

Torbay and South Devon NHS Foundation Trust

Torbay 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 Torbay Hospital

Requires Improvement   

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

We inspected the maternity service at Torbay 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.

Torbay Hospital provides maternity services to the population of Torquay and South Devon.

Maternity services include antenatal clinics and a day assessment unit, a consultant led delivery suite and a mixed antenatal and postnatal ward (John Macpherson ward).

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 stayed the same. We rated it as Requires Improvement because:

- Our rating of Requires Improvement for maternity services did not change ratings for the hospital overall. We rated safe as Requires Improvement 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 the day assessment, antenatal clinics, delivery suite, obstetric theatres, and the antenatal and postnatal ward.

We spoke with 9 midwives and 6 women and birthing people. We received 5 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 3 patient care records, 3 Observation and escalation charts and 3 medicines records.

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 stayed the same. We rated it as requires improvement because:

- Arrangements for a second theatre for emergency obstetric surgery and provision of an emergency theatre team may lead to delays for women and birthing people requiring emergency surgery.
- Not all equipment was in place or fit for purpose.
- Systems and processes for triage did not meet best practice guidance because there was no dedicated triage phone and no prioritisation tool to indicate the required clinical response and treatment.
- Staff did not consistently follow the trust's policies for 'fresh eyes' checks of cardiotocography (fetal heart rate) monitoring or modified early obstetric warning scores in order to identify and escalate women and birthing people at risk of deterioration.
- There were not always enough medical staff deployed to keep women, birthing people and babies safe.
- Leaders did not always take swift action to address known risks in a timely way or take enough action to mitigate known risks.

However

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Action was taken to retain and develop the existing workforce.
- Leaders used reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.
- Managers monitored the effectiveness of the service and made sure staff were competent. They were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with women and birthing people and the community to plan and manage services.

Is the service safe?

Requires Improvement   

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Medical staff, and midwifery staff received and kept up-to-date with their mandatory training. At least 80% per cent of staff had completed all 7 mandatory training courses against a trust target of 80%.

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The service made sure that staff received multi-professional simulated obstetric emergency training where staff could practice what action to take in emergency situations. The compliance rate for this training for all staff was at 90%. The service employed a practice development midwife and a practice education midwife to oversee and monitor the training needs of maternity staff. Training needs analyses was carried out and training compliance monitored. Staff attended a mixture of face to face and online mandatory training.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. Training was up-to-date and reviewed regularly; training compliance with this training was at 90%. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

A practice development team supported midwives and midwifery support workers and monitored compliance. The team included 1 practice development lead midwife and practice education facilitator. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training. Bank staff were unable to work unless they had attended all mandatory training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that most staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. The compliance rate among some medical staff was low at 45%, however, the trust told us there were 7 medical staff new to the trust and had been booked to attend this training in January 2024.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. This included maternity specific staff who attended additional safeguarding supervision and training. There was a lead midwife for safeguarding staff could refer to.

Care records detailed where safeguarding concerns had been escalated in line with local procedures. The service dealt with a high number of complex safeguarding concerns and ensured a multi-disciplinary approach and information sharing with all relevant professionals.

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Staff followed the baby abduction policy and had training about how to prevent baby abduction drills. Staff had not attended a recent baby abduction drill but 87% of staff had watched a video as part of their training and a drill was planned for later in the year. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. Leaders told us a 'baby abduction drill was planned for early 2024.

Cleanliness, infection control and hygiene

The service managed infection risks well. 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.

Maternity service areas had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use and it was clear most equipment was clean and ready for use. Monthly cleaning audits of all areas within maternity serves scored high. The cleaning audit for September 2023 scored 100% compliance.

However, in the day assessment unit there was rust on a bin and a returns box, this makes this equipment difficult to clean thoroughly. On the delivery suite there was some dust on 3 resuscitaires. Boxes of equipment were stored on the floor in the sluice on day assessment unit and delivery suite, which is against good practice guidance.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last 4 months, August to November 2023 compliance was at 100% for each month except September where compliance fell to 50% on 1 ward. Action was taken to address shortfalls such as discussion at team meetings and increased staff training.

Environment and equipment

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

The design of the environment mostly followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

The service did not have enough suitable equipment to help them to safely care for women and birthing people and babies such as resuscitaires (equipment which combines a warming therapy platform along with the additional equipment required for managing neonatal clinical emergencies and resuscitation), and CTG machines (CTG continuous cardiotocograph to monitor the babies heart rate).

There was no resuscitaire available on the antenatal/postnatal ward. Leaders told us 7 new resuscitaires had been ordered with a predicted delivery date of February 2024.

There was a risk assessment which included additional neonatal resuscitation equipment and an overhead heater for use on the antenatal/postnatal ward. Plans were in place to undertake estates work to include a clinical treatment area for neonatal care and resuscitation on the antenatal/postnatal ward by the end of January 2024

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The CTG machines were old and frequently required maintenance. A flexible approach was in place regarding the allocation of CTG machines between antenatal clinic and the other clinical areas according to need. Leaders told us this equipment was delivered in December 2023.

There was no seated waiting area for women and birthing people attending triage on the delivery suite. Staff told us they were allocated a room as required.

Space in the service was limited such as the room used for staff handovers and safety huddles and for the storage of equipment. Trolleys were seen in the corridor on the delivery suite.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment was checked daily. Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

In the birth centre there was a pool evacuation net in the pool room and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

There was a bereavement suite which was sensitively decorated and furnished. There was a separate entrance, and this provided bereaved women, birthing people and their families with the necessary space and distance from the rest of the department.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Electronic equipment was maintained and tested by the medical electronics department who produced an annual report on the safety and condition of all equipment.

Assessing and responding to risk

Staff did not consistently complete nor update risk assessments and did not always 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 a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. Staff had recently carried out an audit over a 3-month period. This audit had identified issues with the documentation of escalation, medical review and actions taken. An action plan was implemented, and all actions were completed with further audits planned. However, we reviewed 3 MEOWS records and found 1 had not been assigned a score and another did not have observations recorded. This meant there was a risk staff would not correctly identify or escalate concerns to senior staff.

There was no second on-site emergency theatre team or allocated theatre for out of hours emergency obstetric surgery. There was a risk of delay in women and birthing people getting emergency surgery within the required timescales. We

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sought further assurances following our site visit. Leaders took action to strengthen the management of this risk. This included risk assessment and improved risk management controls. Oversight around the timeliness and effectiveness of these arrangements was strengthened and practice drills and simulations to test the timeliness and effectiveness of these arrangements were commenced.

Funding had been agreed for the full-time staffing of an emergency obstetric theatre outside of normal working hours and the trust were actively recruiting to these roles.

Staff were not using an evidence-based, standardised risk assessment tool for maternity triage. However, following this inspection, leaders took swift action to introduce a prioritisation tool for midwives to use and this included expected timescales for clinical assessment and treatment pathways. At the time of our visit, there was no dedicated triage telephone, and at risk women and birthing people would receive telephone triage from staff without the right skills and experience. Following our inspection leaders acted and allocated a telephone on the delivery suite as the dedicated triage phone and an experienced midwife to triage women and birthing people on every shift.

Triage waiting times were not routinely audited, however an audit completed in July 2023 found out of 175 appointments, only on 104 occasions were women and birthing people seen within 15 minutes of arrival. The service explained there had been issues with the incorrect recording of the time of assessment which had contributed to the negative results of the audit. Leaders told us they were taking action to strengthen the triage audit framework, this included auditing timelines, application of the prioritisation tool, experience of women and birthing people and the timeliness of signposting, escalation, and review.

Staff used the fresh eyes approach (where a midwife or obstetrician regularly reviews the fetal heart rate with a colleague) to carry out fetal monitoring safely and effectively. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). From May to August 2023 audits showed clear interpretation and management plans following CTG in 100% of cases and staff did 'fresh eyes' at each hourly assessment in 88% of cases. There was an action plan to increase compliance and to repeat this audit month. However, on inspection we saw inconsistencies in CTG monitoring within 2 sets of patient records and this included staff not following the 'fresh eyes' approach.

Weekly CTG meetings were held so staff could learn about interpretation with input from a multidisciplinary team. Staff told us they could usually access these meetings but at times there were not enough staff to allow them to do so.

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.

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

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in women's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

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Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person. A recent audit of 20 sets of notes found an SBAR handover was completed in 100% of cases. This audit was repeated every 6 months.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

The service provided transitional care for babies who required additional care.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge.

Midwifery Staffing

The service mostly had 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. Staffing levels usually achieved the planned numbers.

The service experienced challenges recruiting midwifery staff because of national shortages of midwives and also because of the rural location of Torbay Hospital. However, the service had a reducing vacancy rate and levels of long-term sickness and vacancies were monitored. Staffing levels usually achieved the planned numbers.

Midwifery staff were organised into 1 core team of midwives based within maternity wards and 6 community continuity of carer team (where women and birthing people received dedicated support from the same midwifery team throughout their pregnancy). The midwifery staffing establishment was reviewed monthly.

Safe staffing levels had been agreed for all areas of maternity services and were calculated utilising a recognised staffing and acuity tool. Staffing levels were monitored and reviewed daily against the clinical needs of women and birthing people by the staffing coordinator, the delivery suite manager and maternity matron. At times when staffing numbers were short, an escalation pathway was followed to make leaders aware of staffing needs in each area and to organise appropriate cover. The escalation pathway included a risk-based tool setting out actions staff and leaders must take depending on the severity of risk. Managers regularly reviewed and adjusted staffing levels and skill mix.

A midwifery staffing oversight report was presented to the relevant Care Group for oversight and monitoring every month and to the trust board every 6 months. The staffing oversight report dated September 2023 reported good compliance with staffing levels meeting acuity levels more than 90% and an improvement in the overall sickness rate. The vacancy rate in maternity services was at 10.91%. There was a recruitment and retention action plan in place to reduce midwifery vacancy rates. Women and birthing people received 1 to 1 care during labour 100% of the time. There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between May 2023 and November 2023 there were 10 red flag incidents, the most frequent reasons for a red flag within this reporting period being, the inability to provide an out-of-hospital birth and the inability of the labour ward coordinator to maintain supernumerary status.

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The maternity matron reviewed any red flag events with the delivery suite co-ordinator. The red flags are also discussed at the daily safety huddle and actions were taken to mitigate any associated risks.

The service did not always ensure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, only 76 % of midwifery staff and midwifery support staff had an up-to-date appraisal at October 2023.

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. Managers reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff to keep women and birthing people and babies safe. The Service had recently completed a full review of consultant medical workforce and had identified an uplift requirement of 4 additional consultant posts. This had been escalated to executive level and was being considered. There was a lack of resilience within the consultant rota and limited time to attend training, provide teaching and support to junior doctors and for rest following 'on call' shifts and not enough time to review and update guidelines and policies. Seven out of 10 obstetric consultants were overdue an appraisal of their performance.

The services' maternity workforce oversight report in September 2023 acknowledged the continuing challenges within the obstetric workforce, however an improvement in consultant cover following all consultants returning from sick leave was noted.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends. Consultant attendance was required for certain clinical situations, and this was known and understood by medical and midwifery staff.

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 the opportunities to develop. Improvements had been made to the support and supervision provided to junior doctors.

Records

Staff mainly kept detailed records of women and birthing people's care and treatment. Records were stored securely.

Women and birthing people's notes were mostly comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 3 electronic records, 2 did not have observations fully recorded. The service had an action plan to improve documentation and were reviewing progress through a weekly audit of electronic notes.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

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

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Medicines

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

Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 8 prescription charts. We found some medicine administration charts had missing information such as patient's weights and the designated roles of staff. There was no full exemption list of medicines which could be prescribed by midwives available to staff. On the mixed ward, the medicine fridge temperature had exceeded safe temperatures 5 times in 1 week and the medicine room was warm but there were no temperature records so may have exceeded safe temperature limits for medicine storage.

Staff reviewed each women's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff stored and managed all medicines securely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and staff checked controlled drug stocks daily.

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

Staff learned from safety alerts and incidents to improve practice. Seventy- eight percent of staff had received additional training about medicine management. There was an action plan in place to ensure all new starters completed this training. Staff had their competency to manage medicines in a safe way assessed.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Clinical governance and incident reporting was included in mandatory training for staff. 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. Staff could describe what incidents were reportable and how to use the electronic reporting system. All reported incidents were reviewed at weekly risk review meetings by senior leaders and clinicians. We reviewed 2 incidents reported in the 3 months before inspection and found them to be reported correctly.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions.

The service had an incident reporting and management policy for staff to follow which set out actions staff must take along with roles and responsibilities.

Action plans were in place following investigations carried out by the Health Safety Investigation Branch (HSIB) and following perinatal mortality reviews. For example, learning from HSIB investigations was included in the mandatory training for 2024.

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Drills were carried out so staff could practice how to respond to an emergency. Learning from incidents was used as part of the drill scenarios so staff could improve their response individually and as a team.

Learning for staff was also shared via the maternity safety and learning newsletter and through learning after serious event review (laser) information. For example, the policy for women and birthing people giving birth outside of guidance was updated to improve support planning. This information was displayed to staff in a quick reference format to support learning.

Quarterly engagement with local maternity services enabled learning from national investigation findings to be shared and improvements made. As a result of this engagement and learning from others, the service was developing plans for a separate telephone triage service for the future. Managers debriefed and supported staff after any serious incident. Staff were also supported by the chaplaincy team.

Is the service well-led?

Requires Improvement   

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles. However, executive leaders did not always manage the priorities and issues the service faced in a timely way.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly.

However, the inspection identified how the leadership team did not always manage the maternity service priorities for ensuring the best outcomes in a timely way for women, birthing people and babies. Some staff told us they did not feel maternity services were a priority for the trust board and did not implement changes to manage identified risk, quickly enough. Some staff said the issues they raised were not always taken seriously.

The service was supported by maternity safety champions and non-executive directors. Posters were displayed for staff about safety champions and monthly walk arounds took place where safety champions spoke with women, birthing people and staff.

The director of midwifery held weekly meetings known as ‘here to hear’ meetings for staff to meet with them.

Leaders supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. For example, the digital midwife completed a foundation course for digital leaders in April 2023. Band 6 and 7 midwives and consultants had access to leadership training.

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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 service had a vision for what it wanted to achieve. This was developed in conjunction with Devon maternity neonatal services. The maternity service strategy for 2023 to 2025 set out the key strategic priorities and developments for the next 3 years. Action to achieve the 3-year plan had commenced.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 and Kirkup (2022) reports on the review of maternity services and had included these within the key objectives.

Leaders and staff understood and knew how to apply them and monitor progress. The trust board was kept updated with progress reports around key aspects of maternity safety.

Culture

Staff felt respected and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff were positive about the department and the immediate leadership team and felt able to speak to those leaders about difficult issues and when things went wrong. Staff described an open culture which was kind and supportive.

The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

However, across the trust (not specific to maternity services), staff from ethnic minorities and those with a disability or long-term illness experienced poorer outcomes than staff from other ethnic groups or those without a long-term illness or disability. An 'equality, diversity and inclusion strategy was developed to address these poorer outcomes. The trust had set up a set of behaviours staff must abide by including compassion and inclusion and had identified cultural ambassadors.

The trust scored lower than the national average in the 2023 survey for doctors in training for clinical supervision and reporting incident indicators. The service had taken action to address this and doctors in training we spoke with told us they were receiving supervision and training. We were given examples of staff supporting new staff to improve communication. A follow up visit from Health Education England in September 2023 reported improvements with the number of consultant obstetricians remaining an issue.

There was a staff retention plan to grow, support and retain the workforce. Retention midwives had been recognised for the positive results of their retention work to improve culture and support staff including newly qualified midwives. This included the provision of wellbeing resources for staff and the development of support provided for women and birthing people following a traumatic delivery. Ten professional midwifery advocates were available to support staff.

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Staff were focused on the needs of women and birthing people receiving care. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Leaders understood how health inequalities affected treatment and outcomes for women, birthing people and babies from ethnic minority and disadvantaged groups in their local population. However, the service did not include data to identify when ethnicity or disadvantage affected treatment and outcomes. Leaders told us they planned to do this and to share this with staff to help improve care.

The service developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said this helped them understand the issues and provide better care. Training to increase staff skills, knowledge and understanding of the needs of autistic people or people with a learning disability was mandatory for all clinical staff.

Midwives supported women and birthing people who may have experienced trauma or difficulty during their birth experience through a 'birth afterthoughts' service. Women and birthing people were invited to reflect, discuss and ask questions and could also be supported to make a complaint should they need to.

The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them. They knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item at maternity clinical governance and each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

The trust scored 'about the same as other trusts for 43 questions in the 'CQC maternity survey 2022', they scored better than expected for 6 questions including, choice, information and confidence in staff. The survey found the service could improve the most in relation to feeding support and communication. The service ran communication after feedback events. Following negative feedback from women, birthing people or families, learning to improve action plans were developed and shared with staff.

The service had achieved level 3 'baby friendly accreditation', this meant services supported an optimal level of care for infant feeding and mother-baby bonding.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance oversight to reduce risks was lacking, such as ineffective processes for the provision of a second theatre or a dedicated theatre team, medical staffing, triage processes, telephone triage and equipment replacement were not addressed in a timely manner or not enough action was taken to mitigate these known risks. However, leaders did take action to address these risks once we raised our concerns following our site visit.

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The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders monitored key safety and performance metrics through governance meetings and a maternity dashboard. Key metrics for quality and safety such as audits, serious incidents, safety alerts and patient feedback were timetabled into the meeting structure to be reported and discussed. A maternity risk report was produced and presented monthly. An overview of maternity services was presented to the trust board.

A programme of quality improvement audits took place, where any shortfalls with compliance or safety were identified, action plans were put in place. Clinical outcome reports, complaints, acuity and patient experience reports were produced and reviewed on a monthly or quarterly schedule.

The service had declared compliance with the Clinical Negligence Scheme for Trusts. All 10 safety actions had a designated lead who had responsibility and oversight. Action plans to ensure compliance would be maintained for all 10 safety actions had been developed.

Leaders had identified several policies and guidelines were overdue for review, which required input from obstetric consultants; however, this had not been completed due to the identified shortfall in the consultant workforce. We reviewed key policies such as the guideline for early recognition of severely ill pregnant women and the guideline for fetal monitoring in labour. We found they were in date, version controlled and referenced relevant national guidance.

Management of risk, issues, and performance

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

We identified concerns at our last inspection in March 2020 with low compliance rates for medical staff attending safeguarding training and with staff not always following trust policy for the completion of modified early warning obstetric scores so deteriorating patients could be recognised and escalated quickly. On this inspection we saw that although action had been taken by the service to address these concerns, further work was needed to improve compliance.

Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. However, the leadership team did not always take timely action to make change where risks were identified.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

Managers and staff carried out a full programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed.

A 'safety and learning' maternity governance newsletter was produced so staff and the service could learn from incidents and good practice examples from within trust and from the wider maternity network. For example, the Newsletter for June 2023 highlighted incident reporting, pre-term birth and medicine safety in hot weather.

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Information Management

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

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The service had identified a risk regarding the different systems used to record care and treatment not linking together. This created a risk of other departments would not have up to date information. There was an action plan ongoing to refine systems and this was monitored by the digital midwife and reviewed at risk meetings.

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The MVP chairs said they had a good relationship with leaders and with midwives, they were invited to maternity governance and risk meetings. The MVP used a range of methods to engage with the local population, these included 'listening groups', visiting children's centres and 'baby café's' to seek feedback about maternity services. This had resulted in improvements to support on the postnatal ward and developing a behaviour policy for partners staying overnight. The MVP were also included in policy review such as 'teenage pregnancy pathways' so the voices of women and birthing people were included. Leaders understood the needs of the local population.

The service understood the needs of the community they served and had taken action to reduce health inequalities in childbearing women and birthing people experiencing social deprivation. A quality improvement project considered the barriers faced by woman and birthing people attending ultrasound appointments and planned a range of actions to increase attendance and awareness of the importance of ultrasound scans. The service provided a free phone telephone line for women and birthing people experiencing financial difficulties.

The service made available interpreting services for women and birthing people and collected data on ethnicity. Feedback was sought from ethnic minority groups.

Perinatal biases training was included in training so staff had an awareness of different cultures and health inequalities they may face.

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We received 5 responses to our give feedback on care posters which were on display during the inspection. Of these responses 4 were positive and described compassionate individualised care and support including support with mental health and baby loss. One negative response described a lack of support, delays and poor communication.

Changes had been made to staff shift patterns as a result of feedback from staff. Staff were consulted and involved in the process. The shift changes meant hospital and community staff shifts were aligned and the 'on call model of care' was discontinued. Leaders told us a specific clinic for women who have experienced baby loss was being initiated in spring 2024 and there was a named consultant with specific interest in bereavement

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. Leaders told us they were working towards increasing all staff involvement in quality improvement projects.

There had been significant improvements in the compliance rate for reduction in smoking in pregnancy and carbon monoxide monitoring following targeted intervention led by the director of midwifery and team. A compliance rate of over 80% was achieved. The introduction of a smoke-free pregnancy team resulted in a significant drop in the rate of women and birthing people smoking at the time of delivery.

The service was one of the top 10 trusts in the county for the detection of babies 'small for gestational age'.

'Restorative clinical supervision' sessions were offered to staff to discuss their practice and share learning with other midwives.

Quality improvement projects were ongoing. For example, the mechanism for reporting 'sepsis' had been improved through staff training and the introduction of an electronic recording system for Modified Early Obstetric Warning Score (MEOWS) which included clear clinical escalation processes.

An education video about free birthing had been produced for learning through shared stories.

Midwifery staff had won or been nominated for awards for innovation and good practice in bereavement services, for smoking cessation, leadership, and innovative work carried out by the retention midwife.

Systems were in place to recognise staff achievements. Key learning from staff nominations was shared across the maternity teams. For example, the value of 'checking in' with women and birthing people and a 'non-judgemental attitude and approach were identified as good practice.

Outstanding practice

We found the following areas of outstanding practice:

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The service provided a free phone telephone line for women and birthing people experiencing financial difficulties.

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:

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- The service must operate clear triage processes to ensure the safety of women, birthing people, and babies. Regulation 12 (1)(2)(a)(b)
- The service must ensure an on-site obstetric emergency theatre team are available to ensure women and birthing people have access to emergency surgery without delay. Regulation 12 (1)(2)(a)(b)
- The service must ensure 'fresh eyes' checks of cardiotocography (fetal heart rate) monitoring are carried out. (Regulation 12 (2) (a) (b))
- The service must ensure staff accurately complete, and document modified early obstetric warning scores in order to identify and escalate women and birthing people at risk of deterioration. (Regulation 12 (2) (a) (b))
- The service must ensure there are sufficient numbers of medical staff deployed to keep women, birthing people and babies safe. (Regulation 18 (1))
- The service must ensure the provision of enough equipment such as resuscitaires and cardiography machines Regulation 15 (1)(b)(c)(e)
- The service must ensure all medical staff have up to date training compliance with safeguarding training. (Regulation 18 (2)(a))
- The service must ensure effective governance and oversight of audits and action plans to improve performance and manage risks in the maternity service. (Regulation 17 (1) (2) (a) (b))

Action the trust **SHOULD** take to improve:

- The service should ensure staff practise baby abduction drills.
- The service should ensure all equipment is cleaned, maintained and stored in line with best practice infection and prevention and control policies.
- The service should ensure records of women and birthing people's care and treatment are accurate and accessible.
- The service should ensure medicine records are completed and storage temperatures are monitored.
- The service should ensure all staff must receive annual appraisals.
- The service should use data to identify when ethnicity or disadvantage affected treatment and outcomes.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, an obstetric consultant specialist advisor and 2 midwifery specialist advisors. 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

Maternity and midwifery services

Regulation

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

Regulated activity

Maternity and midwifery services

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity

Maternity and midwifery services

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Maternity and midwifery services

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing