.

Data submitted for diverts in the 12 months prior to inspection showed 2 incidents of divert, 1 in January 2023 and 1 in April 2023. Staff told us the service had closed most recently in the week before the inspection following agreement with 3 hospitals in the region. Managers explained the process where the Local Maternity and Neonatal System facilitates a system to offer voluntary provider to provider mutual aid for elective work (IOL and caesarean sections) for organisations that are experiencing pressures resulting in a delayed elective workload.

In addition, between May and July 2023 we found 30% of shifts in triage when actual staffing was below planned staffing. However, it was unknown whether these shifts had been covered by redeployment from other areas. During the inspection, we saw, and we heard, specialist midwives were often redeployed to work clinically away from their specialist roles.

The service had reviewed and amended the staffing escalation processes, and we were told this had resulted in avoiding having triage midwives being redeployed across the service. We were told by staff that the antenatal/postnatal ward usually started each shift fully staffed, but typically at least 1 midwife would be re-deployed.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. There was also a dedicated band 6 midwife to manage care for women and birthing people who attended for IOL.

Staff told us there was a resident operating department practitioner (ODP) to assist the obstetric anaesthetic doctor, but they were not dedicated to obstetrics and may be busy elsewhere. When this happened, the theatre coordinator would need to arrange alternative assistance. There was a non-resident on call ODP at home, but travel time was 30 minutes, which would not meet the category 1 caesarean response time of maximum 30 minutes from decision to birth. However, after the inspection leaders explained that the obstetrics ODP only covered obstetrics and paediatrics, and the second resident ODP (for main theatres) would support an obstetric emergency and be backfilled by the third non-resident ODP.

There was no routine support from neonatal staff for babies requiring transitional care, and there was no routine medical ward round of babies on transitional care, but we were told they would be included as part of the neonatal handover.

Managers used bank staff who were familiar with the service. Data for September 2022 to August 2023 for wards 23 and 26 showed no use of agency staff to fill gaps in the rota. However the roster was not always filled.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Compliance with annual appraisals for midwifery staff ranged between 71% and 93%.

Managers did not always make sure staff received any specialist training for their role. Staff told us that senior midwifery staff completed a half day 'in house' training session on enhanced care only, with the anaesthetic team. Considering the PROMPT compliance figures at the time of the inspection, we were not assured about the management of cases needing enhanced care. Staff told us they would liaise with anaesthetists and obstetricians about women and birthing people if they needed a higher level of care when on labour ward.

We found midwives provided care for women in theatre recovery, including those who had a general anaesthetic. Staff received 'in house' training to undertake this role, however this was not in accordance with the Royal College of Anaesthetists (RCOA) guidelines on recovery care for obstetric patients. The RCOA guidance states staff should be trained to the same standard as for all recovery practitioners working in other areas of general surgical work, should maintain their skills through regular work on the theatre recovery unit and should have undergone a supernumerary preceptorship in this environment before undertaking unsupervised work. Anaesthetic staff told us they ensured they were easily accessible for any problems in recovery, but recognised that women and birthing people were not receiving the same standard of care as patients in main theatres. The anaesthetic staffing policy stated that ‘The Anaesthetist will not be available for another case until they are happy with the woman in recovery. The Anaesthetist will not leave the delivery suite (unless for a clinical emergency) until the woman in recovery meets discharge criteria for the ward.’ Leaders told us funding had been requested for an appropriately trained recovery nurse for maternity 24/7.

Midwives scrubbed for all emergency operative cases overnight. They had received 'in house' training for this, which is not in line with the recommendations of the Association of Perioperative Practice (2009). This also meant midwives were removed from the labour ward floor to assist in theatre. We were told the practice of midwives scrubbing overnight was

planned to end in December 2023. Use of midwives for scrubbing for emergency cases was on the trust's risk register and sometimes caused delays in finding available staff members. Leaders told us funding for a scrub practitioner for all elective and emergency cases had been approved and it was planned this would be in place by June 2024, but recruitment challenges meant that currently there was a scrub practitioner for elective and overnight cases only.

Midwives providing transitional care on postnatal ward were trained to give intravenous medications to newborns.

Medical staffing

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

The service did not always have enough medical staff to keep women and birthing people and babies safe. We saw the impact on delays in care such as for triage and theatres, along with delays in completion of mandatory or specialist training updates. However, leaders told us they felt assured they provided sufficient medical staffing at all times. We were told there were 13 consultants, 11 of which provided out of hours cover. Data for April to August 2023 showed there had been 12 consultants, which was 11.98 WTE. There were 22 junior doctors, of which 9 were sub-middle grade. There were also foundation doctors, but these were not listed in the data submitted. We requested, but did not receive, data on vacancies and turnover for medical staff. For the period September 2022 to August 2023, sickness absence for obstetric medical staff, which included consultants, junior doctors and also advanced nurse practitioners, was 4.8%.

The service had very recently (18 September 2023) introduced a separate dedicated full day elective caesarean section list twice a week with 5 slots per day (previously a daily half day list combined with emergency cases). This had a separate consultant and junior doctor. This was an improvement on these days as it reduced the impact of elective sections on emergencies and vice versa. However, there remained an additional 2 mornings per week where elective cases in excess of the 5 dedicated slots would be conducted. This additional elective work was not a dedicated list and ran as part of the labour ward workload. This meant elective and emergency work was not separated and therefore could impact on each other. As this was unpredictable, it was not possible to formally staff this in advance. We were told midwives would be redeployed from specialist roles or administrative work to cover these.

There was no dedicated anaesthetist to cover these protected elective lists in the rotas, and the service relied on cover by anaesthetists willing to do extra sessions, although staff told us there had not been any problems with getting this cover.

On the day of inspection there was no SHO doctor cover for the 5-9pm evening shift, so the evening medical staffing, when there are less doctors around out of hours, was reduced further.

The service did not always have good availability of medical staff on each shift. On call cover included a consultant, middle grade, and sub-middle grade doctor, with these doctors also covering gynaecology, and covering obstetrics and gynaecology in the emergency department, except for a separate sub-middle grade covering gynaecology during the day until 5pm. The morning labour ward round also saw gynaecology patients and the more complex antenatal patients. The service always had a consultant on call during evenings and weekends.

Although leaders told us the service was compliant with Royal College of Obstetricians and Gynaecologists (RCOG) staffing standards and the Ockenden safe staffing recommendations 2022, staff told us there were delays in getting

medical reviews at weekends and when the labour ward was busy. We noted multiple references to staff being unavailable for a second concurrent obstetric emergency within the data. Triage staff told us waiting for doctor reviews caused delays in triage. However the performance data for triage for September 2023 showed 100% compliance for red and orange prioritisation categories, and 96% and 99% for yellow and green respectively.

Anaesthetic cover for obstetrics in hours was a junior anaesthetist and consultant anaesthetist. Out of hours there was a junior anaesthetist and a consultant, with the consultant also covering main theatres and supervising the main theatres junior anaesthetist. This meant the main theatres junior anaesthetist may be left with a case if the obstetric junior anaesthetist needed help from the consultant at the same time as a main theatres case. We noted a significant number of the delayed emergency sections stated anaesthetic complications as the reason for delay. With the very recent separation of emergency and elective work, there was a separate consultant anaesthetist required for the elective lists. There was a business case for additional funding for this ongoing at the time of the inspection, and in the meantime, staff told us these shifts were filled by anaesthetists willing to do extra sessions.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given opportunities to develop. Results from the most recent General Medical Council National Training Survey (2023) were positive, and the department was ranked highest in the country for obstetrics and gynaecology training.

We received appraisal data for consultants only, not junior doctors, which showed all consultants had completed a 2022/2023 appraisal.

Records

Staff did not always keep detailed records of women and birthing people’s care and treatment. Records were stored securely, but not always easily available to staff providing care.

Women and birthing people's notes were not always comprehensive and there was no single point of overall visibility of care. The trust used a combination of paper and electronic records. The electronic records system was used for antenatal contacts including triage and community visits, telephone calls and also postnatal calls. However, the intrapartum patient medical record was paper based so could not be viewed on the electronic record together with the person's other care episodes. Staff would also need to input information from the paper intrapartum record for the electronic system to generate a delivery summary, which was duplication of work. Blood results from antenatal screening were kept in inconsistent formats, with some being electronic and some on paper.

Evidence provided showed poor compliance with completion of fluid balance charts. Audits showed compliance with completing the chart and 24-hour total ranged between 0% and 25% from June to August 2023. We did not see any action plans in place to improve compliance.

When women and birthing people transferred to a new team, staff could access their records. Inpatient records were paper, but the electronic records system generated a discharge summary that was automatically sent to the GP.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

Maternity

The service generally used systems and processes to safely prescribe and record medicines, but did not always store medicines correctly.

Staff generally followed systems and processes to prescribe and administer medicines safely. We reviewed 3 prescription charts and found staff had mostly correctly completed them.

Staff did not always store and manage all medicines safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date; however, temperatures had not been consistently checked for fridges storing medicines and milk. For example, on the antenatal/postnatal ward we found multiple gaps in fridge temperature checks. We also saw that when they had been checked and the temperature was out of range, there was no evidence this was reported, or actions taken. The room temperature of the medicines room on labour ward was too high, being regularly above 25 degrees, but there was no evidence that action had been taken to address this. This meant the service could not be assured medicines were safe to use as the temperatures were not monitored effectively.

Controlled drugs (CD) were stored in a locked cupboard and the handover of CD keys was recorded. CDs had been checked with no gaps and there was also a handover sheet to confirm CDs had been checked and handed over.

Incidents

The service did not always manage safety incidents well. Staff recognised incidents and near misses but did not always report them. Managers did not always investigate incidents and share lessons learned in a timely way. Managers did not always ensure that actions from safety alerts were implemented and monitored. However, when things went wrong, staff apologised and gave women and birthing people suitable support.

Staff could describe what incidents were reportable and how to use the electronic reporting system. However, they did not always report incidents. The service conducted a review of all post-partum haemorrhages (PPH) of 1500mls or above (ranging from 1.5L to 10L) for the period April 2022 to March 2023. The service PPH policy stated all PPHs 1500mls or more at delivery should be recorded as an incident. The review found there were 93 incident forms completed, however, 137 PPHs of 1500mls or more were found on the electronic patient record (EPR) system. This meant that 32% (n44) of PPHs had not been reported. Following this review, the trust introduced a tracker for cross referencing EPR and incident management data to ensure all reportable PPHs had been reported and would receive an MDT review.

Staff reported serious incidents in line with trust policy and investigated serious incidents. The service had recently adopted the most recent national standard operating procedure for incident investigations known as the Patient Safety Incident Response Policy (PSIRF). The procedure included flow charts on how to review and grade incidents.

Records showed that managers completed rapid reviews of care for cases that met the serious incident criteria. There had been 8 maternity serious incidents reported by the trust from 1 February 2023 to 16 August 2023. We found repeating themes in serious incidents, for example failure to interpret and escalate deteriorations in CTGs and staffing.

Staff followed the national Perinatal Mortality Review Tool (PMRT) to review perinatal deaths. We saw these involved women and birthing people and their families in the investigations. At the time of our inspection there was no external review of PMRT investigations as recommended by Ockenden (2022). In the 6 months prior to the inspection, there had been 2 new referrals to the Maternity and Newborn Safety Investigation programme (MNSI) (formerly Health Services Safety Investigation Branch (HSIB)). In addition, there were 5 ongoing cases under review by MNSI.

Maternity

The service provided us with data showing 229 incidents that had been open for over 60 days. We noted on the national reporting and learning system (NRLS) that it often took many months before incident investigation reports were ready, sometimes up to a year. This meant learning from incidents may not be passed on in a timely way. We attended the weekly divisional risk meeting during our inspection, where we heard that there were currently 6 open serious incident or root cause analysis investigations. Following the inspection the trust advised us that 105 of these incidents had been reported retrospectively. This meant 124 incidents were open for over 60 days at the time. The trust also shared "Lessons Learned" documents, which were shared with staff during handovers and in training sessions. These documents showed learning to be taken from incidents around dealing with triage calls, as well as a serious incident where staff had not followed the trusts procedures.

Managers presented incidents graded as moderate and above harm at the weekly Patient Safety Summit (PSS) which was chaired by the chief medical officer. In line with PSIRF the summit considered whether these incidents qualified as serious incidents and what further investigation was required. Staff told us the divisional leaders could use discretion to bring 'no' or 'low harm' incidents to the PSS if they wanted to discuss these with the wider teams.

We found, and were told, leaders graded harm or injury according to clinical outcome and whether there were any care issues identified. This meant a greater number of incidents were classified as no or low harm, which meant the board were not always appraised of the total number of incidents reported. Following the inspection the trust informed us they had undertaken a semi-independent review of PPHs and tears. This review has led to changes, going forward the trust will classify PPH and 3rd and 4th degree tears as moderate incidents.

There was not always evidence that health inequalities were considered as part of the incident review and investigation process. The PSIRF operating procedure included a patient safety response toolkit, which looked at particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. At the time of the inspection the service had no completed PSIRF investigations as this was a new system that the trust was in the process of implementing. We saw that ethnicity was recorded on the Perinatal Mortality Review Tool (PMRT) and internal incident review reports. However, ethnicity data was not captured on 5 out of the 6 72 hour reports we reviewed. Following the inspection the service shared an example where they had translated an investigation report into the first language of the person concerned.

Staff understood the duty of candour. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed. However, as not all incidents were graded appropriately, we were not assured that all cases eligible for duty of candour had this completed.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. We attended the weekly divisional risk meeting during the inspection and learned that there were currently 8 complaints (within maternity, paediatrics, gynaecology, and neonatal care). We were told the division was meeting weekly with the complaints team about these.

Managers debriefed and supported staff after any serious incident. Records showed that staff involved in serious incidents were offered a hot debrief after the event.

Is the service well-led?

Requires Improvement 

Maternity

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

Leadership

Leaders were generally visible and approachable in the service for women and birthing people and staff. However, they did not always understand and manage the priorities and issues the service faced.

Leaders did not always understand and manage the priorities and issues the service faced. The Women and Children's Division triumvirate included the Director of Midwifery (DOM) who was also the Head of Nursing for Paediatrics and Gynaecology, a Divisional Director, and an Associate Medical Director reporting to the Chief Medical Director. The DOM was supported by the Deputy Head of Midwifery, quality and safety, a consultant midwife, and the Head of Nursing for Paediatrics. A Deputy Divisional Director and a Service Manager supported the Divisional Director. The Associate Medical Director was supported by the obstetric, gynaecological, and paediatric clinical leads.

The chosen structure for triage leadership was limited to the arrangement on a daily basis of oversight by the labour ward coordinator. This meant triage was effectively an extension of the labour ward with missed opportunity for close monitoring of emerging risk and performance improvement.

Leaders were generally visible and approachable in the service for women and birthing people and staff.

The service was supported by Maternity Safety Champions, including a Non-executive Director (NED) Safety Champion. The NED and Safety Champion were also involved in patient safety walk abouts to explore and highlight risks and learning from incidents. The NED was invited to independent reviews to review data and intelligence.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The trust provided information on their recent and current strategy plan for the next 3-5 years, called 'Plan on a Page' (September 2023). The key objectives and priorities included strengthening leadership, the digital strategy and achieving national maternity targets.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations. The strategy was aligned to the overarching trust strategy to ensure the same principles were applied to all aspects of care and service delivery. Records showed that so far, the division had a training plan with actions to improve training compliance, had opened a bespoke bereavement room for parents who had suffered a baby loss, and recruited specialist midwives who had established roles.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The 'Plan on a Page' document showed that leaders had considered key interdependencies to be financial constraints and maintenance of the midwifery and medical workforce.

In addition to the proposed strategy, service leaders developed the 'Our Divisional People Plan', which included a mapping exercise that showed the expected changes within the division. The document included plans to create more outpatient capacity, improve staffing, review the elective and emergency surgery requirements for maternity and fund recruitment of additional specialist midwives and experienced maternity support workers. The plans included an overview of cost so that trust leaders had full oversight of the financial impact.

Culture

Staff did not always feel respected, supported, and valued. However, they were focused on the needs of women and birthing people receiving care.

At the inspection staff were positive about working in the service, but a few staff told us they did not feel part of the team.

The trust completed the annual NHS staff survey. Divisional leaders used the information to monitor staff wellbeing and improve the retention of the workforce. Records for the 2022 divisional survey showed that only 32% of staff completed the survey, which was less than the previous year. This meant that 68% of staff had not completed the survey, which meant a significant proportion of staff views had not been captured on survey matters. However, the trust also used other channels in addition to the staff survey to learn about workforce concerns. These included informal drop-in sessions with the senior leadership team, safety champion walkarounds, a labour ward survey, exit interviews with a retention midwife, and access to professional midwifery advocates. Leaders told us information from these various sources contributed to their divisional people plan, which was last updated in November 2022.

The NED and Safety Champion held monthly staff meetings and completed bi-monthly walk arounds, they reviewed data and gave staff time to raise concerns. Feedback from concerns was reported at the monthly meetings so that staff were kept up to date with feedback and learning from incidents. Information from the meetings was reported via the quality and safety committee and then presented to the board via quarterly reports.

Staff were focused on the needs of women and birthing people receiving care; however, they were not always able to deliver the standard of care they aspired to. Staff we spoke with wanted to provide high quality care to women and birthing people using their service, but the limitations of aspects such as staffing meant they were not always able to do so.

Leaders understood that health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population.

The NED had a role in reducing risks for women from different ethnic minority groups where English was their second language and women with complex mental health needs. The NED understood the health implications for women and people of colour and stated that the trust collected ethnicity data at various points of care. One example highlighted risks with interpreting services. However incident data we saw did not capture ethnicity during the review process.

Leaders linked with the local authority and staff were trained on how to access interpretation services.

The service acknowledged equality and diversity in work. The service had an equality, diversity and inclusion policy and process. The policies and guidance we saw had an equality and diversity statement.

Maternity

Women and birthing people, their families and staff could raise concerns about the service. The service used the most informal approach that was applicable to deal with complaints. Records we reviewed showed that the service followed a process to respond to complaints that included a detailed breakdown of aspects of the complaints, and apologised when things went wrong.

Managers investigated complaints and identified themes. This was a standing agenda item on regular team meetings. Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint. Records confirmed that leaders reviewed complaints and provided explanations and apologies, and shared learning from complaints.

Governance

Leaders did not always operate effective governance processes. Staff had opportunities to meet, discuss and learn from the performance of the service, but this did not always translate into prompt and timely action.

Leaders did not always operate effective governance processes throughout the service. The service had a governance structure which we were told was designed to allow the flow of information from frontline staff to senior managers.

Leaders did not have full oversight of data submitted to the national incident reporting system (NRLS). We found evidence that the trust was under-reporting on the NRLS platform. For example, the internal reporting dashboard from September 2022 to July 2023 showed 93 postpartum haemorrhages of volume 1500-2000mls, but the NRLS only showed 34 of these incidents. The dashboard showed 31 postpartum haemorrhages of over 2000mls, but the NRLS showed 11. Also, audit data for triage breaches for June 2023 showed 42 breaches, but only 25 were recorded on the NRLS platform. Therefore, we are not assured that all aspects of the governance process were robust.

The quarterly maternity safety reports on compliance and progress towards national incentive schemes were reviewed by the quality and safety committee. A key recommendation of the Ockenden (2021 and 2022) reports was for trust boards to provide oversight of the quality and safety of maternity services.

Maternity & Neonatal Safety Champions attended monthly meetings, to review various aspects of service delivery. Minutes from meetings showed that there was a formal agenda that had 17 agenda items. These included, but were not limited to, the review of the perinatal board assurance tool metrics, review of most recent serious incidents, training compliance, workforce issues, service user feedback, updates from various national maternity schemes like the Ockenden recommendations, and a risk update.

The trust had declared themselves compliant and had been identified as achieving full compliance with the NHS Resolution maternity incentive scheme year 4. We found board reports did not include details of the performance of key maternity services such as triage or induction of labour, or compliance with the national recommendations for timeliness of emergency caesarean sections. This was a missed opportunity to report on key safety factors in maternity. However, leaders told us that maternity reports were presented to the Quality and Safety Committee, which was a sub-committee of the board attended by some board members, and from which a chair's report would be made to the trust board including any maternity key messages. This did not include caesarean section and IOL data, which was kept on the maternity dashboard. The chair was a non-executive director who was also a maternity safety champion. There was also an Executive Quality Governance Group which received some maternity data and which reported to QSC via a chair's report. Therefore leaders felt assured that the trust board was sighted on maternity data via their sub-board committee reporting structure.

The service had a process for monitoring and risk assessing guidelines, and a process for ensuring compliance with national guidance such as guidance from the National Institute for Health and Care Excellence. Policies, standard operating procedures, and guidelines were monitored via divisional groups and we were told that reviews of maternity guidelines were at 95% as of August 2023. The trust wide safeguarding policy should have been reviewed in June 2023, but we were told Local Authority updates were awaited and changes would be minimal only.

Leaders had been slow to create a standard operating procedure (SOP) for the opening of a second theatre when there were 2 obstetric emergencies at the same time, even though this was a repeating theme in incidents. This had not been completed by the time of the inspection. Following our request for this the service told us the document was being finalised and then would need to be agreed via the appropriate governance process. An SOP for opening a second theatre has since been produced.

Management of risk, issues, and performance

Leaders and teams had systems to manage performance, but these were not always effective. They did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. However, they had plans to cope with unexpected events.

The service participated in relevant national clinical audits. Records showed that the service submitted data to 4 national audits. These were the MBRRACE Saving Lives Improving Mother's Care, the National Pregnancy in Diabetes (NPID), the National Maternity and Perinatal Audit (NMPA) and the Baby Friendly Initiative audits.

The service monitored compliance with the Saving Babies Lives Care Bundle and records showed that 100% of women and pregnant people were risk assessed for fetal growth restriction at their first appointment.

Service leaders followed a standard operating procedure for the Perinatal Clinical Quality Surveillance model, which described how the Perinatal Clinical Quality Surveillance model was embedded into the Integrated Care System (ICS) governance structure and signed off by the ICS. Records showed that from January to August 2023 there were a total of 12 stillbirths, 1 neonatal death under 24 weeks of pregnancy and 2 neonatal deaths over 24 weeks. This equated to a rate of 1.8 per 1000 births which reflected the national mortality rate of 1.6 per 1000 for 2021. Data showed that there were 3 perinatal mortality reviews in July 2023 all with divisional and external representation, and reviews concluded that there were no care issues that would have changed the outcome for the babies.

The service demonstrated compliance to the requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year 4 and had received the year 5 scheme requirements in May 2023. Service leaders developed a new training needs analysis to benchmark against the requirements of the MIS and released updates for the core competency framework.

Managers and staff conducted audits. Records showed that there were 31 maternity audits. They audited performance and identified where improvements were needed, but this was not always acted upon in a timely way.

The maternity dashboard monitored outcomes, and identified themes, trends and benchmarked against national outcomes. We were told the dashboard data was reported to obstetric governance monthly, and that this data was contained within the monthly perinatal quality surveillance report seen by board level leaders attending the Quality and Safety Committee, a board sub-group.

Leaders did not always identify risks, escalate risks and issues, and identify actions to reduce their impact. There was a process to identify risks through the incident management system, and review and record this in meeting minutes for the monthly risk assurance meeting. Records from the division showed that incidents were reviewed by a multi-professional team and there was some evidence that recommendations were acted upon. However, we noted several examples where leaders did not identify risks, and there was a general lack of oversight of risk and performance. For example, the lack of pool evacuation drill and the lack of up to date environmental ligature risk assessments. Maternity and governance leaders told us at the inspection that ligature risk assessments had not been completed for maternity and subsequently completed and submitted these as part of immediate assurances. Further information provided later stated that ligature risk was last assessed in 2018. In addition, leaders lacked the necessary pace in addressing compliance with emergency Caesarean section response times due to theatre and staff being unavailable, and in producing a standard operating procedure for opening a second theatre in the event of concurrent emergencies, despite identifying this from an HSIB (now MNSI) report.

There were often very extended periods between the date of the incident and the date of the incident report. This meant learning, and therefore improvements, would not be made promptly in a timely way. This also meant risks were not always identified from incidents and acted upon.

Because incidents were graded on the basis of the final clinical outcome, with the approach that complications relating to labour and birth were expected events or known complications, rather than on the impact on the person, the majority of incidents were rated as no or low harm. This meant the impact on the person was not recognised or acknowledged, but also that these incidents did not receive detailed robust reviews, and therefore the service could not be assured that it had good oversight of all risk and performance, or that their safety and performance was good.

Leaders monitored the Women & Childrens risk register monthly using a trust wide standard risk register RAG (red, amber, green) rated template. The register showed the owner of the risk, and the review dates, cause and consequences, and the risk controls to mitigate expected risk. We observed a meeting which demonstrated there was a standard agenda which included review of the divisional risk register for existing risks and consideration of new risks.

There were plans to cope with unexpected events. The service had a local business continuity plan. Records showed service leaders completed incident reviews when the escalation process created a divert to a neighbouring maternity unit, this happened 3 times from December 2022 to April 2023. The investigation reports included learning that was discussed at the Obstetric and Paediatric governance committee.

Information Management

The service did not always collect reliable data and analyse it. Staff could find the data they needed, to understand performance, make decisions and improvements, but this did not always happen in a timely way. The information systems were not integrated but were secure. Data or notifications were not always submitted to external organisations as required.

The service did not always collect reliable data, and when it was collected, it was not always analysed correctly. There was a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. The service dashboard included data on category 1 and 2 caesarean section response times. Category 1 sections require delivery within 30 minutes of the decision for emergency section, and category 2 within 75 minutes. This data showed numerous occasions when the required time limit had not been met. Upon further investigation at our request, managers advised

us the data collected had been inaccurate in many cases, due to emergency sections being mis-categorised as category 1 or 2 when they should have been category 3. Leaders told us that following these findings, the NICE guidance summary on emergency caesarean sections was sent to all medical staff performing these and individual staff would be emailed about incorrect categorisations. However, it was concerning that this education action was needed.

Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. This was because the information systems were not integrated**.** Service leaders were in the initial stages of procuring a new electronic patient record system because the current system was obsolete and did not reflect current requirements. Trust board papers published following our inspection referenced the Maternity Digital Strategy and the need to migrate to a new maternity information system. Leaders told us a maternity digital strategy had been published in August 2022, which included improving access to data for staff and patients. Leaders said a nationally recognised maternity system aligned to systems used across their Integrated Care System (ICS) had been procured and that they were on track for completing this process.

Data or notifications were not always submitted to external organisations as required. Records from the national maternity dashboard showed that the trust had submitted data within set time limits, unless there was a reported fault with the national reporting system. However not all incidents on the local dashboard were on the National Reporting and Learning System.

Engagement

Leaders and staff 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.

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. Leaders met with the MNVP quarterly, and meetings followed an agenda and minutes were recorded and stored. The MNVP provided feedback on care from service users who accessed the MNVP as a voice and advocacy service. Also, leaders worked with the MNVP to create and review a rolling action plan of improvements that would enhance care for women and pregnant people using the service. Records showed that work had been completed on improving the experience and outcomes for Asian and Black communities, also a birthing experience group had been set up on social media and the local MNVP representatives were invited to attend perinatal audit meetings.

Leaders worked on the strategy in co-production with the local MNVP. Also, leaders planned to measure success via staff survey results, reductions in complaints and compensation, reductions in serious and other avoidable incidents, and a reduction in the perinatal mortality and morbidity rates and avoidable term admission to neonatal services.

Leaders understood the needs of the local population. The trust ranked in top 6 maternity trusts in England scoring above national average in the CQC maternity patient survey 2022. We received approximately 81 responses to our ‘give feedback on care’ posters which were in place during the inspection. Of these responses 56 were positive, 18 were mixed and 7 were negative. Positive themes included continuity of care, polite staff, and escalation when things went wrong. Negative themes were inconsistent care, and lack of consent.

Learning, continuous improvement and innovation

Staff were committed to learning and improving services. The service understood quality improvement methods, but improvement was not always timely or effective.

Maternity

Staff wanted to learn and improve services, but there were key elements of an obstetric service that had gone without important learning and improvements for extended periods of time before being addressed. We noted the same themes repeating in incidents, suggesting that any learning that might have been taken from these incidents had not been effective. We saw leaders were not always proactive in making timely and effective changes. This was evident from the examples of management of post-partum haemorrhages and delayed category 1 and 2 Caesarean sections. In addition to the delayed caesarean section data for September 2022 to August 2023, the trust provided an audit of category 2 sections from January to December 2021 as part of the factual accuracy checking process, which also showed some delays. However, the reasons for delay were not included, except for 2 delayed cases requiring resuscitation, which were delayed due to there being another emergency and theatre being unavailable. Therefore, difficulties with theatre and staff being unavailable for concurrent emergencies, which existed at least as far back as 2021, persisted in 2023. Therefore, it would seem that any actions taken had not been effective.

The service was able to describe and provide evidence of mechanisms by which learning was acquired and distributed to staff, for example newsletters, initial incident reviews, complaints and thematic reviews. However, data outside of the normal range was not picked up and acted upon comprehensively in a timely way, and the service was not always able to provide evidence that the learning distributed had been translated into embedded changes that led to improved results and outcomes. Leaders also told us that at the time of the inspection there were 7 staff leaders trained in quality improvement, and we saw evidence of improvement project work within staff newsletters.

Leaders published the Women and Children's Nursing and Midwifery Summit Newsletter every month. The newsletter gave detailed updates on quality improvement and updates on service provision for staff working in women and childrens' services.

Leaders encouraged innovation and participation in research. The service had created a research team that included a lead for research, a paediatric nurse, a midwife, and an administrator.

There was some evidence that changes had been made following feedback. We saw an example of a poster informing staff about the reduced fetal movement (RFM) pathway not being followed and those with RFMs not being referred for assessment. The poster listed actions including a training video and flow chart for further updates. Records showed that leaders completed and updated a Perinatal Mortality Review Tool action log, which included plans for improvements.

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 service must ensure that all staff are up to date with maternity mandatory training modules, safeguarding training and regular 'skills and drills' training. Regulation 12 (1)(2) (c)
- The service must ensure there are enough staff with the right skills, qualifications, competencies, and experience to provide safe care and treatment for women, birthing people, and their babies. This includes staffing of maternity theatres and the maternity theatres recovery area in line with national guidance. Regulation 18 (1)

Maternity

- The service must ensure that incidents are graded in accordance with the Health and Social Care Act Regulation 20 Duty of Candour level of harm criteria to make sure people receive follow up care following an incident. Regulation 20 (1) (7) (a) (b)
- The service must ensure incidents are investigated and reported in a timely manner. Regulation 17 (1) (a) (b)
- The service must ensure it implements a standard operating procedure for timely second emergency theatre provision at all times so that staff follow a reliable and standardised process to ensure compliance with the emergency caesarean response times to ensure women and birthing people and their babies are not exposed to risk of harm. Regulation 12, 17 (1) (a) (b)
- The service must ensure staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (a) (d)
- The service must ensure medical staffing is reviewed so there are sufficient numbers of suitably qualified, competent staff to deliver the service in line with national guidance. Regulation 18 (1)
- The service must ensure it operates effective governance systems and processes in order to monitor risk and performance in key safety metrics and to collect accurate and reliable data to enable oversight of this. Regulation 17 (2) (a) (b)

Maternity

Action the trust SHOULD take to improve:

- The service should ensure it continues to monitor staff compliance with completing and escalating baby early warning scores so that all babies are risk categorised at birth.
- The service should ensure that it implements a standard operating guideline for managing the telephone triage service in line with the most recent national guidance.
- The trust should ensure that plans to develop and implement a new maternity digital patient record are completed as a priority so that the service can monitor outcomes for women and birthing people.
- The service should consider capturing ethnicity data on all incident reviews and investigations to have full oversight of the care and treatment to ensure equality of access to care.
- The service should ensure oxygen cylinders are stored securely in line with national guidance.

Our inspection team

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

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