East and North Hertfordshire NHS Trust

Lister Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Lister Hospital

Requires Improvement 

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

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

We carried out a short notice announced focused inspection of maternity services at Lister Hospital on the 04 and 05 October 2022 looking only at the safe and well-led key questions.

East and North Hertfordshire NHS Trust provide maternity services solely from Lister Hospital. Lister Hospital is based in Stevenage, Hertfordshire. It provides services for people across Hertfordshire and Bedfordshire. Services are aimed at a diverse population and included antenatal, consultant led labour ward and a midwifery led birth centre, postnatal and community midwifery services to the local population. There are 75 inpatient beds, spread across the consultant-led unit, the midwife-led unit, and antenatal and postnatal wards. Outpatient services include antenatal clinics, a day assessment unit, a triage unit and screening services. From August 2021 to July 2022 there were 5,233 babies born at the hospital.

Our rating of this hospital stayed the same overall. We rated it as requires improvement.

How we carried out the inspection

This focused inspection reviewed the domains of safe and well led using the CQC's established key lines of enquiry (KLOES).

We visited the clinical areas of the labour ward, midwifery led unit, triage, maternity day assessment unit and the antenatal clinic.

We spoke to 29 staff to better understand what it was like working in the service including senior leaders, matrons, midwifes, obstetric staff, practice development midwives, and the patient safety team.

We interviewed leaders to gain insight into the trusts group leadership model and governance of the service.

We reviewed eight sets of maternity records and eight prescription charts. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recently reported incidents and audit results.

After the inspection we requested further documentary evidence to support our judgements including policies and procedures, staffing rotas and quality improvement initiatives.

Our findings

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

Maternity

Inadequate ↓↓

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

- The service did not have enough staff to care for women and keep them safe. The service provided mandatory and maternity specific training in key skills to all staff but did not always ensure everyone had completed it. Staff did not always follow best practice to protect women, themselves and others from infection. Staff did not always assess risks to women, act on them and keep good care records. They did not manage medicines well and there were delays in the investigations of incidents.
- Although staff understood how to protect women from abuse and had training on how to recognise and report abuse, not all staff had completed the mandatory safeguarding training and safeguarding supervision. The service did not always maintain, service or replace equipment.
- The trust performed worse than other trusts for one question in the CQC 2021 maternity survey and was highlighted as 1 of 8 'worse than expected' Trusts in England on cleanliness.
- Leaders did not always ensure staff were competent and supported staff to develop their skills. Staff were not always clear about their roles and accountabilities. People could not access the service when they needed it and had to wait too long for treatment, which impacted on the care received. Leaders did not always effectively identify and mitigate risks to the service. There was no systematic approach to prioritising women who attended triage.

However:

- Staff worked well together for the benefit of women. Managers monitored the effectiveness of the service. The service engaged well with women, staff, equality groups and the community to plan and manage services. There was a strong culture for improvement, research and innovation. The service celebrated safe innovation, exemplary staff and team success. They used the findings to make improvements and achieved good outcomes for women. Leaders ran services well using reliable information systems.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. We found that the service had deteriorated since the last inspection in July 2018.

Is the service safe?

Inadequate ↓

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

Mandatory training

The service provided mandatory training in key skills to all staff, however not all staff completed it.

The service did not have effective systems in place to ensure staff were appropriately trained and competent to be able to provide safe and evidence-based care for women, which posed a safety risk to women and babies.

Maternity

Core skills training was delivered online and included but was not limited to conflict resolution, fire safety, infection and prevention control, information governance and preventing radicalisation.

Not all staff had completed mandatory and maternity specific training. The services' overall completion rate was below trust target of 90% for doctors, nurses, and additional clinical service staff. The overall compliance rate at the time of inspection was 78% for all staff, broken down as 70% for nursing staff, 76% for medical staff and 83% for midwifery staff. This had not improved from the previous CQC inspection of the maternity services in July 2018.

Not all staff had completed multidisciplinary training of obstetric emergencies, medicines and life support nor did staff receive adequate safeguarding training and supervision to carry out their roles and responsibilities safely. Medicine management training overall compliance for all staff was 31%, this was against a trust target of 90%. Compliance for medical staff was 23%, 31% for midwives and 38% for nurses. Managers told us compliance was low as they had just implemented the training.

Adult basic life support (BLS) training level 1 overall compliance rate was 72.3% and the level 2 Adult BLS overall compliance was 52% for all staff at the time of inspection. The Newborn Basic Life Support (NBLS) was 62.7% overall compliance, this was against a trust target of 90%. Staff we spoke with told us they felt they had completed their training, however, could not give specifics of the training they thought they might have completed.

The June 2022 joint safeguarding committee meeting minutes highlighted that 61 midwives were not complaint with the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) trainings, which was a concern regarding their competencies as there was a rise in mums accessing the service with mental ill health, learning disabilities and postnatal depression.

Staff were also required to complete a core competency framework which included training and competency assessments in measuring symphysis fundal height (SFH), appropriate interpretation, cord prolapse emergencies, amongst many other training subjects. The completion rate was 16% for junior obstetricians, 56% for consultant obstetricians and 71% for midwives, this was against a trust target of 90%.

Staff completed Practical Obstetric Multi Professional Training (PROMPT), which was a standardised course covering practical training scenarios such as management of obstetric emergencies. The service had an overall completion rate of 82%. Theatre staff achieved 50%, 52% compliance for consultant anesthetists, 57% for junior anesthetists, 61% for junior obstetricians, 82% for support staff and 88% compliance rate for consultant obstetricians. However, we note that the midwifery workforce met the trust target.

Clinical staff received training to interpret and categorise cardiotocograph (CTG) results. Training was delivered annually and included an assessment. Evidence provided by the hospital showed, at the time of inspection, midwives were 95% compliant with the training, 81% compliance for consultant obstetricians and 88% for trainee medical staff. This was against a trust target of 100% compliance.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism.

Managers did not always monitor mandatory training and were not always alerting staff when they needed to update their training. Staff responsible for monitoring compliance, were not always alerting line managers of staff who had out-of-date training.

Maternity

Safeguarding

The service did not have effective systems in place to ensure staff received adequate safeguarding training and supervision to carry out their roles and responsibilities safely. There was inadequate oversight of staff safeguarding training and supervision. The service did not always work collaboratively with other agencies to protect women from abuse.

Safeguarding training was delivered by the named midwife for safeguarding and included training on significant mental illness, learning and physical disabilities and records confirmed this.

Staff received safeguarding to a level relevant to their role. However, overall completion of mandatory safeguarding training was below the trust target of 90%, with all staff having achieved 61% completion at the time of inspection. The trust had a plan to improve this to 70% by the end of October 2022. However, the service had an adult safeguarding training plan in place to improve compliance.

Safeguarding children level 3 was 72% for midwifery and medical staff and 82% overall for all staff. This was against a trust target of 90%. Records showed level 3 adult safeguarding compliance rates did not meet trust target. Sixty eight percent of doctors and 74% of midwives were trained to the required level. Leaders told us that level 3 rates were low due to a backlog created by Covid-19 and confusion around the requirement to conduct online and virtual sessions. The reduced oversight of maternity safeguarding and safeguarding adult and children training compliance was included in the maternity safeguarding risk register as children were at risk if training compliance was less than 90%, as staff may not be competent to identify and escalate safeguarding concerns. Staff had attended a 'modern slavery day' event in October 2021 to raise awareness of the trust strategy and focused on homelessness and sexual exploitation.

Data received from the trust showed that only 19.6% of maternity staff had received safeguarding supervision appropriate to their role.

On the day of inspection, we observed and were told staff had not escalated concerns to the safeguarding team in line with trust policy regarding school aged children who stayed in the maternity unit overnight. Therefore, we were not assured proper systems and processes were in place to support, care and keep women and their children safe on the unit. The labour ward was not a suitable environment for children to visit or stay overnight with the cry of women in pain during labour. This was followed up with the trust, we were provided assurance on actions taking to ensure women and children were safe in the service.

We received several whistleblowing concerns from staff during the inspection that some of their colleagues did not always complete a referral or work collaboratively with other agencies such as social services or police when domestic violence concerns were disclosed by women.

We found during a review of the national reporting and learning system (NRLS) an incident where a safeguarding concern was inappropriately managed by clinical staff and there was a delay in responding to disclosure. Although, there was a delay in responding to the safeguarding disclosure however the trust was aware of all safeguarding incidents as staff reported these using the electronic incident reporting system.

The maternity service had a safeguarding quality assurance supportive visit in September 2022 following concerns raised by staff. The safeguarding report findings highlighted that the lack of organisational values and poor professional behaviour had resulted in multiple grievances and a poor working relationship between maternity staff and the safeguarding team. There were reports of bullying, staff shouting at each other, there was lack of clear process including safeguarding escalation pathway which had direct impact on protecting families and babies and significant concerns

and confusion about how safeguarding risk were identified. This had been evident in several high-risk cases that were poorly managed due to lack of cohesive working, poor knowledge, and decision-making as well as poor communication between team members and lack of support to the named midwife. Whilst on inspection concerns were raised by staff regarding abduction of baby risk on the postnatal ward. The baby cots were equipped with keys and when babies are taken out the cots would normally sound an alarm. However, some cots were old and, the alarm was disabled or not working correctly. This was not on the risk register at the time of inspection. The trust had a policy on the abduction or suspected abduction of an infant which has been in place since January 2022. However, staff we spoke with during the inspection were not aware of baby abduction processes or when the baby abduction policy had last been tested and any learning shared. Staff told us they have not received a baby abduction training.

We reviewed the trust adult safeguarding policy and note that this policy was in draft and did not include any information about the ratification process and when it was next due for review. We were not assured if the policy was in date and there was a robust process in the development, review and ratification of policies and guidelines.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. We reviewed the trust safeguarding annual report 2021/2022 which highlight that staff had attended 100% of child protection conference to ensure women and babies were safe.

The named midwife for safeguarding worked closely with the specialist midwife for perinatal mental health and held daily ward rounds. Both were passionate about the services provided at Lister Hospital and the neighbouring integrated care systems.

Cleanliness, infection control and hygiene

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

The service did not have effective systems to identify, assess and manage risks in relation to care environments including the risks related to infection prevention and control.

Equipment was not always visibly clean. We found equipment such as chairs and birthing stools damaged which posed a safety and infection prevention control risk.

On the postnatal ward, we found mould on the bathroom and toilet wall and a rusty mirror. The mould posed a safety risk of allergy reaction, respiratory infection, or cause asthma attacks to women and public. We observed a ceiling board was hanging off another patient toilet. There was a damaged wall observed outside the operating theatre.

We found no evidence that staff completed cleaning and room preparation checks in accordance with trust policy. There were no cleaning schedules for each room including toilets and bathrooms across the maternity unit. Staff on the midwifery led unit were unclear which rooms were clean and ready for use.

Staff did not always clean equipment after contact with women and labelled equipment to show when it was last cleaned. Staff did not always ensure equipment and environment was clean and adhered to infection prevention and control guidance. There was inconsistency in the use of the green ‘I am clean’ stickers and these were not used on labour ward. We saw ‘I am clean’ stickers used on equipment which was visibly soiled. We also saw a blood stain on a piece of macerator equipment, which also had an ‘I am a clean’ label in the midwifery led unit.

Maternity

On the labour ward we observed the resuscitation (resus) trolley, sonicaid and oxygen cylinder were visibly dirty and saw a damaged bandage hanging from the resus trolley. An oxygen canister was also found lying unsecure on the floor. In the triage area, we observed the bathroom and toilet were visibly dirty, we saw dirt behind a shower over the bath.

We spoke with staff across the maternity unit, who were unable to explain who was responsible for cleaning in the evening, mattress checks and change of the curtains. Although the trust held a contract with an external cleaning provider, it was unclear which areas were the responsibility of the cleaning staff and which was the responsibility of nursing and midwifery staff. There was no evidence of mattress integrity checks across the whole maternity unit.

On entry to the midwifery led unit (MLU), a sign notified members of the public that for the month of September 2022, the unit had scored a 3-star out of 5-star for cleanliness. Staff we spoke with were unclear about what it was related to and suggested it was for the external cleaning company to be concerned with and not clinical staff.

We observed staff not using personal protective equipment when undertaking urinalysis in triage. The urinalysis was also not conducted in an appropriate environment and equipment, we observed staff carrying the urinalysis test on a table in triage and not in a designated area such as a dirty utility room in line with best practice.

For the period of 01 January 2022 to 05 October 2022, there was one case of hospital acquired E. coli bacteremia.

For the period of June 2022, staff achieved an overall 93% compliance on the hand hygiene audit against the trust 80% target.

Women who were booked for elective caesarean section were screened for MRSA (methicillin-resistant staphylococcus aureus) during their pre-operative assessment appointment. This was evident in the records reviewed.

Staff carried out the decontamination of surgical instruments in the maternity theatre in accordance with national guidance.

Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas in the maternity areas and hospital entrance for staff, patients and visitors to use. We observed staff applying hand sanitising gel when they entered clinical areas and washing their hands between patient contact.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards. Some equipment safety checks were out of date, not fit for purpose and daily checks were not always completed. The maternity service did not have enough equipment.

Equipment was not always fit for purpose and did not always adhere to safety standards. Daily checks were not completed for equipment, including emergency equipment, across all maternity units. On the postnatal ward, we found 35 gaps in a post-partum hemorrhage box daily checks and 27 gaps in checks of adult resuscitation trolley for the last 10 months. The resuscitaire checklist audit for the period of July to September 2022, which showed an overall 74.6% compliance. Staff achieved 87% compliance in July 2022, 57% in August 2022 and 80% in September 2022.

We saw an incident reported where equipment such as oxygen cylinders, was not checked appropriately and this had impacted on the care of a new-born when needed for a cardiopulmonary resuscitation (CPR).

Maternity

Across all maternity units we found items of equipment had not been serviced or portable appliance tested. For example, on the postnatal ward, five blood pressure machines were overdue servicing from February to June 2022 and not portable appliance tested (PAT) tested between March 2019 to June 2022. Five mattresses were overdue servicing or PAT testing since January 2022 and a weighing scale had not been serviced since January 2020. One CTG machine had not been serviced since April 2019.

We found expired equipment in a clinical trolley on postnatal ward; with 31 expired blood bottles which had been out of date since May 2022, one expired tracheal tube and four arterial blood collection syringes had expired in January 2022. We found there was not enough suitable equipment to help staff to safely care for women and new-borns. For example, there was no hand-held doppler on the MLU, staff told us they were borrowing this device from other areas such as triage. However, staff on triage told us they do not have hand-held doppler machines. Staff described a shortage of equipment including CTG machines. We saw three incidents were there was no available CTG machines for women which resulted in delays in providing safe care. The September 2022 Women's Speciality Clinical Governance Report showed that staff had raised some safety concerns around faulty or not enough equipment in the service such as CTG machines and transcutaneous bilirubinometers equipment, which was used for managing jaundice.

Women could not always reach call bells and staff did not always respond quickly when called. We saw evidence which showed emergency buzzers were not always audible in maternity particularly the maternity recovery area and triage and women and staff had escalated this issue. There were also broken call bells on the postnatal ward on the September 2022 action tracker reviewed and there was no updates on whether this have been resolved. We observed a toilet on the post-natal ward which did not have a call bell to contact staff during an emergency. Women told us the call bells were not working or answered by staff when they tried to call for help when they were in distress or had an emergency.

We saw evidence which showed staff managed the disposal of sharps well.

The environmental audit for June 2022 showed an overall 93% compliance across the maternity units against the trust target of 80%. It was unclear what standards were audited in this audit from the data received from the trust. The June 2022 COVID-19 spot-check audit showed an overall 98% compliance across the maternity service against the trust target of 80%. The service carried out a re-audit in August 2022, which showed an improvement and overall compliance was 100%.

The layout of the unit supported the volume of women who arrived. Areas were private and there were rooms for partners and relatives to sit if required.

Staff disposed of clinical waste safely. Colour coded clinical waste and sharps bins were available and accessible in all areas. Sharps bins were labelled correctly.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman using the up-to-date tools. Staff did not always identify and quickly act upon women at risk of deterioration.

Staff did not effectively assess, document, and respond to ongoing risks to the safety of women and babies at all stages of pregnancy in line with national guidance. We saw evidence which showed 77% of women felt midwives or doctors were aware of their medical history antenatally, which was worse than the England average of 83%. During a review of 8 care records, we found risk assessments were not always documented we saw maternity early obstetric warning score (MEOWS) was only documented in 3 records and VTE assessment was seen in only 4 records. Vitamin D was only documented on 4 records and carbon monoxide was recorded on 5 records.

Maternity

The service carried out a MEOWS audit between July and September 2022, which showed an overall compliance rate of 99.2% across the maternity areas, however, we found there were significant gaps in the audit for July and August. We found inconsistency in the completion of physiological monitoring and MEOWS. We reviewed four women records on the postnatal ward and note that MEOWS was not completed for three of the records. In the patient records that had a MEOWS chart, we saw that staff had not scored the MEOWS chart for the previous day.

We observed that not all women on the wards were reviewed within appropriate timeframes as per the nationally recognised risk assessment tool used. Staff did not always complete initial assessments on admission or arrival and risk assessments of women were not always documented. Staff did not always use a tool or system to identify women at risk of deterioration and escalated them appropriately. The service did not have effective systems to ensure staff consistently assessed and managed the risks to service users including those whose condition may deteriorate.

There was no identified risk assessment and care prioritisation process in place in the maternity triage area, staff articulated they were not sure when or if this would be implemented. Patients were not being seen or prioritised based on their clinical need. A recent Healthcare Safety Investigation Branch (HSIB) investigation report highlighted delays in fetal monitoring of up to 30 minutes for women in active labour. Feedback from women stated they were left in triage for significant periods of time and no member of staff checked on them when in active labour. Incidents reviewed also highlighted that low-risk women were often seen before women in active labour or distress and which resulted in poor outcomes. We saw evidence which showed the triage red, amber, green (RAG) traffic light system rating stickers were often incomplete. Therefore, we were not assured there was adequate assessment, oversight and prioritisation of women who were waiting to be seen.

Although staff were aware of the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information, we saw this was not always used. In September 2022, evidence showed an overall compliance rate of 82.5%.

Fresh eyes was routinely used for the regular review of CTG interpretation and escalation. The service carried out a fresh eye audit in May 2021 which showed an overall compliance rate of 78.8%. Staff achieved 89.5% compliance on the first stage of assessment and 69.2% compliance on the second stage of assessment. The first stage of assessment included appropriate plan, sticker completed every hour, assessment completed in full, correct classification, escalation of concerns in a timely manner and signed by two clinicians. The second stage of assessment included completion of assessment every 30 minutes in active second stage of labour, assessment completed in full, correct classification, escalation in a timely manner, appropriate plan and signed by two clinicians. The result also highlighted that stickers were not completed every 30 minutes, assessments were not completed in full (60%) and signing by a second clinicians was 70% at the second stage. The service carried out a re-audit in November 2021 which showed an overall 96.2% compliance rate with staff achieving 100% on appropriate plan, escalation, and correct classification but there were gaps in completion every 30 minutes (55%), completing of assessments in full (80%) and signing by two clinicians (80%) in the second stage. Although this had been an improvement from the previous audit however, the service had not carried out a follow-up fresh eyes audit in over 11 months.

There was no environmental ligature risk assessment following the national patient safety alert on 3 March 2020. The trust told us this would be carried out if a woman presented with acute mental health concerns, however we were not assured of this process.

Maternity

We saw there were no emergency pulls in a bathroom on the postnatal ward. Staff had frequently escalated faulty emergency call bells across the maternity areas from meeting minutes reviewed, however, it was unclear what, if any, actions had been taken. Feedback from women has corroborated this finding with information that call bells were not working or answered by staff when they were in active labour, needed help or their condition deteriorating.

At the time of inspection, there was no policy or risk assessment in place for women to use the birthing pool in labour, particularly those with complex pregnancies or medical condition. This was escalated to senior managers. Following inspection, the service provided the waterbirth guideline dated December 2019, however, this document contained tracked changes and comments. There was no specific inclusion exclusion criteria for use of the birth pool - specifically mentions individual risk assessments for women who wished to use the birth pool. However, we saw no evidence of this during our inspection.

Staff did not always share key information to keep women safe when handing over their care to others nor did shift changes and handovers include all necessary key information to keep women and babies safe. We saw handovers did not use a standardised approach, including vital information, and risk assessment such as VTE, outlier, safeguarding and women's blood rhesus factor. Rhesus factor is a certain type of protein found on the outside of red blood cells. The patient information board on the labour ward did not include vital information such as rhesus status. Staff did not use a handover sheet on the labour wards and birth centre and staff were seen handing over care of women verbally from memory. Therefore, we were not assured all necessary key information to keep women and babies safe was spoken about.

The service did not always monitor waiting times of women admitted, treated and discharged women in the service in line with national standards. Managers had not carried out audits of the waiting times in triage, day assessment unit and antenatal clinics. The hospital had not carried out audits on delays in induction of labour and emergency caesarean section. Staff and women told us the antenatal clinic were often over run due to staffing issues. Therefore, we were not assured managers and staff generally worked to make sure women did not stay longer than they needed to.

From September 2021 to August 2022, the maternity dashboard showed there were two unit closures in maternity areas due to low staffing. However, from the feedback received from staff and women, the MLU had been frequently closed due to low staffing. A senior executive confirmed the MLU is often closed every week due to staffing capacity. Staff did not always report on the hospital electronic incident reporting system when the maternity areas was closed. The closure of the MLU had resulted in significant delays in admission, induction of labour and transfer of women from triage. We were concerned in the inaccuracy of data in the maternity dashboard received.

The trust carried out a triage reduced fetal movement audit from July to September 2022. The result showed 91.7% women had CTG within 60 minutes. Intermittent auscultation (IA) of the fetal heart should occur every 15 minutes, the audit showed 81% of fetal hearts were auscultated within 15 minutes. The audit result also showed there was poor compliance in July 2022 (80%) and August 2022 (75%).

We reviewed the maternity dashboard from September 2021 to August 2022, which showed the trust was meeting the trust target on percentage of women booked for an antenatal appointment within 10 and 12 weeks.

We observed that staff in theatres made sure that the World Health Organisation (WHO) safer surgery checklist was completed, and leaders monitored compliance. Theatre staff attended team briefings prior to surgery and were given time to review complex cases.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Midwifery Staffing

The service did not have enough maternity staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers did not always appraise staff's work performance, made sure staff were competent for their roles and held supervision meetings with them to provide support and development.

The service did not have enough nursing and midwifery staff to keep women and babies safe. We found there was insufficient numbers of suitably qualified, skilled, competent, and experienced staff in the maternity service to keep women and babies safe from avoidable harm and meet their needs. This was not an improvement from the previous CQC inspection of the maternity services in July 2018. This had exposed women and their babies to the risk of avoidable harm.

The MLU was frequently closed due to staff shortage and had a significant impact on the access and flow to labour ward. The August 2022 incident log showed 25 low risk women were cared for on the consultant led unit due to MLU closure. Feedback received from women also reflected this and how the closure of MLU have impacted on delay in admission and assessment, induction of labour and poor outcome. Feedback received from women highlighted how they had experienced significant delay in induction of labour up to 4 to 8 days. Some women also gave feedback of how they have self-discharged or threatened to self-discharge as they felt the postnatal wards was unsafe mainly due to staffing, cleanliness, IPC, and call bells not been answered.

Women also gave feedback that the community midwifery service had been suspended due to staffing issues and we saw an instance of where a mother had given birth in a birthing pool at home without any support. When the woman called the hospital in May 2022, she was advised that the community midwives service had been suspended and three on call community midwives were unavailable as they have been called to support activity on the hospital wards.

We found evidence in incidents of delays in treatment where women may have suffered harm as a result of delays up to in transfer to the labour ward due to low staffing from the NRLS and feedback from women reviewed. We identified 16 recent incidents from NRLS where women have experienced delays in treatment due to lack of staffing including a delay of up to 120 hours for transfer of a woman to the labour ward for artificial rupture of membranes. We saw cases of women in active labour who needed blood and magnesium sulphate transfusions or diagnosed with thick meconium in triage could not be admitted in labour ward due to low staffing and high acuity. Another woman who presented to triage while in active labour was sent home with constipation medicine and was told she was not in labour. Two hours later the woman delivered the baby at home, which was 10 weeks early and the baby was born poorly, deteriorated, and passed away six days later.

Recent external serious incident reports and the hospital maternity thematic review report highlighted staffing as a concern which had resulted in delay in care, women being sent home multiple times, triage telephone not always answered and instances of patient deterioration.

The hospital used Birthrate Plus to monitor acuity and calculate midwifery staffing levels to undertake a systematic assessment of workforce requirements as recommended by the Royal College of Midwives (RCM). Staffing was reviewed

at daily huddles and any staff shortages were escalated to matrons, labour ward coordinators, flow midwife and matrons in and out of hours. The November 2021 Birthrate Plus Workforce report highlighted that the service had a shortfall of 13.2WTE (Whole Time Equivalent) of band 3 to 8 staff. The shortfalls were mainly related to the postnatal support staff (6.1 WTE) and specialist and management midwifery staff (7.1WTE).

The number of midwives and healthcare assistants did not always match the planned numbers. For example, on the day of inspection, the obstetrics and gynecology rota was short staffed. There was no consultant cover for the antenatal clinic in the afternoon and this was covered by a specialist trainee. Staff told us of concerns where one foundation doctor (SHO) covered all wards on the weekend. Staff told us this happened on a regular basis. In triage, the established staffing for this area should be two midwives and one maternity support worker. Staff told us a midwife is normally assigned to handle the triage telephone line, but this does not always occur particularly at night. This added to the pressure of one midwife to care for the three-bay triage area and two induction rooms.

The trust submitted the maternity headline concerns for the period of August and September 2022, which showed reduced staffing for midwifery and medical staff, which had impacted on delay in care, staff morale, triage staffing, safety and staff morale.

Staff raised concerns regarding the number of midwives without scrub training and competencies needed to scrub in theatre due to lack of available scrub nurses. The practice of midwives scrubbing in obstetric theatres was not in line with best practice guidance around national staffing of obstetric theatre guidance consensus statement (May 2009), which recommends that a scrub practitioner must be a registered nurse/midwife or operating department practitioner with scrub competencies.

The overall fill rate for day shift in August 2022 across maternity units was 62%, 31% for care staff on labour ward, 32.7% on MLU, 73% on postnatal ward and 79% on antenatal ward. The fill rate for night shift was significantly poor on MLU, which was 46.2% and 39.3% for the labour ward. The service had high rates of bank and agency nurses. The use of bank staff across the maternity areas between April and October 2022 was 4147.2 hours. In August 2022, the agency staff were used to cover 200 shifts of which 165 shifts needed a medical staff cover and 35 shifts needed a midwife cover. For the period of April to October 2022, the trust reported there was an average shortfall of 38.1% use of agency staff to cover requested shifts. However, managers made sure all bank and agency staff had a full induction and understood the service.

The service had high vacancy rates for midwives and maternity support workers. As of August 2022, the vacancy rate for midwives was 24.6 WTE and 2.9WTE for band 3 and 4 staff. Recent data received from the hospital post inspection showed that as of October 2022 the vacancy rate for midwives was 8.7% and 7.1% for maternity support workers. The trust target for vacancy rate was 6%. The service had recruited 17 newly qualified midwives since May 2022 and recently appointed an overseas midwife in August 2022. The service had 8 overseas midwives currently recruited and in the pipeline. They had a retention lead in place to oversee recruitment and retention and had plan to improve staffing levels through international recruitment, return to practice, offering advanced clinical practice, retention, leadership development, workforce transformation and increase in student midwifery university placements. Staff told us they had a triage working group to support safety and staffing in triage.

The August 2022 maternity workforce recruitment and retention plan highlighted that the trust was recently awarded funds to recruit 9.8 WTE additional midwifery posts and 0.8 WTE consultants as a result of the national Ockendon report.

Maternity

The July 2022 maternity and obstetrics workforce planning report highlight that the service had high turnover rates for midwives and support staff. As of October 2022, the overall turnover rate for the maternity service was 10.6% compared to the trust average of 12%. The trust turnover rate target was 10%.

The service had reducing sickness rates. The overall staff sickness rate was 6.4%. The medical trainee staff (13.8%), band 2 staff (11.9%), band 7 staff (8%) and band 4 staff (7.4%) had high sickness rates. The hospital told us the sickness rate target was 3.8%.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Not all staff have had their annual appraisal and regular safeguarding supervision in the last 12 months. As of 4 October 2022, 25.2% of staff in maternity had completed their annual appraisal. Medical staff achieved 54.1% compliance and midwifery and nursing staff achieved 23.5% compliance. Recent data submitted by the trust 7 October 2022 showed the appraisal rate had increased from 25.2% to 32.5%.

Managers did not make sure staff received any specialist training for their role. For example, not all midwives working in the HDU have had their specialist training and as a result there was no guarantee there would be an HDU trained midwife in the HDU unit on each shift.

Managers gave all new staff a full induction tailored to their role before they started work. The managers, practice development team, lead professional midwifery advocate and clinical educators supported the learning and development needs of staff and addressed any performance or development issues.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment most of the time. However, the service had enough anaesthetists to keep women safe from harm.

Staff told us the number of obstetricians and paediatricians did not always match the planned numbers to keep women and babies safe. When we inspected, we saw that the labour ward was short staffed for a registrar. We attended the Sitrep meeting during inspection and observed that staffing was flagged during the meeting as the staffing level for trainees, consultant and registrars on the day. They did not have a consultant to cover the antenatal clinic that day and a senior registrar was allocated to cover this clinic. However, the service always had a resident consultant or consultant on call during evenings and weekends.

Consultants carried out twice a day daily ward round on the clinical areas and there was consultant presence on the clinical led unit until 8.30pm 7 days a week. There was a consultant presence on the labour ward 125 hours per week. There was a resident obstetric consultant and consultant on call at night cover Monday to Thursday. There was an on call consultant cover at night Fridays to Sunday and Bank Holidays. The on call consultants were available to attend the consultant led unit within 30 minutes.

The perinatal quality surveillance report for the period of July and August 2022 showed their gaps in medical staff rotas and this was flagged as a risk.

The service employed 25 consultants for obstetrics and gynaecology and of which 12 were dedicated obstetric consultants. The service had 15 middle grade doctors, two on call middle grade doctors and 14 junior doctors.

Maternity

Sickness rates for medical and dental staff within the maternity service steadily increased from September 2021 (2.2%) to a peak in February 2022 (9.4%). A reduction in sickness rate was seen in May (3.6%) and June 2022 (1.6%). During inspection, senior managers informed us that the short-term sickness had improved in the last six months and while the long-term sickness had increased by 1.6% for maternity staff.

Staff told us they had low locum (agency) usage in the service and any gaps were covered by the bank medical staff. Staff reported good anaesthetist cover during the day and out of hours. The hospital told us that they had reduced unfilled trends and now had bank filled shifts of less than 60 shifts per month from a peak of over 160 shifts in April 2022.

The Anaesthetic Clinical Services Accreditation Compliance 2022 board paper highlighted that the service was fully compliant with the standard audited as the service had a duty anaesthetist available 24 hours a day within the maternity service.

The service had low vacancy rate for medical staff. The vacancy rate for middle grades was to 2.5 WTE and 1WTE for junior doctors. The service had recently recruited an additional 2 WTEs middle grade doctors and therefore from November 2022 the vacancy rate will have improved to 0.5 WTE vacancy.

Records

Staff kept records of women's care and treatment and was easily available to all staff providing care. However, records were not always clear, up-to-date or stored securely.

The service used a paper and electronic patient records system. Staff told us there were plans in place for the service to transition to an electronic patient record system from 2023. Staff reported no issues in the use of a mixed record system, and they could easily access and audit patient records.

Women's notes were comprehensive, and all staff could access them easily. We reviewed 8 maternity records for women at different stages of the maternity pathway and found records were not always comprehensive, we found all risk assessments and clinical assessment were documented such as VTE, fetal movement, carbon monoxide, vitamin D, fresh ears if auscultated, high or low risk pregnancy, mental health and safeguarding questions and MEOWS.

During our inspection, we reviewed the triage flow record and observed that 39 women were seen previous day and not all triage sheets were dated and had an outcome of the women visit and assessment.

Records were not always stored securely, we observed pages coming out of patients record. This was not an improvement from the last inspection.

The August 2022 MLU monthly documentation audit showed an overall 78% on the clinical risk assessment audited. There was poor compliance particularly on risk factors and VTE assessment. Compliance was 45% on 20 standards audited for maternal and fetal observation.

A recent maternal and fetal observation audit in labour audit showed an overall 44.6% compliance on all 20 standards audits. Physiological observation in the first and second stage labour was significantly poor.

The service carried out a care in labour audit in September 2021 which, examined 85 separate aspects of care in labour records which include standards such as VTE, fetal monitoring documentation and full risk assessment. The result showed the overall compliance was 67%. The service had not repeated this audit to identify if improvements had been made.

Maternity

When women transferred to a new team, there were no delays in staff accessing their records. We saw that discharge summaries were sent to health visitors and GPs. We saw that staff communicated effectively with community staff where there were safeguarding, mental health, domestic violence and specific mother or baby concerns.

Medicines

Medicines were not always stored or managed appropriately. The controlled drugs were not checked and reconciled in line with trust policy. Not all clinical staff had completed their medicines training. However, the service used systems and processes to safely prescribe and administer medicines.

Staff did not always complete medicines records accurately and kept them up to date. The controlled drugs were not checked and reconciled daily in the midwifery led unit.

Staff did not always store and manage all medicines safely. In triage, we observed medicines cupboard were not always locked securely. Staff told us that codeine was now treated as a controlled drug in the service as some of these medicines have often gone missing. This was not on the service risk register. It was unclear if the missing medicines were reported by staff and investigated by managers.

Staff did not receive adequate multidisciplinary training on medicines management. Not all staff had completed their medicines management training. The overall training compliance rate for medicine management training for all clinical staff was 31%, which was significantly below the trust target of 90%. However, managers informed us this training had recently started therefore this was the reason for the low compliance percentage.

The service did not effectively carry out medicines risk assessments. The service had not carried out a recent risk assessment on where medicines were stored. We saw a labour ward and community medicines risk assessments however, we found the labour ward medicines risk assessment form was developed in 2015 and there had been no update of this risk assessment. Staff had annotated ‘no changes’ in pen which was last signed 06 October 2022. Similarly, the community medicines risk assessment form was developed July 2020 and was due to be reviewed 17 July 2021, which had been crossed out and replaced with a new date 17 July 2022. This community medicine risk assessment had not been reviewed for over two years.

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

Staff learned from safety alerts and incidents to improve practice. Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

Staff across the maternity service regularly monitored the fridge and ambient temperature where medicines were stored except the MLU where monitoring of fridge and ambient temperature were not checked daily in line with the trust policy. Staff learned from safety alerts and incidents to improve practice through staff meetings, newsletters, handovers and emails.

Maternity

Incidents

Staff recognised and reported incidents and near misses. Managers shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, the service did not always investigate and manage safety incidents well.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had no never events in the last 12 months. Staff reported serious incidents clearly and in line with trust policy. From 01 September 2021 to 31 August 2022, the trust reported 15 maternity related serious incidents (SIs) for the service and nine incidents were declared to the healthcare safety investigation branch (HSIB). No themes were identified from the SIs.

The trust carried out a thematic review of maternity SI (Serious Incidents) and HSIB cases in 2021. The thematic review report showed that 14 cases were referred to HSIB and 10 were accepted for investigation. The hospital investigated three hospital SIs. The human factors from both SIs and HSIB cases included communication, not recognising to escalate, equipment, physical presence of consultant on labour ward, acuity, staffing, staff busy in labour ward, no recognised CTG baseline, women being sent up to the antenatal ward without review. The equipment factors relate to where the availability, positioning, integrity or usability of equipment was not optimal to be able to deliver care to women and/or babies effectively.

We reviewed the August 2022 monthly maternity serious incident report. The report highlighted there were 55 term babies admitted to NICU (Neonatal Intensive Care Unit) of which 12 were transitional care, 25 women were cared for on the labour ward due to the maternity led unit closure, two reported incidents in triage, six reported incidents for antenatal clinic and seven reported incidents for unsafe staffing and high acuity. The top reported incidents for this period were admission to NICU, inadequate care, PPH (Postpartum Haemorrhage), shoulder dystocia, staff shortage, pathology sample, delay in receiving care, readmission, communication and equipment.

In the last 12 months, the service reported 29 sepsis related incidents. These were mainly related to medication incidents (10.3%) and obstetric incidents (79.3%). The obstetric incidents were mainly related to the transfer of babies to special care baby unit (SCBU) or neonatal intensive care unit (NICU). Other reasons for the reported sepsis incidents include admission, care, diagnosis and treatment.

All still births, maternal deaths and neonatal deaths were investigated and reported to the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) in line with the national guidance. MBBRACE launched the perinatal mortality review tool kit (PMRT) and the service used this tool to review perinatal mortality. MDT (multidisciplinary team) staff reviewed and discussed patient deaths in their service during regular mortality monitoring committee meetings and perinatal mortality review meetings across both sites.

In the MBRRACE perinatal mortality surveillance report published in October 2021 (based on births in 2019), the stabilised and adjusted perinatal mortality rate at the trust was more than 5% higher (worse) than the comparator group average for all births and for births excluding congenital anomalies.

Two maternal deaths were reported by the trust in the 12 months from 02 September 2021 to 01 September 2022, which were appropriately reported for incident investigation.

Maternity

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff are kept up to date about learning from incidents through various means which include clinical governance newsletters, Facebook, safety alerts, message of the month, rolling half day, daily situation reports (SitReps), Email response from datix, local maternity network system (LMNS) safety forums, national reports and safety boards. Staff met to discuss the feedback and look at improvements to the care of women. Incidents was a standing agenda item on the monthly governance, staff and safety meetings. Women and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident.

Managers did not always investigate and close incidents in line with the trust policy. The August 2022 monthly maternity SI report showed there were 104 backlog of open maternity incidents awaiting review or action plan reviews as of August 2022 due to staffing capacity. It was clear what the service was doing to close the open overdue incidents and how long the incidents have been opened. The report also highlighted that the August 2022 escalation had included MLU closure in May and August 2022, triage overflow appointment, pathology observation missed or labelling error sample, SBAR handover to neonatal unit.

Is the service well-led?

Inadequate 

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

Leadership

Local leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles. However, they were not always visible and approachable in the service for women and staff. Executive leaders did not always understand and manage the priorities and issues the service faced.

The maternity leadership team included the managing director, deputy division medical director, clinical director and director of midwifery and neonates. They were supported by deputy director midwifery, matrons, consultant midwives, governance coordinator, quality and safety improvement program manager and named safeguarding midwife.

The service had a clearly defined accountability structure. Majority of staff told us that leaders were visible and accessible however staff in the midwifery led unit (MLU) told us that senior leaders were not always visible and have not visited their unit.

The maternity service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The trust ran regular leadership development bite size sessions to develop staff leadership skills in the service.

Staff and senior leaders told us there were safety champions in place. Staff were aware of who the champions were. Staff told us they had regular safety champion walk around and monthly action plans were developed following the visit.

Maternity

Vision and Strategy

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

The maternity service vision was to support each woman to get the best possible outcome for her and her baby ensuring that she has a safe, positive experience of pregnancy and birth.

The service had a strategy in place which focused on quality, people, pathways, ease of use and sustainability. Staff told us they had been provided opportunity to contribute to the strategy and had read it.

The service had a 2022-2025 digital maternity strategy which include end to end electronic patient records, creating an appetite and ambition to further exploit digital technology to benefit women and staff and funding to invest further in digital developments. This will be achieved via collaboration with stakeholders within the trust, local maternity network system (LMNS) region and the digital midwife network. The service had liaised with staff and the maternity voice partnership (MVP) in developing this strategy.

Culture

Staff did not always feel respected, supported, and valued due to workload and lack of resources. Staff were focused on the needs of women receiving care. The service promoted equality and diversity in daily work. The service had an open culture where women, their families and staff could raise concerns without fear.

The majority of staff told us the multidisciplinary teams were very close, respected each other and very united to improve the women outcomes. However, not all staff felt well supported, listened to and valued by their colleagues and senior managers. Some staff had experienced bullying and we saw how poor culture and friction among specialists had impacted on care from external reviews carried out in the service.

The trust had a freedom to speak up guardian (FTSUG). Staff told us they knew their freedom to speak up champions and they would be confident to raise a concern with their managers and freedom to speak guardian or champions. Staff told us they were able to escalate any concerns they had through the FTSUG, safety champions, ward manager, ward meeting, risk manager, safety huddle, handover, SitRep, MDT round table meeting, monthly trainee meeting, education supervisors and the weekly datix review on labour ward.

Staff told us the service was open and transparent and there was a no blame culture when incidents happened, and the team supported each other. Staff received debriefs and support from their managers following serious incidents.

New members of staff, junior doctors and student midwives told us they were made to feel welcome, and everyone was willing to help. We observed displayed student and staff appreciation board on the labour ward which was used by students to leave feedback about staff and the service. The board was also used to celebrate students that were exemplary whilst working on the ward. Staff told us they had dedicated staff that supported junior doctors and student midwives.

The service had monthly team meetings in place to promote staff wellbeing, this included topics such as briefing and debriefing the team, inclusion, psychological safety, wellbeing, culture of civility and respect.

Maternity

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas and trust website. Staff signposted people to the Patient Advice and Liaison Service (PALS). However, we received feedback from two women which highlighted that they had been waiting for an acknowledgement and investigation outcome of their formal complaints between one and four months consecutively.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints include incorporating ethnicity of women to understand the impacts this may have on care provided.

From September 2021 to August 2022, the maternity service had received 48 formal complaints. These were mainly related to communication, staff attitude, quality of care, physiological observation and call bells. As of September 2022, the service had 8 overdue formal complaints. We were unclear how long these complaints have been overdue and what actions were in place to complete the complaint investigations.

Staff had developed a regional equity and equality action plan to promote equality and diversity within their network, which had received regional praise and had been nominated for a national award.

Governance

Leaders did not always operate effective governance processes throughout the service and not all staff were clear about their roles and accountabilities. Some policies and guidelines reviewed were still in the draft format and we were not assured this were up to date and had been ratified. However, staff had regular opportunities to meet, discuss and learn from the performance of the service.

We found several safety concerns on the management of equipment, medicines management, records, cleanliness, infection prevention and control (IPC), uniform compliance and ligature risks. There was lack of oversight on these issues and in some cases, there had been no recent audits carried out to monitor compliance or improvement. Clinical staff were not clear about who was responsible in the checks of mattress and curtains in the maternity areas. Senior staff including governance leads we spoke to were not aware of the service performance such as the MBBRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) audit.

Managers did not always investigate and close incidents in line with the trust policy. The trust had a backlog of 104 open overdue maternity incidents as of August 2022 due to staffing capacity. It was clear what the service was doing to close the open overdue incidents and how long the incidents have been opened. There was lack of oversight on the allocation of incident investigations to senior staff.

The maternity service sought assurance through various governance meetings in the service, divisional meetings and trust board meetings. This included risk meetings, maternity serious incident meetings, senior team meeting, maternity board and maternity quality governance meetings. The governance meetings were chaired by senior leaders, with clinical leads or executive leads attending as necessary. We reviewed a selection of meeting minutes and found them to be detailed and clear. Meetings were well attended with full multidisciplinary attendance, and actions were highlighted and reviewed at each meeting. Outcome of governance meetings and service dashboard were shared with staff through emails, newsletters and posters.

Maternity

The service displayed the maternity dashboard and performance in all clinical areas. Outcomes of governance meetings were shared with staff through the service weekly newsletter and message of the week which were sent to staff via emails and displayed on the wards.

Medicines and safety alerts were also shared with staff via emails and displayed posters on the ward. However, we found some posters had not been updated. For example, we observed a displayed medicine poster about particles in solutions for intravenous (IV) administration from 19 November 2021 displayed on the postnatal ward.

In response to a national maternity safety report, the trust had carried out a cross site gap analysis on the maternity services and developed an action tracker to monitor their actions. The trust had benchmarked themselves against the actions. Evidence received from the trust and displayed on the wards showed the service was on track in their assessment against the immediate and essential action from the national maternity safety report. We saw the service had also benchmarked themselves to other national maternity reports, recommendations and sought assurance from regional maternity assurance visits.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a selection of policies relating to the maternity services and found these reflected national guidance, however, some were titled as draft and we were not assured this was up to date and had been ratified. There was evidence the trust had used green-top guidelines in the development of policies. Green-top guidelines are national recommendations which assist clinicians and patients, developed by the Royal College of Obstetricians and Gynaecologists. Staff were informed of new or updated policies during handovers, meetings and emails. Staff had access to clinical guidelines and policies on an electronic system.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. Staff referred or signposted women for further support as appropriate. However, at the handover meetings, we observed staff did not always routinely refer to the psychological and emotional needs of women, their relatives and carers.

Management of risk, issues and performance

The service did not have robust systems in place to identify all risks in the first instance, and plan to eliminate or reduce them. However, leaders and teams used systems to manage performance effectively most of the time. Staff monitored the effectiveness of care and treatment.

Maternity performance measures were reported using the maternity dashboard, which was RAG rated with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected.

The service did not have effective systems and processes in place to identify risk in the first instance. The maternity service had a risk register and included risks such as risk to babies due to insufficient neonatal doctors, risk to care and safety of women due to lack of middle grade medical staff. Other risks included on the risk register include staffing levels which was below establishment, mandatory training, anaesthetic staffing not meeting minimum standards from Royal College of Anaesthetists (RCoA) and Guidelines for the Provision of Anaesthetic Services (GPAS) and risk to the safety of women accessing triage. We found all risks on the risk register did not have a risk owner for reviewing and monitoring them, action plan in place to mitigate the risk and when the risk was last reviewed and due for review. The risk register only included a risk ID, title, pre-rating, current risk level, risk target rating and an update. The September 2022 Women's Speciality Clinical Governance Report highlighted that all risk targets on the risk register had not been met. Therefore, we were not assured the risk on the risk register were regularly reviewed and managed effectively to mitigate risk.

Maternity

We observed that not all risks the inspection team had identified were included in the risk register such as ligature risk, children staying overnight on the wards, call bells and faulty alarms on baby cot. These risks were escalated to senior managers. Service leads were not fully aware of the risks across the service and did not had plans in place to address them.

There was a maternity dashboard and a systematic programme of clinical and internal audits, which were used to monitor risks and quality to identify where action should be taken. However, we saw not all audits were repeated to identify improvement or share learning.

The service participated in relevant national clinical audits such as National Neonatal Audit Programme, National Maternity Dashboard audit and MBBRACE. Outcomes for women were a combination of positive, negative and partially met on some national standards.

The trust participated in the 2022 National Neonatal Audit Programme (NNAP). The result showed that the service was performing better than national and regional average on the proportion of women who delivered a baby at 23 to 33 weeks gestation and received at least one dose of antenatal steroids by 3.7%. However, the service performed below the expected range and national average of women who delivered a baby at 23 to 33 weeks gestation and received magnesium sulphate in the 24 hours prior to delivery. The service scored 66.7% on this outcome compared to the national average of 85.7%

The hospital participated in the MBBRACE 2021 audit. The result showed the stabilised and adjusted perinatal mortality rate at the trust was more than 5% higher than the comparator group average for all births and for births excluding congenital anomalies. Senior staff we spoke to were not aware of the audit result and felt they performed similar or better than the national average. Therefore, senior managers did not share the action plans they had in place to improve outcomes.

Clinical Quality Improvement Metrics (CQIMS) are a set of 12 metrics derived from the Maternity Services Dataset for the purpose of identifying areas that may require local clinical quality improvement. The May 2022 result showed that the rate of Babies who were born preterm at the trust was in the upper 75% of all trusts nationally.

We reviewed the maternity dashboard from September 2021 to August 2022. The service was not meeting the trust target on neonatal death, baby born before arrival, midwifery led unit birth, term admission to neonatal unit and induction of labour. The service was also not meeting the trust target on the number of births in the labour wards, this was 4.5% above the trust target. This was as a result of frequent closures of the midwifery led unit. The service was not meeting the target for some of the saving babies lives care bundles such as steroid administration, puerperal sepsis, fetal monitoring and magnesium sulphate.

The maternity dashboard showed that the service was meeting the target on number of bookings per month, women booked at 10 and 12 weeks for antenatal appointment, midwifery led unit transfer to the labour ward, vaginal births after previous Caesarean section, smoking at birth and delivery and breastfeeding initiated and at discharge. However, the breastfeeding rate for July and August 2022 was lower than the trust target.

The service was fully compliant and meeting the target on the May 2022 audit of repair of episiotomies and perineal tears. The August 2022 Perinatal Quality Surveillance audit report showed that the service had met 8 of the 10 standards audited on the 10 Steps to safety Year 4. The service was rated amber for MDT training and saving babies' lives care bundle.

Maternity

The service was partially meeting some of the targets on some national and clinical audit. This includes the 2022 National Maternity and Perinatal Audit (NMPA), inducing labour November 2021 audit, 2022 antenatal care audit, June 2022 low PAPPA and SGA (Small Gestational Age) audit and May 2022 Management of Hyperthyroidism in Pregnancy audit. The April 2022 neonatal resuscitation audit showed the service was partially meeting the trust target on the management of neonatal resuscitation and the neonatal team attendance at delivery.

Managers and staff did not always carry out a comprehensive programme of repeated audits to check improvement over time and improve women's outcomes. However, we saw evidence that audit findings were shared with staff at meetings, teaching sessions and case study audit meetings. Managers shared and made sure staff understood information from the audits.

The maternity service had a research lead that had oversight on the research and audits in the services. The audit team decided on the audit programme in response to national audits, national guidance, best practice initiative, divisional objectives, practice related issues, risks and trends from incident reports.

Information Management

The service collected data and analysed it. However, the information on the maternity dashboard were not always accurate and the website was not updated when the unit was closed or service was suspended.

The service had clear performance measures such as key performance indicator (KPI), local and national audits which were reported and monitored. These included the MBRRACE-UK audit, maternity safety thermometer, maternity dashboard and friends and family test (FFT) results. Performance results were discussed at service, divisional and board level to improve care and patient outcome.

The maternity dashboard performance was displayed on the wards for staff, women and visitors to access. We were concerned about the accuracy of data received. The maternity dashboard showed the service achieved 100% in the number of women who received one to one care in labour. This does not reflect the feedback received from women who experienced delay in being seen, delay in assessment or one to one care been given when in active labour on the ward, triage, and labour ward. External serious incidents reviewed also highlighted instances where there had been delay in one to one care been given to women following admission. We also received whistleblowing concerns from staff that data had been changed by senior staff since we announced we would be inspecting the service although no evidence was provided. We received several policies and guidelines that were in draft format and had track changes which were not recently developed. The hospital submitted medicines risk assessments which had not been recently reviewed for at least two years and the review date had been annotated with purple text, track changes and cancelled text for submission to the commission. Therefore, we were not assured the data in the maternity dashboard was accurate.

The service was in the process of implementing the use of handover electronic screens, we saw from governance meeting minutes that the purchased handover screens had been delivered to the units and awaiting installation.

The service was planning to go paper free by February 2023 and all patient records will be electronic including the use of a centralised CTG. Staff told us more computers were being purchased for the maternity service in preparation for this digital transformation. At the time of inspection, the trust used a combination of electronic and paper records systems.

Feedback received from women highlighted that the hospital did not always update the website to inform women and the public when the midwifery led unit was closed or community midwifery service was suspended.

Maternity

Engagement

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

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

The maternity service had an active and functioning Maternity Voices Partnership (MVP) which met regularly and was involved in the service planning and delivery, and review and development of policies, guidelines, update of website, creating of information leaflets and videos for the public on the website. The service had engaged with women and the public on the development of their maternity and digital strategy. Staff reported a good relationship with their MVP. The service had also worked with the MVP to encourage diverse membership, specific cultural survey events run by the MVP in the family centres and libraries, and meetings with local groups faith leaders. Also, the hospital had worked with the MVP to develop a healthcare passport for babies, children and young people with learning disabilities, autism and complex health needs.

Feedback from women fed into safety concerns board meetings. We reviewed meeting minutes which include discussion around MVP raising concerns regarding partners not been present in triage when upsetting news were communicated to women, staffing levels and recruitment drive, access to drink water for parents as fountain water out of use as a result bottled water was supplied. We saw evidence that improvements were made to the service following the feedback given to senior managers by the MVP.

The service regularly presented a patient experience summary report to the board. We reviewed the recent June 2022 to August 2022 report which included feedback, complaints, MVP feedback, which was reported to the maternity and trust boards.

The service had engaged with BAME (black, Asian and minority ethnic) staff to obtain their experience in working in the maternity service in England during Covid and beyond and established a minority ethnic women service user group. The hospital had processes and systems in place to reduce health inequalities, which include the reducing inequalities working group to support staff and women, celebrating together and inclusion during the Black history month, cinema visits, travelling books and online quizzes. The hospital had established maternity Black, Asian and Minority Ethnic Ambassadors and staff told us that two of the ambassadors were currently involved in teaching, walk rounds, engaging staff and women for feedback and offered advice.

The trust had specific groups set up for minority ethnic services users through engagement and recruitment. The service also had regular engagement meetings with various ethnic support groups such as Black Voices Letchworth.

The managers engaged with staff through various staff meetings, staff forums, listening events, newsletters and messages of the month. For example, the August 2022 maternity board newsletter included what are we doing section around staffing update. Staff were advised they had recruited seven new maternity support workers (MSWs) and there was a vacancy for a midwife and the service leaders had an open-door policy and staff could come and see them for any concerns. Examples of feedback given to staff from recent message of the months message include discharge of postnatal women to community, escalation of damaged equipment to manager, MEOWS and a maternity alert about a baby who suffered a fall in hospital.

Maternity

The safeguarding, perinatal mental health and bereavement midwives engaged with external organisations and charities to provide care and support for women with complex or additional needs. The service had developed a tokophobia (pathological fear of pregnancy which can lead to avoidance of childbirth) pathway for women in collaboration with the perinatal mental health team.

The maternity friends and family test (FFT) results for the period of January to June 2022 showed the service achieved an overall 95.8% satisfaction rate, which was better than the trust target of 93%. The maternity areas were meeting the trust target except the postnatal ward which did not meet the trust target in February 2022 (88.9%) and June 2022 (90%). In the 2022 General Medical Council national training survey (GMC NTS), the service scores were significantly worse than the national aggregate for reporting systems, teamwork, supportive environment and study leave. The scores for several metrics had declined since 2021. Following the GMC survey, the service had put together an action plan, and progress was monitored at the specialty and divisional boards meetings.

We received over 230 instances of negative feedback from women and staff. The themes from which, included staff attitude, lack of staffing, environment not clean, bed sheet or gown not changed for one to two days following birth, pain relief not offered, delayed induction of labour, midwife led unit closed, not happy with service received, call bell not working or answered, lack of informed consent, lack of update about care and treatment, allegation that there is no scrub nurse in theatre and backdating of records as a result of CQC coming to inspect the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Staff and leaders were committed to improving services by learning from when things went well and making changes in practice through shared learning, external reviews, promoting training, research and innovation.

The hospital had commissioned a mum and baby app to provide personalised care and choice for women.

The service had supported the LMNS to set up the reducing inequalities forum in the region. The service was involved in the development of the new LMNS social media platforms and the launch of the new enhanced stop smoking service support for women during pregnancy and postnatally.

The service had created a video with the support of service users to support staff to have culturally competent conversation.

The service had successfully bid to be one of the 14 national early implementers sites to develop a new perinatal pelvic health service for women.

The service had multiple pregnancies midwives to support women with multiple pregnancies. The support given to women with multiple pregnancies was exemplary and 100% of women had been seen antenatally by a named multiple pregnancy midwife (MPM), 53% women had an MPM present at birth and 67% women had a postnatal visit by the MPM.

Staff had received several awards which include Florence Nightingale Leadership Award for midwife, National Chief Midwifery Office award, Best paper RCOG (Royal College of Obstetricians and Gynaecologists) congress 2022, Birmingham Symptom-specific Obstetric Triage System (BSOTs) award: Inspiring individual award for triage improvement.

Maternity

Staff had also been nominated for the trust 2022 awards for safety first finalist, team experience and inspiring ward manager finalist awards.

The service had improved their website and created videos for induction of labour and experience on having a caesarean section for women.

The trust was the only NHS trust in the region to have a named obstetric consultant and midwifery manager for triage to help implement BSOTS in the maternity service.

The service had obtained funding to allow all women to be fitted with a continuing blood glucose monitoring device in line with the perinatal quality surveillance model with is part of the maternity neonatal safety initiative. The service was performing exceptionally well with all women captured within their first trimester to help manage diabetes in pregnancy.

The service was awarded the national chief midwifery officer awards for changes to diabetes pathway to include choice of remote of face to face monitoring which allowed for rapid trouble shooting.

The service had developed a band 8A named midwife safeguarding post, this was previously a band 7 post. The new band 8A post brings the safeguarding position in line with the leads for children and adult safeguarding with additional roles.

Outstanding practice

We found the following outstanding practice:

The support given to women with multiple pregnancies was exemplary and 100% of women had been seen antenatally by a named multiple pregnancies midwife.

The maternity voice partnership (MVP) was exemplary, active, and engaged well with the service to drive improvement, service delivery, updating of policies and strategy, and providing assurance to women and public through a recorded video available on the hospital website on the hospital response to a recent national maternity report.

Areas for improvement

Action the trust must take to improve:

- The trust must ensure they implement a system to assess risks to women attending the triage unit and prioritise their care appropriately and monitored. (Regulation 12(1)(2))
- The trust must ensure staff complete timely risk assessments for each woman and take action to remove or minimise risks. (Regulation 12(1)(2))
- The trust must ensure staff adhere assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. (Regulation 12(1)(2))
- The trust must ensure the abduction policy is embedded and tested to ensure its effectiveness. (Regulation 12(1)(2))

Maternity

- The trust must ensure there are enough equipment, particularly the cardiotocograph (CTG) monitors on labour ward to support staff assess fetal heart rates in a timely manner. (Regulation 12 (1)(2))
- The trust must ensure medicines are managed and stored appropriately, and medicine storage temperatures were monitored and recorded in line with trust requirements. (Regulation 12(1)(2))
- The trust must ensure all equipment is clean, fit for purpose, regularly maintained, replaced and checked in line with Trust policy and documented clearly. (Regulation 15 (1)(2))
- The trust must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (Regulation 17(1)(2))
- The Trust must ensure incidents are investigated without delay in line with trust policy. (Regulation 17(1)(2))
- The trust must ensure the risk register accurately reflects the risks in the service. (Regulations 17 (1)(2))
- The trust must ensure effective risk and governance systems are implemented which supports safe, quality care. (Regulation 17(1)(2))
- The trust should ensure that there are enough suitably qualified competent staff to meet the needs of the service and any shortfall is mitigated as much as possible. (Regulation 18(1)(2))
- The trust must ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform in line with the Trust's own target. (Regulation 18(1)(2))

Action the trust should take to improve:

- The trust should continue to address the high turnover rates in maternity staffing.
- The trust should comply with guidance around daily multidisciplinary safety huddles. Maternity 27 Lister Hospital Inspection report
- The trust should ensure that staff complete and store patient records appropriately.
- The trust should continue addressing the high vacancy rates for maternity staff.
- The trust should ensure that policies, guidelines, and procedures are reviewed and follow national guidance.

Our inspection team

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation