Mid and South Essex NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Mid and South Essex NHS Foundation Trust was formed on 1 April 2020 following the acquisition of Mid Essex Hospitals Services NHS Trust and Basildon and Thurrock University Hospital Trust by Southend University Hospital NHS Foundation Trust.

It is one of the largest hospital trusts in England, serving a population of over 1.2 million people in Central and South Essex.

The combined organisation provides acute and some community services across three main hospitals:

- Southend University Hospital
- Basildon University Hospital
- Broomfield Hospital

The trust also runs some community services and a number of smaller satellite units, enabling people to be treated as close to home as possible. The trust has around 1,800 in-patient beds over the 3 main sites and other community sites. The trust employs over 15,000 members of staff.

At the time of our inspection, and since the acquisition, the trust had not yet been fully inspected. This means that Basildon University Hospital and Broomfield Hospital remain unrated. Southend University Hospital retains its rating of requires improvement.

We carried an unannounced focussed inspection of the following acute services provided by the trust:

- Diagnostic Imaging at Southend university Hospital because we received information giving us concerns about the safety and quality of the service.

Our findings

- Maternity services at Basildon University Hospital, Broomfield Hospital and Southend University Hospital because we received information giving us concerns about the safety and quality of the service.

We also inspected the well-led key question for the trust overall.

We did not inspect several services previously rated requires improvement because this inspection was focused only on services where we had concerns. We did not inspect any of the other services at the trust as we did not have any information of concern. Our current methodology requires us to apply a risk-based approach to some services. We did not inspect all the services at the Basildon or Broomfield locations even though they have not previously been rated because we did not have any information of concern. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

At our previous inspection, we issued an urgent notice of decision, under Section 31 of the Health and Social Care Act 2008, to impose conditions on the trust's registration as a service provider in respect of the regulated activity: maternity and
midwifery services. The conditions set out specific actions to enable the improvement of safety within the service. Following this inspection, the Conditions remain in place.

Our rating of this trust remained the same. We rated them as requires improvement because:

- We rated safe, responsive and well led as requires improvement.
- Not all staff had completed their mandatory training.
- The services 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.
- The trust did not always share learning from incidents and take action to ensure mitigating actions were embedded as appropriate across the trust.
- The trust did not always ensure that duty of candour was discharged as soon as reasonably practicable after becoming aware of a notifiable safety incident had occurred in line with the duty of candour regulation.
- Nurses and midwives did not always receive an appraisal in line with the trust's target.
- Women were not always triaged in line with target times.
- People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were not always in line with national standards.

However:

- Staff provided care and treatment based on national guidance and evidence based practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.
- It was easy for people to give feedback and raise concerns about care received. The service treated complaints seriously.
- Leaders operated effective governance processes throughout the trust and with partner organisations.

How we carried out the inspection

Our findings

We carried out the core service inspections from 16 August to 21 September 2022 and the well-led inspection on 11 and 12 October 2022. We visited areas relevant to each of the core services inspected and spoke with several patients, patient representatives and staff.

We spoke with 104 members of staff at all levels of the organisation including healthcare assistants, nurses, midwives, junior doctors, radiographers, radiologists, pharmacy staff, consultants and administrative staff.

We also spoke with 12 patients and relatives. We observed care and reviewed 29 sets of care records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, risk assessments, training records and audit results.

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

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 Regulation, but it would be disproportionate to find a breach of regulation overall, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the trust MUST take to improve:

Trust wide

- The trust must ensure that duty of candour is discharged as soon as reasonably practicable after becoming aware of a notifiable safety incident has occurred in line with the duty of candour regulation. (Regulation 20(2)(4))
- The trust must ensure it shares learning from incidents and takes action to ensure mitigating actions are embedded as appropriate across the trust. (Regulation 17(2)(b))

Location/core service

Action the service MUST take to improve:

Basildon Maternity Services

- The service must ensure that there are adequate numbers of staff to meet the demands of the service. (Regulation 18(1))
- The service must ensure that compliance with all mandatory and safeguarding training is in line with the trust target. (Regulation 18(2)(a))
- The service must ensure nursing and midwifery staff are appraised in line with trust target. (Regulation 18(2)(a))
- The service must ensure it has processes in place for the safe storage of all medicines. Regulation 12(2)(g))
- The service must ensure equipment is checked in line with policy to ensure it is suitable for use. (Regulation 12(2)e))

Broomfield Maternity Services

Our findings

- The service must ensure that there are adequate numbers of staff to meet the demands of the service, including midwives and maternity support workers. (Regulation 18 (1))
- The service must ensure that compliance with all mandatory training is in line with the trust target. (Regulation 18 (2)(a))
- The service must ensure nursing and midwifery staff are appraised in line with trust target. (Regulation 18 (2) (a))
- The service must ensure that there is a robust process for all handovers. (Regulation 17 (2) (a))
- The service must ensure that it has processes in place for the safe storage and distribution of breast milk. (Regulation 17 (2) (a))
- The service must ensure women are triaged in line with target times. (Regulation 12 (a) (b))
- The service must ensure there are processes in place to record the cleaning and equipment checks and that these records are reviewed, and non-compliance escalated. (Regulation 12 (e) (d))

Southend Diagnostic Imaging Services

- The service must ensure there are policies in place to support staff to provide safe care and treatment for children. Reg 17 (1)(2)(a)
- The service must ensure it continues to put actions in place to improve access to patients to ensure that they receive treatment within agreed timeframes and national targets. Reg 12 (1) (2)(a)
- The service must continue to recruit radiography staff to fill vacancies to meet the required staffing levels. Reg 18(1)
- The service must ensure that learning from incidents is escalated, shared and clearly recorded with the out of hours provider. Reg 12 (1)(2)(a)
- The service must ensure that the CCTV in the CT and plain film waiting area is operational to provide staff oversight of patients waiting to keep patients and staff safe, particularly out of hours. Reg 12 (1)(2)(e)
- The service must ensure that staff have a full understanding of duty of candour and that it is applied appropriately. Reg 20 (1)

Southend Maternity Services

- The service must ensure there are sufficient numbers of staff to meet the demands of the service. (Regulation 18 (1)).
- The service must ensure that compliance with all mandatory and safeguarding training is in line with the trust target. (Regulation 18 (2)(a)).
- The service must ensure nursing and midwifery staff are appraised in line with trust target. (Regulation 18 (2) (a)).
- The service must ensure care records audits are undertaken. (Regulation 17 (2) (a))
- The service must ensure data is recorded without omission in the saving babies lives dashboard. (Regulation 17 (2) (a)).
- The service must ensure that anaesthetists are present at multidisciplinary team handovers in line with trust target. (Regulation 17 (2) (a)).

Action the service SHOULD take to improve:

Basildon Maternity Services

Our findings

- The service should ensure that medicines fridge temperature checks are completed in line with trust policy. (Regulation 12)
- The service should ensure incidents and complaints are managed within the time frames set out in the trust policies. (Regulation 17)
- The service should ensure that staff adhere to the uniform policy and refrain from wearing jewelry. (Regulation 12)
- The service should ensure the safety champions are embedded within the service. (Regulation 17)
- The service should ensure staff know who the freedom to speak up guardian is. (Regulation 17)
- The service should ensure regular staff meetings are reintroduced on the delivery suite and post-natal unit. (Regulation 17)
- The service should ensure new members of staff receive their induction to the service in a timely manner. (Regulation 18)

Southend Diagnostic Imaging Services

- The service should ensure that the staff changing room is in good condition and fit for purpose. (Regulation 15)
- The service should ensure that appropriate signage is in place to advise staff and patients where CCTV is in use. (Regulation 10)

Southend Maternity Services

- The trust should ensure that corridors throughout the department are clear from clutter, equipment and consumables. (Regulation 17)
- The service should consider developing a local strategy and vision. (Regulation 17)

Is this organisation well-led?

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

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services; in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Leadership

Leaders had the skills and abilities to run the trust. They mostly understood the priorities and issues the trust faced. Leaders at board level were not always visible and approachable. Staff did not always feel supported to develop their skills and take on more senior roles.

Our findings

To write this well led report, and rate this organisation, we interviewed members of the board, including executive and non-executive directors, governors and a range of senior leaders across the trust. We also talked with staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes and reports to the board, investigations, and complaints. We also observed a private and a public board meeting.

The leadership team had remained relatively stable, however, the capacity and working relationships, particularly professional challenge in formal meetings, between the executive team required further development to ensure the leadership team were able to reflect and respond to the issues the trust was facing, as well as making a demonstratable impact on the quality and sustainability of services.

The trust board was made up from voting members and non-voting members There were 12 executive team members, of which 6 were voting members. There was also a chairperson and 7 non-executive directors (NEDs). Since our last inspection, the trust had appointed a new interim Chief Executive Officer (CEO) following the resignation of the previous substantive CEO.

The trust also had 48 governor positions, 35 of which were public elected, 6 were staff elected and 7 were appointed governors who had been nominated from partner organisations. At the time of our inspection there were 6 vacancies.

The trust was accountable to its members through its council of governors. The council of governors represented the interest of the local community, patients, public, staff, members and stakeholders. The council of governors had clear statutory duties and contributed to the trust's strategic planning, while holding the board of directors to account.

The trust had an experienced Chief Finance Officer (CFO) who was well regarded externally, by the non-executive directors and carried influence within the executive team. However, capacity had been a challenge as the CFO had been covering the Integrated Care Board Director of Finance role, and turnover at the trust had meant some roles such as the Deputy CFO role had been filled on an interim basis.

The chairs of the Audit Committee and Finance and Performance Committee were experienced local authority and NHS finance professionals, who demonstrated a good grasp of their areas of expertise.

The NEDs we spoke with had appropriate support to carry out their role and told us their voice and challenges were heard. We also observed this through the board meetings we observed. NEDs also had a lead role within the organisation.

We observed formal meetings, such as private and public board meetings, and noted a lack of challenge between the executive team when discussing concerns. We also heard concerns regarding this during our well led inspection, although those raising this concern felt the challenge may occur outside the formal meetings.

The chief pharmacist and their senior leadership team were able to provide sustainable leadership for medicines optimisation in the trust. There was good engagement with the trust executive and awareness of medicines optimisation challenges. However, significant staff shortages and increases in service demand, for example in chemotherapy services affects the quality of services provided. Significant challenges with HR recruitment process had sometimes resulted in failed recruitment campaigns.

Staff had good access to training, ensuring that staff were aware of organisational aims and able to incorporate this into the medicine's optimisation strategy.

Our findings

Throughout our interviews with the trust's senior leadership team, they mostly demonstrated a good level of awareness of the challenges and priorities facing the trust and how these were being addressed.

Some of the leaders modelled inclusive and empathic leadership styles. The chief executive officer had a strong focus on compassionate leadership and developing staff.

A board development programme was in place to support the development of the senior leadership team.

During our well led inspection, we undertook checks to determine whether appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. We checked the personnel folders for 14 executive directors and 6 non-executive directors. We found that appropriate FPPR checks had been completed within all the personnel folders we checked.

Executive and non-executive directors were also required to complete an annual self-declaration, to confirm they did not fall into the definition of an 'unfit person', or any other criteria set out in the guidance. We reviewed evidence to confirm this was completed. In addition, the trust had an appropriate FPPR policy and procedure in place.

Throughout our core service inspection, staff told us that local leaders were visible and approachable. However, staff did not consistently know who the senior leaders were.

Vision and Strategy

The trust 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 trust had developed a revised strategy in 2021 and had launched its Foundations for the Future programme which was a 6-month initiative aimed at accelerating improvements in safety, quality, and efficiency in one focussed approach.

The revised strategy was made up of 1 vision, three 3-year goals and 6 strategic objectives for 2022 to 2023. The overarching ambition was to be 1 team working together for excellent patient care. This was driven by the trust's three 3-year strategic goals to:

- Build local services that were high quality and integrated.
- Drive equity as their priority, including in specialist services, taking advantage of digital.
- Investing in becoming an employer where everyone has the opportunity to grow, innovate and improve.

The 3-year strategic goals were supported by 6 strategic objectives for 2022-3. These were:

- **Strategic objective one:** Keeping our patients safe every day by minimising avoidable harm and maintaining appropriate numbers of skilled and capable staff in all the places we provide care.
- **Strategic objective two:** Improving access to cancer care and reducing waiting times for planned care for our patients.

Our findings

- **Strategic objective three:** Enhancing the skills and confidence of our people to realise the benefits of innovation and technology for them and our patients.
- **Strategic objective four:** Valuing our people through structured and supportive conversations about health, wellbeing and individual development between them and their manager.
- **Strategic objective five:** Embedding the trust's values of excellent, compassionate and respectful behaviour, leading to improved engagement and retention.
- **Strategic objective six:** Working as an effective partner in our financially sustainable Health and Care Partnership to improve population health outcomes.

The trust's values were to be 'excellent', 'compassionate' and 'respectful'.

There were various trust strategies in place that were supportive of the trusts' vision and 3-year strategy, however this was not well embedded. Foundation for the Future had been agreed and rolled out to support the delivery of the strategy. Stakeholder consultations had taken place in the development of the strategies.

The trust had a medicines optimisation strategy and plans. There were key priorities to ensure the safe and effective delivery of medicines optimisation, including the alignment of electronic prescribing and medicines administration (EPMA) across the trust and harmonisation of processes and governance across all sites. The use of EPMA had significantly improved audit monitoring of medicines usage, and the trust was working with partners across the wider healthcare economy to improve transfer of care. The medicines optimisation strategy was not able to be delivered effectively due to workforce staffing and capacity issues across the trust.

Progress against the delivery of the strategy was discussed at relevant committee meetings, however how executives and care groups were held to account and relevant action as a result, was not always evident.

The merger to create Mid and South Essex NHS Foundation Trust was still work in progress. A key part of realising the benefits of the merger was securing national capital investment to support service rationalisation across the 3 sites. Prior to the COVID-19 pandemic this appeared high on the trust's agenda but did not currently feature prominently in the strategy or on the trust's corporate risk register but was a likely future driver of operational and financial improvement.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust worked to encourage an open culture where patients, their families and staff could raise concerns without fear of retribution, however, not all staff felt comfortable raising concerns. The trust had a plan to promote equality and diversity in daily work and provided opportunities for career development. Patients did not always receive a timely apology when things went wrong.

There was a mixed perspective from staff regarding feeling respected, supported, and valued. However, staff were focused on the needs of patients receiving care. We heard from numerous leaders throughout our inspection about how staff morale was low. This was also reflected in the staff survey.

Trust leaders recognised that staff were tired and, in some cases, 'burnt out' from the demand on services. There was support in place for staff for their physical and mental wellbeing. However, staff and leaders remained concerned about the demands on them and the service.

Our findings

The trust had undertaken the annual NHS staff survey for 2021. The trust achieved a 47% completion rate for the survey, which was 4% higher than the previous year. The trust's overall staff 'engagement' score had deteriorated from 6.7 in 2020 to 6.4 in 2021 and was below the national average of 6.8. The trust's closest score to the national average was 'we work flexibly'. The lowest score the trust achieved was for 'we are learning'. The trust achieved lowest category national scores for 'morale', 'we are a team' and 'we are rewarded and recognised'.

Following the National Staff Survey in 2021, the trust had created an organisational-wide action plan to focus responses across the organisation. In addition, the divisions and departments had maintained local plans to identify good practice or barriers to progress. In addition, a new campaign, Your Voice Matters and quarterly staff involvement forums had been established to ensure robust and regular listening and feedback opportunities for all staff.

The senior finance team responded proactively to feedback in the staff survey, with the development of a comprehensive staff development strategy and a training package for non-finance staff. Staff engagement within finance was seen as a strength and morale was positive. The department was aiming to achieve national accreditation at level 2 for finance staff development (FSD) in December 2022.

The alignment of the finance team to care groups had been received positively by the operational teams in the care groups, who saw their finance lead as part of the senior leadership team which had overall responsibility for ensuring services were clinically and financial sustainable.

The trust had made a decision to separate out the Women's and Children's directorate into a separate care group. This was a fixed term arrangement for one year. However, whilst this meant there was focused operational management for the Women's and Children's directorate, much of the corporate support was still provided from the originating care group.

We heard that at times, it felt like people were still working in 3 hospitals rather than 1 organisation, and that people affiliated with the location rather than the organisation. The trust was working on this as part of the culture agenda.

The Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) reports for the trust demonstrated there was a lack of diversity in senior leadership posts and the experience for people from a black and minority ethnic (BAME) background was not the same as those from a white background. The trust had looked to address this through the NExT Director scheme in collaboration with NHS England (NHSE) with the aim of improving the diversity of the trust's board. The aim of the NExT Director scheme is to help people from under-represented groups who have the skills and expertise necessary to contribute to the NHS and to make a difference a non-executive director (NED) level.

The trust had a 5-year equality, diversity and inclusion strategy that had been launched in 2021. This had been created with the involvement of staff and the local community and with the support of stakeholders. This led to the establishment of 6 diversity network groups who met on a regular basis.

The trust worked to encourage openness and honesty at all levels within the organisation and for those who used services. However, the Care Quality Commission (CQC) received 21 whistle-blowing enquiries from staff members from March 2022 to August 2022. The themes from the whistle-blowers were around staffing, bullying and culture. This demonstrated that despite having various channels for staff to raise concerns, some people still felt that their voices were not being heard by senior leaders.

Our findings

Following Sir Robert Francis' Freedom to Speak Up (FTSU) review in 2015, NHS England and NHS Improvement expected all NHS organisations in England to adopt the Freedom to Speak Up: Raising Concerns policy for the NHS (April 2016), as a minimum standard. The trust had a whistleblowing policy, which explained how staff could raise concerns within the trust.

The trust had 2 Freedom to Speak Up Guardians (FTSUGs) who provided an independent staff liaison service. The FTSUGs were not employed by the trust but provided the service through an independent organisation. The guardian service provided a 24 hour, 7 days a week service by which staff could raise concerns, worries or risks in their workplace. They worked closely with the National Guardian Office (NGO) and attended FTSU workshops, regional network meetings and FTSU conferences. The FTSUGs were supported by Freedom to Speak Up Champions. These were staff who were employed across the care groups and the hospital sites. In addition, the trust had a non-executive director (NED) who served as the board lead for Freedom to Speak Up.

The FTSUGs reported a good working relationship with the executive leadership team and the non-executive director sponsor.

The FTSUGs were required to provide an annual report to the board of directors. The most recent report set out the Freedom to Speak Up concerns raised between 1 April 2021 and March 2022. The report confirmed that between this timeframe there had been 140 concerns raised, of these, 5 related to patient safety concerns, 48 related to management issues, 32 related to systems and processes, 27 related to bullying and harassment, 6 related to discrimination and inequality, 21 related to behavioural /relationship issues and 1 was COVID-19 related. The concerns raised with the FTSUGs reflected the results from the 2021 NHS staff survey as well as data in the WRES report. The trust had developed action plans to address the concerns.

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to the person.

The trust had a 'Being open/duty of candour policy which set out how to meet the duty of candour requirements. Throughout our core service inspections, staff were aware of their responsibility to be open, transparent, and honest when things went wrong. However, we reviewed 7 serious incidents throughout our well led inspection and found there was no evidence of verbal or written duty of candour being discharged within 3 of the incidents and of the other 4 incidents, 1 had evidence of verbal duty of candour and the other 3 evidenced that verbal and written duty of candour was discharged 3 to 6 months following the date of the incident. This was not in line with the trust's being open and duty of candour policy, which stated *'the relevant person must be informed as soon as reasonably practicable after the incident has been identified. Normally this will be within 10 days of the incident being identified. An initial duty of candour letter should be sent to the patient or relevant person as soon as reasonably practicable'.*

The trust had 3 guardians of safe working (1 for each hospital site) whose role was to protect patients and junior doctors by making sure they were not working unsafe hours. There was also a junior doctors forum, and we heard there had been concerns raised about the rest facilities for junior doctors at the Basildon site. Particularly, the concerns related to the bleep system functionality and delays with the relocation and improvement of the doctor's rest facilities. We raised this a concern throughout our well led inspection. In response, the trust undertook a review of the facilities and developed an action plan to address the issues identified by the junior doctors. However, the action plan did not include dates by when the actions would be completed.

Our findings

The trust had systems and process in place to enable staff to report medicine related issues and incidents, which were then reviewed by the medication safety officer (MSO) and discussed at monthly medicine safety committees. However, reporting had significantly gone down, and staff suggested this might be due to the introduction of a new reporting platform which took a significant amount of time to complete.

Governance

Leaders mostly operated effective governance processes, throughout the trust and with partner organisations. However, more work was required around the amount of information received. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of services.

The trust had a director of governance who was responsible for patient safety, risk and compliance, patient experience, clinical legal and safeguarding. In addition, the trust had a director of corporate affairs who undertook the trust company secretary role and provided leadership across the integrated governance agenda.

There was a clear scheme of accountability and delegation, which set out the executive responsibilities with clear delegated limits. In addition, the trust had an accountability framework which enabled ward to board performance reviews of quality, safety, operational and finance. This included ward, divisional and care group reviews.

There were clear committee reporting structures in place to support good governance. However, we heard how both executives and Non-Executive Directors (NEDs) could be overwhelmed by the amount of information they received to support the meetings. Equally we heard the infrastructure within care groups did not currently support effective clinical governance and actions were underway to improve this. We also heard a review was to be undertaken regarding information flow and governance papers.

Medicines optimisation was well integrated into the trust's governance structure and there was no evidence of gaps in the reporting structure between different committees, and medicines incidents were reported through the trust's electronic recording system. The Medication Safety Officer (MSO) was involved in the review of medicines incidents including the serious incident investigations.

Governance processes in place ensured there were opportunities for the senior leadership team to discuss and learn from the performance of services, including reviewing actions taken to mitigate risk. However, both the executive and non-executive members of the board recognised that papers submitted to the Board and Committees needed to be strengthened.

Financial assurance was provided through the finance reporting routes, and the trust executive team demonstrated a high level of confidence in the Director of Finance and the supporting team.

The Finance and Performance Committee undertook a deep dive into the trust's financial position in July 2022. Despite the trust's deteriorating financial position there was no record of the findings or actions from this deep dive in the following public Board minutes. Generally, recorded Board discussion on the financial position was light, especially considering the financial challenges faced by the trust.

The trust had a quality governance group and quality governance committee who had a workplan which included a deep dive agenda and reporting to the board.

Our findings

Each executive director held their own portfolio for management responsibilities.

As of 20 October 2022, the trust had a backlog of open patient safety incidents (3,879), 151 serious incidents and 429 overdue initial management reviews (IMRs). The trust had measures in place for dealing with these with a trajectory to deal with the backlog. However, with new incidents occurring, the trust was struggling to meet the number of incidents planned to be closed. This meant the backlog continued to remain a concern and prevented the ability to embed learning and prevent future incidents from occurring.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues; however, they did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. The trust had a risk management strategy and a risk management policy which set out the processes for risk management. In addition, the trust had a corporate business and continuity plan and a major incident plan that provided guidance on what action to take during unexpected events.

Risks were identified within the Board Assurance Framework (BAF) and corporate risk register which were aligned to the trusts' strategic objectives. Mitigating actions were reviewed on a continuous basis. However, we noted that the BAF provided during our inspection appeared to be a high-level risk register with more than 20 risks rather than a BAF. Risk management received a reasonable assurance opinion from internal audit in May 2022. However, the BAF and risk management processes were being further developed in conjunction with the Board of Directors.

Risks on the BAF and corporate risk register were aligned to a member of the executive team who was required to review BAF risks quarterly and the corporate risks in alignment with the trust's risk review matrix. Corporate risks rated 15 or above were reviewed on a monthly basis. These were reported to the board of directors.

There was a programme of clinical and internal audit to monitor quality, operational and financial processes. Internal audit functions were carried out, however we heard of one example where there was no evidence of action to resolve concerns with no assurance returns for two consecutive years.

There was a positive incident reporting culture. However, the trust did not always take appropriate action to ensure learning from incidents was shared.

The chief pharmacist managed the medicines related risk register. The pharmacy team regularly monitored the performance and quality of pharmacy service through the trust's clinical audit programme, as well as the pharmacy audit plan and undertook benchmarking performance exercises with other hospitals. However, staff suggested that key performance indicators (KPIs) and capacity to carry out clinical audits had decreased due to significant staff shortages as staffing levels in some pharmacy departments did not match the national levels needed to sustain effective and safe delivery of patient care under the current workload circumstances.

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 secure. Data or notifications were consistently submitted to external organisations as required.

Our findings

The board received information to review performance and delivery of care. The

leadership team were committed to using data including statistical process controls (SPCs), however recognised this was work in progress.

The trust had made some improvements to their information technology infrastructure but recognised there was still work to do in this area, for example the trust still had different patient administration systems at the different hospital sites. The trust had a digital strategy in place to support this. In addition, the trust was in the process of seeking funding from NHS England to support a programme of work to deliver a single digital healthcare platform across the trust over the next three years.

Information technology systems were secure, to prevent unauthorised access to information. The trust had a digital strategy committee that reported on cyber statistics.

There were effective arrangements in place to ensure data and notifications were submitted to external bodies as required.

The Caldicott Guardian worked with the senior information risk owner (SIRO) and processes were in place to ensure data was protected.

The implementation of EPMA across the trust had helped with the monitoring of prescribing, and transfer of patient discharge information to GPs and community pharmacies. However, Broomfield hospital did not yet have the EPMA system and all prescribing was still done using paper charts. The pharmacy team had a performance dashboard across the trust. Trust executives were aware of performance issues such as the medicines reconciliation rates within 24 hours of admission and the percentage of pharmacist time spent on clinical services which were both below the national average.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients but acknowledged more work was required in this area.

People who used services, staff and the public were engaged with and were involved to develop trust strategies.

The pharmacy team encouraged feedback from other teams when developing pharmacy services or policies. The medicines optimisation team worked with colleagues in adjacent trusts through networking groups including the chief pharmacist network and formulary work with the Integrated Care Board.

The trust collaborated within the Integrated Care System (ICS) and partnered with the system on the development of a Mid and South Essex (MSE) wide shared clinical service strategy and associated business cases.

The patient experience lead was planning to improve patient feedback by going out to relevant communities which would then be used to enhance patient experience. They were very passionate and focused on ensuring the trust reached out to all population groups to engage and improve services, rather than relying on patients coming to the trust to give feedback.

Our findings

The executive team recognised not all staff felt valued and respected. This had also been raised though the staff survey. The executive team recognised this and acknowledged more work was required in this area. They also recognised staff engagement was an area for further development and were planning on reinstating visits to clinical areas.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods although these were not embedded. Leaders encouraged innovation and participation in research.

The trust had its own innovation programme in place which had seen various projects and innovations successfully trialed and or adapted.

Learning from incidents, serious incidents and learning from deaths did not demonstrate an impact whereby actions were embedded to prevent future similar incidents from reoccurring. This was due to the backlog of incidents, as mentioned within the governance section. While the leadership team had plans in place to address the backlog, the trajectory was not being met. Some of the actions focused on future ways of working and ensuring appropriate support teams were in place.

The trust had established its own innovation programme that promoted innovation within the organisation.

The trust had a menopause in the workplace strategy and had developed line manager awareness sessions as well as hosting online and face to face events to celebrate world menopause day. The trust also published a menopause policy, which included guidance on reasonable adjustments for staff who were experiencing the menopause. The trust was working on a number of initiatives to support becoming a menopause friendly employer.

Continuous learning, improvement and innovation was sustained by the pharmacy team's involvement in clinical services on wards.

Broomfield hospital had acquired a new automated dispensary robot which would speed up processes.

Medication storage standards were included within the trust's Tendable 'app-based' audit platform. This provided live data to nursing staff on the wards to enable effective resolution and implementation of action plans in relation to safe and secure medicines audit; complementary to a full audit undertaken by pharmacy staff.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Dec 2022	Good ➔➔ Dec 2022	Good ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Southend University Hospital	Requires Improvement Dec 2022	Requires Improvement Dec 2022	No action Jul 2022	Not rated	Requires Improvement Dec 2022	Requires Improvement ➔➔ Dec 2022
Basildon University Hospital	Requires Improvement Dec 2022	Requires Improvement Dec 2022	Not rated	Not rated	Requires Improvement Dec 2022	Requires Improvement Dec 2022
Broomfield Hospital	Requires Improvement Dec 2022	Requires Improvement Dec 2022	Not rated	Not rated	Requires Improvement Dec 2022	Requires Improvement Dec 2022
Overall trust	Requires Improvement ➔➔ Dec 2022	Good ➔➔ Dec 2022	Good ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Southend University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Services for children & young people	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Critical care	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Surgery	Requires improvement Dec 2021	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021
Urgent and emergency services	Requires improvement Dec 2021	Requires improvement Mar 2020	Good Mar 2020	Not rated	Requires improvement Dec 2021	Requires improvement Dec 2021
Outpatients	Good Mar 2020	Not rated	Good Mar 2020	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020
Maternity	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Good Mar 2020	Not rated	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022
Diagnostic imaging	Requires Improvement Dec 2022	Not rated	Not rated	Requires Improvement Dec 2022	Requires Improvement Dec 2022	Not rated
Overall	Requires Improvement Dec 2022	Requires Improvement Dec 2022	No action Jul 2022	Not rated	Requires Improvement Dec 2022	Requires Improvement →← Dec 2022

Rating for Basildon University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Not rated	Not rated	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022
Medical care (including older people's care)	Requires improvement Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021
Surgery	Requires improvement Dec 2021	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021
Overall	Requires Improvement Dec 2022	Requires Improvement Dec 2022	Not rated	Not rated	Requires Improvement Dec 2022	Requires Improvement Dec 2022

Rating for Broomfield Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Not rated	Not rated	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022
Surgery	Requires improvement Dec 2021	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021
Overall	Requires Improvement Dec 2022	Requires Improvement Dec 2022	Not rated	Not rated	Requires Improvement Dec 2022	Requires Improvement Dec 2022

Basildon University Hospital

Nethermayne
Basildon
SS16 5NL
Tel: 01268524900

Description of this hospital

Our rating of this location stayed the same. We rated it as requires improvement because:

- The service did not have enough staff to care for women and keep them safe. Staff had not completed their mandatory training in line with the trust target. The service was not meeting its target for staff appraisal.
- The service did not always maintain robust equipment check records to provide oversight that all checks were completed in line with trust policy. Not all equipment had been tested in line with servicing requirements.
- Some medicines were not stored appropriately and not all fridge temperature checks had been completed in line with trust policy.
- Incidents and complaints were not always managed within the time frames set out in the trust policies.
- Some staff did not follow the trust uniform policy.
- The safety champions were not embedded within the service.
- Staff we spoke with did not know who the freedom to speak up guardian was.
- Regular staff meetings did not take place on the delivery suite or post-natal unit.

However:

- Staff had training in key skills. The service controlled infection risk well most of the time. Staff assessed risks to women, acted on them and kept good care records.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of women.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems. Staff were focused on the needs of women receiving care.
- The recently established substantive leadership team demonstrated an understanding of the service and had plans in place to deliver improvements.

Maternity

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

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

Nursing and midwifery staff received but did not always keep up-to-date with their mandatory training. Mandatory training data provided by the trust showed an overall compliance rate of 83.5% against the trust target of 85%.

Medical staff received but did not always keep up-to-date with their mandatory training. Mandatory training data provided by the trust showed an overall compliance rate of 62.5% against the trust target of 85%.

The overall compliance figure for mandatory training for all staff was 80.5%. This was an improvement from our last inspection where the overall mandatory training compliance was 76.6%. We issued a requirement notice following our previous inspection because mandatory training was not in line with trust targets. The ability to undertake mandatory training had been impacted by staffing shortages within the service.

The mandatory training was comprehensive and met the needs of women and staff. Mandatory training was a combination of online training modules and face to face training sessions. Mandatory training included a range of topics, such as equality, diversity and human rights, infection prevention and control, and safeguarding adults and children.

The service provided training on recognising and responding to women with learning disabilities and dementia. Completion of learning disabilities training was 88.5% for nursing and midwifery staff, and 56% for medical staff. Completion of dementia awareness training was 92% for nursing and midwifery staff, and 62.5% for medical staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training records were held electronically. Managers told us there had been a drive to improve mandatory training compliance and they ensured they allocated staff time to complete their training. However, there was a delay with some face-to-face training although managers informed us this was booked. Some staff members told us they did not have time to complete their mandatory training and that some people completed it in their own time.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse, however not all medical staff were up to date with their training.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Data provided following our inspection showed that nursing and midwifery staff compliance with safeguarding adults training level 1

was 95.8%. Compliance with safeguarding adults training level 2 was 92.7%. Compliance with safeguarding children training level 1 was 93.3%. Compliance with safeguarding children training level 2 was 92.7%. Compliance with safeguarding children training level 3 was 83%. All safeguarding training for nursing and midwifery staff was above the trust target of 85%, apart from safeguarding children training level 3 which was slightly below target.

Not all medical staff received training specific for their role on how to recognise and report abuse. Data provided following our inspection showed that medical staff compliance with safeguarding adults training level 1 was 71.8%. Compliance with safeguarding adults training level 2 was 62.5%. Compliance with safeguarding children training level 1 was 78%. Compliance with safeguarding children training level 2 was 65.6%. Compliance with safeguarding children training level 3 was 31.5% All the safeguarding modules for medical staff were below the trust target of 85%. This was worse than our last inspection where medical staff met the trust target for all level 1 and 2 safeguarding training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us the system flagged any known safeguarding issues. Safeguarding issues were discussed in handover and a plan put in place. Staff described that they could contact the safeguarding midwife if required, who could assist with the completion of safeguarding referrals. The safeguarding midwife liaised with local authority safeguarding leads.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a clear and up to date safeguarding policy in place which was version controlled. The service followed the policy to escalate any concerns, which was in line with the local authority safeguarding processes. Staff gave examples of cases where safeguarding referrals had been made.

Staff followed the baby abduction policy and undertook baby abduction drills. There were processes in place to protect babies and prevent abduction. Information provided following our inspection stated that the last abduction exercise was carried in September 2022. Prior to that, one took place in May 2021.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean. However, some staff did not follow the trust uniform policy.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The areas we visited during our inspection were visibly clean and we saw cleaning in progress throughout the department during our inspection.

The service generally performed well for cleanliness. The service carried out cleaning audits. There was a cleaning schedule in place and designated cleaning staff who ensured the schedule was followed. Information provided by the trust following our inspection showed that cleaning was consistently carried out to a high standard. Compliance with cleaning audits was over 90% over a 13-week period before our inspection for all areas of the maternity department.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There was a cleaning schedule in place and designated cleaning staff who ensured the schedule was followed. We saw that staff cleaned equipment after patient contact and labelled it to show when it was last cleaned. Staff used I am clean stickers to confirm that equipment was ready for use.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Hand hygiene audits were completed regularly. Following our inspection, we reviewed the most recent hand hygiene audits from July 2022, August 2022 and September 2022. Compliance with hand hygiene was 100% in all 3 audits. This was an improvement from our last inspection.

We saw that PPE was available throughout clinical areas and staff ensured they wore it when attending to women. Staff were observed to largely follow safe infection control and prevention; however, we observed some members of staff wearing necklaces and multiple earrings.

Environment and equipment

The design, maintenance and use of the facilities and premises kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, not all equipment had been tested in line with servicing requirements.

The design of the environment followed national guidance. The maternity department was in one building where all services could be accessed. All areas were secure and accessible by an electronic pass. There was a central staircase which allowed staff to easily move between maternity services. There was easy access to additional clinical areas, such as theatres and the neonatal unit, which enabled access in an emergency. There were 2 maternity theatres, which were used for elective and emergency cases.

The department had an assessment unit. Triage was undertaken in the assessment unit which was known as Mulberry. Willow was a midwife led birthing unit and the service also had a labour suite for consultant led deliveries. Cedar was the post-natal suite; however, women receiving antenatal care could also be seen on Cedar if required due to space availability and staffing.

Staff told us the midwife led birthing unit was not always available to birthing women due to staffing. It was not open on the day of our inspection. It had also reduced from previously being a 9 bedded unit to having 3 birthing rooms.

The service did not always ensure equipment had been serviced. We found that annual equipment maintenance checks were not always completed. Information provided following our inspection showed there were several pieces of equipment across all department areas which were not in date, including ultrasound scanners and blood pressure monitoring devices. Out of 579 pieces of equipment, 83 of them were out of date for servicing. Of these pieces of equipment, 85.6% were compliant with portable appliance testing (PAT). This was also a concern at our previous inspection where we issued a requirement notice for not completing equipment checks in line with trust policy. The equipment we reviewed on site during our inspection was all in date for PAT testing.

Staff carried out daily safety checks of specialist equipment and we saw that resuscitation equipment was checked daily in most department areas, however, information provided by the trust following our inspection showed there were 5 consecutive days in September 2022 where resuscitation checks had not been completed on the midwife led birthing unit.

The service had suitable facilities to meet the needs of women and their families. The service had a quiet area/ bereavement suite for families to use if needed.

Staff disposed of clinical waste safely. Staff segregated waste appropriately and disposed of it appropriately. Staff labelled and did not overfill sharps waste containers.

Maternity

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. We reviewed 7 women's records and saw that risk assessments were completed for each woman on admission or arrival to the unit, using nationally recognised tools.

Staff completed risk assessments for each woman on admission / arrival, using nationally recognised tools, and reviewed this regularly, including after any incident. Midwives completed risk assessments at women's initial assessments, and streamed women to consultant led care if risks were identified. Clinicians reviewed risk assessments on an ongoing basis throughout each woman's pregnancy.

Staff knew about and dealt with any specific risk issues. Venous thromboembolism (VTE) risk assessments were completed for all women who were inpatients and consideration was taken for risks such as sepsis, depending on the woman's clinical presentation.

Carbon monoxide (CO) monitoring was recorded within all of the women's records that we reviewed. This was an improvement from our last inspection, where it was not routinely being recorded. The service audited the recording of CO, which showed an increase from 54.8% in August 2021 to 91.9% in August 2022 for CO measurements at initial assessment.

Staff completed modified early obstetric warning score (MEOWS) as necessary to monitor women's conditions. We reviewed 7 sets of records during our inspection. We found that MEOWS was documented in all records, however in 4 of those records, it was only partially documented as the charts were not fully completed. The potential impact of this was that warning signs or deterioration may not have been identified or escalated appropriately.

Data included in the saving babies lives care bundle dashboard shared by the trust following our inspection showed that staff monitored fetal growth rates (FGR). Staff carried out risk assessments for FGR in 100% of pregnancies in June 2022. The only data collected in 2022 was from June 2022. The information from July to September 2022 was due to be collated at the end of October 2022. Information from 2021 showed that risk assessments for FGR were carried out in 100% of pregnancies from July to December 2021.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). Staff we spoke with knew how to access mental health support for women who required it. The service had a mental health midwife who was available to provide advice and support.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff followed the local guideline in place for mental health referrals if staff were concerned that a woman had deteriorating mental health concerns.

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. We observed the morning handover which included all the women in attendance and any action plans to help facilitate their care or treatment. The handover followed the situation, background, assessment, recommendation (SBAR) format.

Maternity

We observed the multi-disciplinary team (MDT) handover. This was a structured meeting where any risks or incidents were discussed and shared with all staff. An update was provided from each area within the service. Staff interacted positively and were respectful of one another.

Triage was carried out by 2 allocated midwives on the assessment unit. This was an improvement from our last inspection where triage was completed by any available midwife. This improved consistency in communication and identification of ongoing issues. Triage was carried out in line with the Birmingham Symptom Specific Obstetric Triage System (BSOTS). All band 7 midwives working in triage received training in BSOTS. Women were prioritised according to their symptoms, as either red, amber, or green priority. The service carried out an audit of time taken to review in triage between January 2022 and July 2022. The audit showed 100% of women were triaged within 30 minutes of arrival in January, February, April, May and July 2022. Ninety per cent of women were triaged within 30 minutes of arrival in March, and 80% of women were triaged within 30 minutes of arrival in June. The audit showed the time taken for women to be reviewed by doctors based on their BSOTS category. One hundred percent of women categorised as green were seen within 4 hours, 94% of women categorised as yellow were seen within 1 hour and 75% of women categorised as orange were seen within 15 minutes. This met the BSOTS performance indicator. No women were categorised as red during the timeframe of the audit which was January 2022 to July 2022. The audit included recommendations and was planned to be carried out on a quarterly basis to continue to assess compliance with the maternity triage standard operating procedure (SOP).

The coordinator had oversight of all activity across the department and was supernumerary to the rota. This was an improvement from our last inspection, as coordinators were often included in the rota. Managers told us they regularly monitored the coordinator role. There were 2 occasions during August 2022 where the coordinator was not supernumerary for a short period of time. Managers told us there was a process in place to escalate any concerns to the duty manager.

The service used the World Health Organisation (WHO); five steps to safer surgery checklist for all theatre procedures. We reviewed a completed checklist during our inspection which was completed in full. The service carried out monthly audits of WHO checklists to confirm ongoing compliance. Audits we reviewed between September 2021 and August 2022 showed that most questions achieved 100% compliance with the checklist.

Women were routinely asked about their experience of domestic abuse. This was documented in all 7 sets of records we reviewed, regardless of whether or not there were any suspicions of abuse.

Fresh eyes is a buddy system for reviewing continuous cardiotocography (CTG) records, to ensure appropriate escalation if required. Fresh eyes were routinely completed and recorded in all 7 of the women's records we reviewed during our inspection. Information provided following our inspection stated that compliance with fresh eyes was on the audit programme to be carried out between 2022 and 2023.

Midwife 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 regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Maternity

The service did not have enough nursing and midwifery staff to keep women and babies safe. The trust had previously had challenges with the recruitment of midwives due to the national shortage in this staff group. There had also been a period of time where a number of midwives left the service in a short amount of time. Trust data showed that there were 48.24 whole time equivalent (WTE) midwife shortages at Basildon Hospital as of 31 August 2022. This was worse than our previous inspection in 2021 as the vacancy rate had increased by 23.4 WTE.

The service recently recruited 18 newly qualified midwives and 4 international midwives to the service. A further 4 experienced midwives were due to join the service in October 2022. This would improve the midwife vacancy rate as the new members of staff started their employment after the date the data was taken from. The service had a retention practice development midwife to help support the new staff members and ensure they received appropriate training. Managers expressed they wanted to ensure new members of staff felt supported to ensure that they retained the new staff members who joined the service.

The service reported the midwife to birth ratio was 1:25, 1:22, 1:20, 1:27 and 1:26 for the months of April 2022 to August 2022 respectively. The planned ratio was 1:24 or less.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance. The service used the birth rate plus acuity tool 4 hourly to ensure staffing was appropriate for each area. Concerns were escalated to the duty manager and the manager on call. Managers reviewed the day ahead to plan staffing levels in advance.

The number of midwives and maternity support workers did not always match the planned numbers. On the day of our inspection, the service was operating with 8 midwives less than planned. To mitigate risk, managers met regularly throughout the day to review and plan staffing. Midwives were moved around within the department to ensure the highest risk areas had sufficient cover. The community midwives could also be required to cover in the unit to ensure appropriate skill mix and staff numbers in each area.

We reviewed the staffing rota for the department for August 2022 and September 2022. It showed actual midwife staffing did not match the planned midwife staffing on any days between 1 August 2022 and 28 September 2022. Midwife staffing was at less than 50% on 5 days between the same time period. We did not see evidence of any safety incidents as a result of this.

The service turnover rates were higher than the trust target of 12%. The turnover rate for midwifery staff between September 2021 and August 2022 was 18.6%. The turnover rate for additional clinical staff was slightly over the trust target at 13.7%.

The service had fluctuating sickness rates which increased in the winter and summer months. The sickness rate climbed to 9.8% in December 2021, before reducing to 5.4% in May 2022. It increased to 11.2% in July 2022 and reduced to 7.3% in August 2022.

The service used high rates of bank and agency midwives. In August 2022, 195.71 WTE bank midwives were used. Agency midwives were used less frequently. The service used 16.81 WTE agency midwives in August 2022.

Managers used bank and agency staff and requested staff familiar with the service. Gaps in the rota were covered by bank staff, agency staff and community midwives where possible. Staff told us that ward managers and specialist midwives worked clinically instead of completing their usual work in order to ensure safe cover within the department. These measures helped to mitigate the gaps in the rota, but did not cover all the gaps.

Maternity

Managers made sure all bank and agency staff had a full induction and understood the service. There was a local induction checklist specific to Basildon hospital for bank and agency midwives to complete to confirm their competencies and orientation within the department.

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

The service did not always have enough medical staff to keep women and babies safe. Data shared by the trust following our inspection showed that there were 12.65 whole time equivalent (WTE) medical shortages at Basildon Hospital as of 31 August 2022. Medical vacancies increased from 10.8 WTE in October 2021 to 14.5 WTE in January 2022. Vacancies remained steady at around 14 WTE from January 2022 to July 2022.

The maternity dashboard showed that during April 2022 to August 2022, consultant presence on the delivery suite was 100%.

The medical staff did not always match the planned number. A review of the medical staffing rota showed, for August 2022 and September 2022, the number of actual medical staff mostly matched the planned number. Staff reported there were gaps in the rota but stated there had been recent improvements. Staff reported that it was difficult to maintain the rota, but stated they felt supported by consultants who would always come in when needed.

Staff reported there was only one consultant at night to cover all the emergencies in the hospital which made it difficult to support the obstetric trainees at night.

Managers told us there was a drive to improve vacancy rates, and the service had recently recruited 3 new consultants.

The service had a high turnover rate for medical staff. The turnover rate for medical staff between September 2021 and August 2022 was 32.4%. This was considerably higher than the trust target of 12%.

The service used bank and locum staff to fill gaps in the rota. The service used locums of different grades to ensure the safety of the service. Between 2 WTE and 10 WTE locums of different medical grades were used per month between September 2021 and August 2022. The service used higher levels of bank medical staff in comparison to locums. The service used between 3 WTE and 15 WTE bank medial staff of different grades per month between September 2021 and August 2022.

Managers could access locums when they needed additional medical staff. Some locums informed us they did not receive a full induction to the service straight away, especially if they started in the middle of the year. Staff informed us they still felt supported when they started working at the service.

Sickness rates for medical staff were low and reducing. Sickness rates for medical staff peaked in March 2022 at 6.7% and reduced to 2.3% in August 2022. Sickness rates were below the trust target of 4%.

Records

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

Maternity

Women's notes were comprehensive and all staff could access them easily. We saw that records were complete and reflected regular assessments and reviews. Staff wrote clear descriptions of care given and planned. We reviewed 7 women's records and saw that risk assessments were generally completed well, and records detailed the care and treatment provided. Information recorded was clear.

When women transferred to a new team, there were no delays in staff accessing their records. Women had handheld records which they took to all clinical appointments or when accessing care from other services.

Records were stored securely. Records were stored in secured trolleys which were located by the nursing station. We observed computers were locked when they were not in use which prevented unauthorised access.

Patient identifiable information was not always documented in women's records. This posed a risk to any lost or misplaced documents if they became detached from the main record, as it would not be possible to know which record they came from. We did not see evidence of any incidents where documentation had been lost or misplaced.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, some medicines were not stored appropriately and some temperature checks had not been completed appropriately.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 7 prescription charts and found that medicines were given in line with prescriptions with no omissions. We found dates, signatures, allergies and weight, if medicines were prescribed according to weight, were clearly recorded in all 7 prescription charts we reviewed.

The service had patient group directions (PGDs) in place for midwives. PGDs provide a legal framework that allows some registered health professionals to administer medicines so that the patient does not have to see a prescriber.

Staff stored and managed all controlled drugs documents safely, however some other medicines were not stored appropriately. Controlled drugs were stored in an appropriate medicine cupboard and the controlled drugs logbook was up to date, without any omissions. Any midwife could hold the medicine cupboard keys.

We checked all the controlled drugs and a sample of other medicines in the delivery suite clinic. We also checked a sample of consumables that were stored in the clinic. All were found to be in good condition, within date and stored appropriately. However, we found some neonatal emergency medicines packs that were stored in unlocked containers on the side of the clinic. We escalated this during our inspection. Managers informed us they had ordered a mobile drugs trolley in order to ensure the medicines were stored appropriately. Managers also advised they would seek advice from other maternity units across the region to seek advice on best practice.

There were 4 medicines cupboards that were lockable and locked. However, there were a further 4 medicines cupboards that had no locks and contained medicines such as intravenous antibiotics, N/Saline and water for injections. We escalated this during our inspection and received feedback from managers stating that 4 new lockable cupboards had been ordered to replace the unlockable ones.

We found the freezer was not locked, or lockable and the fridge was not locked. We escalated this during our inspection. We received feedback from managers stating that a lockable freezer had been ordered. The keypad lock for the medicines fridge was broken; this was reported to maintenance for urgent repair.

We found medicines in an unlocked medicines return box on the floor in the clinic. We escalated this at the time of our inspection. Feedback received from managers stated that the medicines belonged to discharged patients and the box needed to be returned to pharmacy. These medicines were immediately returned to pharmacy and were to be returned on a weekly basis, which would be monitored by managers.

Medicines storage temperatures were recorded within normal range. We reviewed the medicines storage temperatures and ambient room temperature checks between July 2022 and September 2022. There were 6 days in July where fridge temperatures and ambient room temperatures were not recorded, 1 day in August and 2 days in September where fridge and ambient room temperatures were not documented.

Incidents

The service managed safety incidents. 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 patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff we spoke with gave examples of incidents they had reported. They knew what types of incidents to report and described that they reported incidents through the electronic reporting system.

There was a risk lead for the service and two local risk midwives. We observed that risks and incidents were discussed in handovers and were discussed by the managers. This included assigning an individual to investigate any new incidents. The risk midwife worked closely with staff teams to provide support and guidance to staff, as well as ensuring the safety of patients and ensuring appropriate action had been taken to incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy. Managers investigated incidents thoroughly. Where appropriate incidents were reported to the Healthcare Safety Investigation Branch (HSIB).

The risk team ensured good practice was recognised within incidents, which helped to promote incident reporting, and support staff not to feel blamed when incidents happened. A risk midwife informed us that there was a good reporting culture within the service.

A risk midwife carried out daily walkarounds of the service to support staff with identifying and responding to incidents if required.

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 were able to describe duty of candour and provide examples where this had been applied. Families were involved in the investigation of incidents. The service's risk register featured lack of compliance with trust key performance information (KPI) for incidents. This indicated that duty of candour may not always have been carried out in a timely manner.

Staff received feedback from investigation of incidents, both internal and external to the service. The service provided weekly 'stepping up' bulletins; these were a weekly internal teleconference which included any recent incidents and any learning that had been identified. The information was recorded and sent to all staff within the service by email.

Maternity

The risk team compiled a monthly risk newsletter which included key performance statistics, top scoring incidents for the service and identified learning. This information was captured on one page to make it easier for staff to access the information.

Staff told us that learning from serious incidents was circulated out to all staff.

Staff met to discuss the feedback and look at improvements to patient care. We saw evidence that risks were discussed in the women's health governance meeting. We reviewed the minutes for June 2022, July 2022 and August 2022 and found that patient safety, risk and compliance and patient experience were standing items on the agenda. The minutes referred to an action log, but we did not receive this information to review it. We had not requested the action log.

Local meetings included discussion around incidents and lessons learned. We saw an example of learning from an incident being shared in the delivery suite ward meeting minutes from 10 August 2022.

Minutes of the Trust Board meeting held on 4 October 2022, confirmed the board had oversight of serious incidents which had occurred in the service.

Service leaders informed us the service was not compliant with trust key performance indicators which included incident investigation and follow up. The service had a backlog of incidents. This was impacted by workforce shortages and the high volume of incident reporting across the service. This issue featured on the service's risk register, and there were mitigations in place such as a daily meeting between midwifery and governance managers to discuss all new incidents and assess their priority. There was also a deep dive planned for September 2022 to be facilitated by NHS Improvement.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff mostly followed 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 and found they were in date and followed national guidance. For example, the maternity triage standard operating policy made reference to National Institute for Health and Care Excellence (NICE) guidance and Nursing and Midwifery Council (NMC) standards.

Staff told us they could easily access policies and guideline which were held centrally and available via the intranet.

Staff informed us some policies were still in the process of being updated and amalgamated following the trust merger. All policies were planned to be amalgamated to a trust version.

A review of women's notes indicated the fetal growth was plotted on the fetal growth chart in line with national guidance.

The service had a comprehensive audit programme in place to monitor local standards and compliance. For example, the service carried out a World Health Organisation (WHO) Maternity checklist audit to assess compliance with the completion of the checklist.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. The trust had a dedicated mental health midwife and the community perinatal mental health midwife. Staff completed mental health training as part of the mandatory training programme.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We observed discussions surrounding how to support the emotional needs of women and relatives who were going through difficult experiences with their pregnancies.

Competent staff

The service made sure staff were competent for their roles. Managers held supervision meetings with staff them to provide support and development. There were plans in place to ensure managers appraised staff's work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers made sure staff received any specialist training for their role. For example, 91.5% of all staff took part in Practical Obstetric Multi-Professional Training (PROMPT). This training covered the management of a range of obstetric emergencies.

Information provided following our inspection demonstrated that 38% of midwifery staff were trained in new-born and infant physical examination (NIPE) screening. The trust informed us that from September 2022 all newly qualified midwives would have received NIPE screening as part of their training, and therefore would have the competencies to perform NIPE, which would show an increase in the training figures. The rosters were organised to ensure a NIPE trained midwife was on duty every day to perform low risk NIPE checks. Paediatricians completed the high risk NIPE checks.

Information provided by the service following our inspection showed that cardiotocography (CTG) training had been completed by 97% of midwives and 63.5% of medical staff, against a trust target of 90%.

Managers gave all new staff a full induction tailored to their role before they started work. New staff were provided with a structured induction programme. Staff told us that their preceptorship programme enabled them to work across all areas of the service to support their development.

There was a local induction checklist specific to Basildon hospital for bank and agency midwives to complete to confirm their competencies and orientation within the department.

Managers had an appraisal process, however not all midwifery staff had completed them. The trust reported an appraisal rate of 90.3% for medical staff, which was above trust target. The trust reported an appraisal rate of 61.2% for midwifery staff. Service leads told us that all appraisal dates were booked between midwifery staff and their managers.

The clinical educators supported the learning and development needs of staff. There were 2 practice development midwives who worked within the service. They supported staff with their ongoing training and the preceptorship of new midwives.

Maternity

The service provided a maternity update day for medical and midwifery staff where key training updates and information was shared. The next maternity update day was scheduled to take place in October 2022, and it was planned to include an update relating to triage.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Local meetings took place within all areas of the service. Minutes from the meetings were held electronically and were accessible to staff who were unable to attend. It was documented within the minutes that they were circulated to all staff within the team and service leaders.

Staff had the opportunity to discuss training needs with their line manager. The service continued to provide specialist training to staff. Staff told us they discussed any additional training needs with their managers during appraisals, however they told us they felt they did not have the time to explore any additional training due to the pressures in the department and how busy they were.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary team meetings to discuss patients and improve their care. Staff held multidisciplinary handover meetings to ensure the safe care and treatment of women. Staff collaborated well in the meetings we observed, and the culture appeared respectful and friendly.

Staff described a positive working relationship between medical and midwifery teams. We saw that staff worked well together to support the care of women and babies.

Staff worked across health care disciplines and with other agencies when required to care for women. Staff could access the neonatal unit directly from the delivery suite if a baby required transfer.

Staff worked with other teams within the hospital when they had outliers who were being looked after in other areas of the hospital. The maternity team maintained oversight of women who required care elsewhere in the hospital.

Service leaders attended a daily cross-site situation report (SitRep) meeting where any issues that caused delay to the service were discussed. The information was escalated to the executive team and a report was shared system wide, to ensure the system, including community teams were aware of pressures across the trust.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. Staff informed us they referred women to the perinatal midwife if they required support with their mental well-being.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent.

Staff gained consent from women for their care and treatment in line with legislation and guidance. We reviewed 7 sets of women’s records. We found evidence that consent had been obtained for surgical procedures in 5 of the records, however, there were 2 records where a surgical procedure had taken place and there was no evidence of women’s consent. We raised this with the trust during our inspection. We received feedback with evidence that consent had been obtained verbally and recorded in the women’s electronic notes.

Maternity

Is the service responsive?

Inspected but not rated

We inspected but did not rate this service.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

The service delivered around 270 to 350 babies each month. Trust data showed there were 273 babies born in June, 347 born in July and 318 born in August 2022 at the hospital.

The service routinely monitored the types of delivery and recorded this on the maternity dashboard. Trust data showed that 48.4% to 57.1% of all deliveries for April to August 2022 had been by vaginal deliveries (VDs). The data showed that 33.8% to 41.2% of deliveries for April to August 2022 were elective and emergency caesarean sections. Elective caesarean sections were 16%, 14%, 11%, 16.4% and 14.2%. Emergency caesarean sections were reported as 18.1%, 25.7%, 22.8%, 22.8% and 27% for the same period.

Managers monitored waiting times and made sure women could access services when needed and received treatment within agreed timeframes and national targets. Women attending the hospital were triaged and allocated to the correct pathway. The service monitored whether women received an initial assessment within 30 minutes of arrival to triage. Data provided by the trust following our inspection showed that 100% of women were triaged within 30 minutes of arrival in January, February, April, May and July 2022. Ninety percent of women were triaged within 30 minutes of arrival in March 2022, and 80% of women were triaged within 30 minutes of arrival in June 2022.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. The trust adopted the BSOTS (Birmingham Symptom Obstetric Triage System) which allowed the level of urgency in which women should be seen to be assessed. There was a system in place to ensure that women presenting with the highest level of urgency should be seen immediately.

Managers and staff worked to make sure women did not stay longer than they needed to. Once women were considered fit to go home, they were encouraged to do so.

Managers worked to keep the number of cancelled appointments/treatments to a minimum. Staff told us that clinical pressures and emergencies sometimes impacted on elective cases which meant that women sometimes stayed in hospital slightly longer than planned. Staff told us that procedures may be moved to the following day if the service was unable to facilitate it.

Staff supported women and babies when they were referred or transferred between services. Staff described a positive transition between services and informed us that women were accompanied if they moved to a new area. Women were able to accompany their babies who were transferred to neonatal care.

Maternity

The service reported that care had to be diverted to another provider on 3 occasions between April 2022 and August 2022.

Managers and staff started planning each woman's discharge as early as possible. Staff communicated with the community midwife team when women were due to be discharged. This enabled community midwives to continue women's care in a timely way.

The service leads informed us there was a higher percentage of deprivation in the locality in comparison to the other hospital sites. There was also a more diverse population and staff reported that community teams focused on women's health including diet and lifestyle. Interpreters were used where necessary to inform discussions. Staff described interpreters were used for all women's appointments if required.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them. Complaints were not always managed in line with the trust target.

Staff understood the policy on complaints and knew how to handle them. Where possible concerns were addressed at the time. Staff escalated to the midwife in charge or matron when issues arose, enabling concerns to be addressed immediately.

Information provided by the trust following our inspection confirmed that 38 complaints were received by the service from 1 September 2021 to 31 August 2022. Within the same time frame, 11 complaints were responded to within the appropriate timeframe, and 25 were responded to outside of the timeframe.

Managers investigated complaints and identified themes. The most common themes identified within incidents was communication with women regarding care and staff behaviour towards patients. The service took action following complaints to address the concerns that were raised and to try and make improvements to the service.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff informed us learning from complaints was shared during the weekly 'stepping up' communications.

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 understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The maternity service was led by a multidisciplinary triumvirate leadership team consisting of a site based head of midwifery, a site based clinical lead obstetrician and a trust wide deputy director of operations for maternity and neonatal services.

Maternity

Women's and children's services, which included maternity services became a standalone care group in September 2022, which was known as care group 5. This was implemented to strengthen the leadership of the service.

Service leaders were experienced in their roles and were aware of the existing risks within the service. Service leaders described feeling supported by the senior leadership team (SLT) and the trust board. The chief nurse was the designated board member lead for maternity services.

The service leads reported directly to the trust's SLT and there were clear escalation pathways and meetings for reviewing performance. Service leads reported daily to the SLT on progress and activity within the service at the daily situation report (SitRep) meeting.

Leaders at every level were visible and approachable. Staff told us the service leaders and line managers were supportive and they felt able to approach the leadership team openly and honestly. There had been recent changes to the local leadership of the service, and staff we spoke with described it as a positive change. Many staff informed us they had approached service leaders and that they felt listened to.

The service had 2 safety champions which consisted of a midwife and a consultant obstetrician. Staff we spoke with did not know who the safety champions were. Service leads informed us that the previous safety champions had recently retired or left the service, which was why not all staff were aware of who they were. Service leads told us they would send communication out to staff about the safety champions.

Vision and Strategy

The service was developing a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Service leaders informed us there was no vision and strategy in place at the time of our inspection. Since the merger of the trust, this site had not had permanent leaders in place to be able to define the vision for the service.

The trust priority was the maternity improvement plan which was in progress across all 3 sites. There were 14 workstreams in place to identify where there were gaps in the service. Leaders told us this work would inform a new strategy and vision for the service.

The integrated care system had a quality strategy implementation plan for 2022 to 2023. It included an objective of maternity services improvements and transformation. This would be achieved by delivery of the maternity improvement plan, support exit from the CQC warning notice and maternity safety support programme, oversight of the immediate and essential actions from the final Ockenden report (and any other national reports) and continued delivery of the national maternity transformation programme priorities.

Culture

The service had an open culture where staff could raise concerns without fear.

We observed an improvement in the culture since our last inspection. Staff told us they felt well supported by their managers. Most staff we spoke with felt supported by the senior leadership team. All staff felt there had been improvements since the new service leaders were in place.

Maternity

We found that some staff were frustrated by the ongoing issues with staffing levels and the impact this had on them being able to undertake their jobs effectively. Some staff felt overwhelmed and vulnerable to risk.

Despite this, teams spoke positively of one another and described their teams as a family. We saw positive interactions and working relationships between medical and midwifery staff. They reported collaborative and effective team working, which was evident during our inspection.

Service leaders told us a lot of work had been done within the service around culture, however they acknowledged there was still work to be done. Staff told us managers and matrons often supported clinically when they were able to during times of extreme pressure within the department.

Staff were aware of and could describe duty of candour.

Staff felt they could raise concerns to their managers without fear, however staff did not know who the freedom to speak up guardian was.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service.

Women's and children's services, which included maternity services became a standalone care group since 1 September 2022 and was known as care group 5.

The service had recently established a local site-specific governance structure. Service leads told us that the new structure gave accountability to the individual sites for risk and governance. They told us the structure provided the necessary governance to run an effective service.

The service had a meeting structure in place to support the delivery of the service. This enabled escalation of issues from ward to board.

The service held a monthly women's health governance meeting. We reviewed the minutes for June 2022, July 2022 and August 2022 and found that the meetings were well attended. The meetings had standing items on the agenda, including patient safety, risk and compliance and patient experience.

The triage and assessment unit and community team held monthly staff meetings. The last meeting for the delivery suite took place in October 2021. The post-natal unit had 2 meetings in 2022 up until the time of our inspection. The last meeting took place in August 2022. The reason for the lack of meetings in these areas was due to clinical activity and acuity in these areas of the service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had a maternity risk register which included a red, amber green (RAG) rating, description of risk, action taken, risk owner and review date. The risk register included the risks that we identified during the inspection; including staffing levels, a backlog of incidents and complaints and out of date policies.

The local governance meetings identified risks and action taken or in progress. The maternity dashboard was routinely discussed in women's health governance meetings.

The oversight of local risk was not robust in all areas. For example, the risk associated with the concerns we escalated relating to the safe storage of medicines had not been identified.

The service had an electronic incident reporting system. All staff were encouraged to report incidents and risks on the system. All incidents graded as moderate or severe harm were reviewed weekly in a multidisciplinary setting.

The service had a trust wide board level safety champion and a local midwife safety champion.

Service leads monitored performance through the maternity dashboard. Service leads informed us that the dashboard updated every day with performance metrics from the previous day. The data from the dashboard could be used to look at the detail behind incidents and could be used to predict future activity based on delivery dates. For example, leaders could use the information to adjust staffing rotas for expected peak delivery times.

The trust had a major incident plan and the women and children's division had a business continuity plan. These provided staff with guidance on action to take during unexpected events. The divisional plan was out of date, however the service was aware of this and it was in the process of being updated.

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. Data or notifications were consistently submitted to external organisations as required.

Service leaders demonstrated that they understood the performance of the maternity service. Leaders had a framework to oversee the quality and safety of patient care, which included the maternity dashboard and the regular audit programme.

The service collected key performance metrics through the maternity dashboard, such as data on bookings, births and serious incidents. This allowed service leads to make decisions based on the information collected. Information could be viewed at trust and site-specific level.

Ongoing oversight of the audit programme meant service leaders understood the performance of the service in relation to compliance with local and national audits. For example, the service was in the process of carrying out a quarterly record keeping audit.

The service used a combination of paper and electronic records for the documentation of women's care. Staff informed us they knew where to find the information they required. Paper records were stored securely and electronic records were held securely as staff required a trust login and password to access the information.

The service had employed a digital midwife to support the integration of electronic records and IT systems into the service.

Maternity

Engagement

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

The service consistently worked to gain feedback from staff, service users and external stakeholders. Managers communicated important messages to staff through 'stepping up' bulletins, handovers, staff meetings and a closed social media group.

The national staff survey results of 2021 (published March 2022) showed trust wide, maternity staff consistently scored worse than the overall organisational score. This meant that staff in maternity were less satisfied than staff in other areas of the trust.

The trust hosted an induction of labour forum in January 2022. It was an open forum to enable women to discuss induction experiences with staff, and enabled the trust to gather feedback from women who had used the services.

Service leaders had a good understanding of the populations they served. The area had higher levels of deprivation in comparison to the other hospital sites, and a greater population of black, Asian and minority ethnic (BAME) people. The local area had higher rates of diabetes diagnoses within the population and smoking rates were higher.

The service had continued to run the continuity of carer resource in the community, despite difficulties with staffing levels in the hospital. Leaders told us this decision was reviewed on a regular basis, and the information held about the demographics of the population they served, promoted the decision to deliver the continuity of carer resource to support the needs of women within the local population.

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.

The service implemented multi-disciplinary team (MDT) handovers with an electronic monitoring tool. This was in response to a previous CQC inspection report that identified handovers historically had not been well-attended, lacked focus, largely relied on manual records and did not always provide an effective handover. The implementation of the electronic monitoring tool was rolled out across the other hospital sites within the trust and improved the effectiveness and efficiency of the twice-daily handover between shifts.

Broomfield Hospital

Court Road
Broomfield
Chelmsford
CM1 7ET
Tel: 01245362000

Description of this hospital

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not have enough staff to care for women and keep them safe. Staff had not completed their mandatory training in line with the trust target. The service was not meeting its target for nursing staff appraisal.
- The service did not maintain robust cleaning and equipment check records to provide oversite that all checks were completed in line with trust policy.
- Triage was not always staffed appropriately, and this led to delays in women being seen within the required timeframe. The service was regularly breaching the target to triage women within 15 minutes.
- The service had not managed safety incidents well and learned lessons from them.
- There were 450 incidents outside of their 20-day target. There was an action plan in place and all incidents had been harm reviewed.
- People could not always access the service when they needed it and sometimes had to wait for treatment. Capacity in the post-natal ward impacted flow through the unit.
- Not all staff felt respected, supported and valued.

However:

- Staff had training in key skills, understood how to protect women from abuse, and managed safety well.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available 7 days a week.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback.
- Staff were focused on the needs of women receiving care.
- The recently established substantive leadership team demonstrated an understanding of the service and had plans in place to deliver improvements.

Maternity

Requires Improvement ● →←

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, however not everyone had completed it.

Nursing and midwifery staff received but did not always keep up to date with their mandatory training. Data provided by the trust showed, nursing and midwifery staff compliance with mandatory training was 68%.

Medical staff received but did not keep up with their mandatory training. Medical staff compliance was 65% against the trust target of 90%.

Training compliance was the same as our last inspection. Compliance had not improved. Managers told us that staff were allocated time to complete the online training. However, due to reduced staffing, staff had been required to work clinically impacting on the ability of managers to release staff for training.

The mandatory training was comprehensive and met the needs of women and staff. Midwifery staff received mandatory training in line with their role. Training was provided either in person or online.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff training was recorded centrally, and managers notified staff to complete training or booked sessions for them when staffing numbers made this possible. Staff confirmed that they were advised what training they needed to complete and when they could attend courses.

Safeguarding

Staff understood how to protect women 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.

The service had clear safeguarding policies which described escalation and reporting processes. The policy was version controlled and was within review date.

There was secure access to the maternity unit in line with the baby abduction policy which was in date and version controlled.

Nursing, midwifery and medical staff received training specific for their role on how to recognise and report abuse. Safeguarding adults' level 2 compliance was 85% and safeguarding children level 3 compliance was 81% against a trust target of 90%.

Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff completed training in safeguarding and knew how to apply this in their work. Staff could access support from the safeguarding midwife if they had concerns.

The service had staff that specialised in complex pregnancies and a specialist mental health midwife. Where women were identified with known safeguarding and mental health concerns, these specialised team members would advise staff in their care.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to describe the process for raising a safeguarding concern and knew how to contact the safeguarding lead for support and advice.

The service had safeguarding midwives who supported staff with any concerns.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The areas we visited on inspection were visibly clean, with furnishing, such as patient chairs, that were easily cleanable.

The service generally performed well for cleanliness. Cleaning audits were completed monthly and were reviewed by service leads to ensure standards were maintained. Cleaning audits for June, July and August 2022 showed that compliance across all areas exceeded the trust target of 95%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below their elbows. PPE was available throughout the department and staff used it while delivering care to women and disposed of the PPE correctly after use.

Hand sanitiser was available on entry to clinical areas and across all units we inspected. We observed staff following good hand hygiene principles.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Cleaning records were not up-to-date and did not demonstrate that all areas were cleaned regularly. Records were not completed for all areas in relation to the cleaning. On the labour ward there was a folder where cleaning records were kept, however, these were inconsistently completed, and staff were not clear about its' use. Therefore, there was no clear record that cleaning had been completed. We raised this at the time of our inspection and a senior midwife told us they were aware of the inconsistencies in the completion of documentation cleaning and that the process was under review.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Maternity

The design of the environment followed national guidance. Maternity services at the hospital consisted of a consultant led delivery suite, a midwife led birthing unit, bereavement suite, antenatal and postnatal ward, day assessment unit with a triage area and outpatient clinics.

Staff carried out daily safety checks of specialist equipment. Some equipment check sheets were kept in a folder on the labour ward. However, these were completed inconsistently. Some equipment check sheets were kept with the equipment, for example with the resuscitaires. Staff were unclear of the process for completing check sheet for equipment checks. Therefore, there was no clear record that equipment checks had been completed in line with policy. We raised this at the time of our inspection and a senior midwife told us that they were aware of the inconsistencies in the completion of documentation cleaning and that the process was under review.

The service did not have suitable facilities to meet the needs of women in all areas. Staff told us the number of post-natal beds were not sufficient to meet the needs of the service and that capacity in the post-natal ward impacted on flow through the unit. Staff told us that this led to delays in inductions of labour and elective caesarean sections. Data provided by the trust showed that in the 6 months prior to our inspection 5 incidents of delayed elective caesarean sections were reported due to lack of capacity in the post- natal ward. We requested information relating to the number of delayed inductions of labour during this period. The trust told us that they do not currently audit data relating to delayed inductions of labour but will implement this going forward.

The service did not always have enough suitable equipment to help them to safely care for women and babies. Three midwives told us that there was not always enough equipment, for example cardiotocography (CTG) machines. Broken equipment was removed and not always replaced.

Staff ensured that emergency clinical equipment, such as adult resuscitation trollies, oxygen, resuscitaires and suction equipment were appropriately stocked and positioned in accessible areas. Resuscitaires are used to support newborn babies who may need extra warmth or resuscitation after delivery.

Staff disposed of clinical waste safely. We observed that staff disposed of clinical waste including needles and domestic waste correctly. Staff ensured that all waste receptacles including sharps bins were not overfilled. Sharps bins on the wards we visited were clean, dated and not overfilled.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The trust used Maternity Early Obstetric Warning System (MEOWS) to detect any deterioration during pregnancy, delivery and postnatal. Staff completed MEOWS manually and recorded the score in the woman's record. We reviewed 11 records that showed staff calculated MEOWS correctly and escalated as appropriate.

We reviewed 2 baby paediatric early warning system (PEWS) charts on the post-natal ward, which were comprehensive and completed appropriately.

Staff completed a CTG assessment tool sticker and inserted this in the paper care record at the start and end of each CTG trace. Two midwives reviewed the CTG and confirmed this by signing and dating the sticker. This was evident in the 11 sets of records we reviewed. This was in line with national guidelines and confirmed fresh eyes reviews of the trace had been completed.

Maternity

All the paper care records we reviewed were legible and orderly. Staff had signed and dated prescription charts and recorded each woman's allergy status.

There were clear processes for doctors and midwives to call for support from consultants during the day and out of hours. Staff confirmed that consultants were responsive when contacted.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Midwives completed risk assessments at the pregnancy booking appointment and allocated women to consultant led care if risks were identified.

Staff completed individual risk assessments on admission to the delivery unit. These included Venous Thromboembolism (VTE), which staff had completed correctly in the medical records.

The service had a policy for monitoring fetal growth rates (FGRs). Data from the saving babies lives dashboard showed staff carried out risk assessments for FGRs in 95% of pregnancies in July and August 2022 in line with policy.

Staff carried out carbon monoxide (CO) monitoring in line with guidance. This was evidenced in 10 out of the 11 sets of records we reviewed. Risks associated with smoking were planned to be recorded at the initial assessment, and at 36 weeks. Data provided by the trust showed that in August 2022 CO monitoring had been carried out at booking for 100%.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. In 11 records we reviewed mental health assessments were completed. There was a dedicated mental health midwife who was accessible to staff offering advice and support where necessary.

The service had a specialist continuity of carer midwifery team. This team was responsible for the care of complex pregnancies of women who were vulnerable for reasons such as mental health or safeguarding concerns.

Staff shared key information to keep women safe when handing over their care to others. Triage was completed by midwives in line with the Birmingham Symptom Specific Obstetric Triage System (BSOTS). Women were prioritised according to their symptoms, as either red, amber, or green priority. Women risk assessed as red were seen immediately in labour ward. Staff raised concerns that due to staffing shortages triage was not always staffed appropriately and this led to delays in women being seen within the required timeframe. Data provided by the trust showed that in August the service was regularly breaching the target to triage women within 15 minutes. Data from August showed that there were only 3 days when there were no breaches of the 15 minute triage target. Breaches ranged from 4% on the 7th August to 59% on 4th August. Staffing and high activity were sited as the reasons for the breaches. We escalated staff concerns and senior leaders told us that there was an escalation process in place when delays were occurring. Triage was on the risk register. There were plans in place to expand the area to increase capacity and recent recruitment would help address staffing concerns.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed a handover on the post-natal ward. All key information was shared but we observed that a situation, background, assessment, recommendation (SBAR) framework was not in use. As information was not shared in a standardised format this meant that information could be missed and handover was not easily monitored for quality and safety. The lack of formalised handover was noted in the last inspection.

On the post-natal ward breast milk was not stored securely in the available locked fridge. We found bottles of breast milk in the formula fridge and the breast milk of a woman who had been discharged was still in the fridge. The checks

had not been done daily over the previous week and there was no process in place to record checks completed when distributing bottled breast milk to women. Therefore, we were not assured that breast milk was stored securely or that there was clear oversight of the safe storage and distribution of breast milk. We escalated this at the time of our inspection and staff took appropriate action immediately. Leaders told us there was a new trust wide guideline due to be rolled out with a training element for staff included. This new guidance aimed to ensure checks were undertaken by 2 members of staff when breast milk was signed out of the breast milk fridge with appropriate records. They told us this process would be audited, and compliance monitored.

Nurse 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 regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. The trust had challenges with the recruitment of midwives due to the national shortage in this staff group. Managers told us they had a recruitment plan which included international recruitment, return to practice midwives and increasing the number of student midwives. At the time of our inspection 17 preceptor midwives had started with the unit.

Managers accurately calculated and reviewed the number and grade of midwives, midwifery support workers and health care assistants needed for each shift in accordance with national guidance. The trust and maternity managers regularly reviewed staffing. Staff moved between antenatal and postnatal wards and the delivery unit to meet the needs of the women in each area. The community midwives could also be required to cover in the unit.

Staffing was also reviewed following the Ockenden recommendations. This meant the service requirements were changed, and the trust needed to recruit additional whole-time equivalent midwives. Several senior midwife posts had been recruited to using internal staff. However, this had impacted on the number of staff working in the unit. Managers told us that senior midwife roles included time working clinically to staff the unit to support staff acuity.

Senior midwives reported that they were frequently required to cover on the unit when they were rostered to non-clinical time impacting their ability to meet the requirements of their role.

Managers calculated and reviewed the number and grade of midwives, midwife support workers and healthcare assistants needed for each shift in accordance with national guidance. The service used the birth rate plus acuity tool 4 hourly to ensure staffing was appropriate for each area. Data provided by the trust showed that in August 2022 staffing met acuity 77% of the time the tool was applied.

The number of midwives and healthcare assistants did not match the planned numbers. On the day of our inspection, the service was operating with 2 midwives less than planned. This meant staff who should have been supernumerary were counted in the numbers and were working clinically.

The service had reducing vacancy rates. At the time of our inspection, the service had a 17% vacancy rate. The service had recruited 17 new midwives, and There was active recruitment continuing.

Medical staffing

The service had 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

Maternity

The service had enough medical staff to keep women and babies safe. The service had a skill mix of doctors including junior doctors, middle grade and consultant obstetricians to care for women. The recommended consultant hours were met by the service. Consultants held ward rounds every day supported by junior medical staff.

The maternity dashboards showed that during the 4 months April to July 2022, consultant presence on delivery suit was 100%.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Consultants completed rounds 7 days a week and were supported by a team of speciality registrars and junior doctors. There was always an anaesthetist available for the delivery suite. A newly appointed consultant supported the service manager with rota planning to balance service and training needs for medical staff. This ensured there was an appropriate skill mix of staff available.

The service always had a consultant on call during evenings and weekends. The service had a consultant available out of hours.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely.

Women's notes were comprehensive. We reviewed 11 sets of maternity care records, all records were completed fully with a summary for each care episode both in the community and in the hospital. Risk assessments were completed and were clear in the records. Entries were legible, signed and dated.

The service used paper records. Staff told us that this did at times present a challenge with notes having to be transferred between teams, for example from post-natal to community. They also told us that this presented a challenge when conducting notes reviews, investigating incidents or conducting audit. Leaders told us that records audit had not been completed due to capacity in the service.

Records were stored securely. Women's records were stored securely in staff areas of the clinical areas within lockable record trolleys.

Medicines

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

Staff stored and managed all medicines safely. Medicines were kept in a locked room. Controlled drugs (CDs) were stored appropriately in a locked cabinet.

Staff checked fridge temperatures where medicines were stored. Temperature monitoring charts confirmed staff had checked the temperature in line with policy.

Staff on the post-natal ward told us that there was often a delay in women obtaining their medication to take home. They told us that prescriptions were completed by the hospital pharmacy and were often not received until 4pm leading to delays in discharge.

Maternity

Incidents

The service managed safety incidents. 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 patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, incident records were not closed inline with trust policy

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Managers we spoke with told us that staff reported incidents in line with trust policy, a review of incidents reported by staff confirmed this.

At the time of our inspection, the service had a backlog of 450 incidents of which 24 were serious incidents over the 60-day key performance indicator (KPI). All the incidents had been harm reviewed and the service had an action plan in place to address the backlog.

The head of midwifery, risk midwives and ward managers attended a safety huddle every morning where incidents were reviewed, harm gradings were reviewed and the incident allocated to a staff member to investigate. Any immediate learning was identified and shared with staff. The head of midwifery told us they were now in a position where there was clear oversite of incidents and that there was a clear trajectory of reducing the number of outstanding incidents. Data provided by the trust confirmed this.

The trust described the process of escalation around incidents; the division leads undertook an Initial Management Review (IMR) to establish the facts known at the time. This report was then presented to the Executive Review Group (ERG) for a decision on declaration / level of investigation. This meant all incidents declared had an initial review which included consideration of any immediate safety concerns and required actions.

Staff knew what incidents to report and how to report them. All staff we spoke with knew how to report incidents using the online electronic system.

Staff received feedback from investigation of incidents. Learning was shared at consultant meetings and midwife meetings. “Themes of the week” were shared every day at the night to day shift handovers. Learning was also shared through closed social media groups. Three members of staff we spoke with told us they received individual feedback from incidents.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Duty of candour was discussed at the daily safety huddles and staff were allocated to complete this when required.

Is the service effective?

Requires Improvement 

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

Maternity

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed 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 and saw that they were in review date and followed national guidance.

Managers had oversight of policies and procedures. The women's and children's division had a monthly clinical audit and national institute for clinical excellence (NICE) monthly report which highlighted polices outstanding for review. The report for August 2022 showed that there were 4 NICE guidelines overdue and 5 quality standards overdue. There were 2 NICE guidelines and three quality standards that provided 'partial compliance'.

Staff knew how to access policies and guidelines. They were easily accessible and were available via the intranet.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. The service had two perinatal mental health midwives to support women. Staff completed mental health training as part of the mandatory training programme.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, current compliance was not in line with trust target.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers made sure staff received any specialist training for their role. Staff that cared for women had a programme of required training in addition to mandatory training requirements. Medical and midwifery staff groups completed this specialist training, for example Practical Obstetric Multi-Professional Training (PROMPT), this formed part of the core competency framework for all clinical staff employed by maternity services. Data showed that 83% of staff were compliant with PROMPT training.

All staff that care for women in labour were required to undertake annual training and competency assessment on cardiotocography (CTG). Staff are assessed through a competency assessment tool and must achieve 90% to pass the module. Data provided by the service showed that 94% of staff were up to date with this training. The service told us that staff that were not compliant were not able to care for women intrapartum until their training was completed.

A review of data following our inspection indicated 65% of the midwifery workforce had completed their maternity update day which included newborn screening (NIPE) compliance. This meant that babies could undergo assessment by midwives earlier and identify any potential issues.

Managers gave all new staff a full induction tailored to their role before they started work. All newly qualified midwives went through a preceptorship programme and were supported to gain skills and experience within their role. All student midwives had an allocated mentor to the sign off their required competencies.

Managers did not always support midwives to develop through yearly, constructive appraisals of their work. The service did not always conduct annual appraisals with their staff. The appraisals for midwifery staff had been impacted by

staffing constraints and was at 60% for nursing and midwifery staff against a trust target of 85%. The head of midwifery told us that now there was a senior leadership in place completing appraisal was a priority and the service had an action plan in place with processes for line managers to complete appraisals. However, 100% of medical staff had completed their annual appraisal.

The clinical educators supported the learning and development needs of staff. Staff had access to practice development midwives to ensure they remained up to date with key skills. A practice development nurse told us that outside of formal training they offered a weekly drop-in session where staff could come and ask for additional training support or discuss concerns and areas for improvement.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The trust continued to develop staff skills and knowledge despite the pandemic. The service had implemented physiological Cardiotocography (CTG) interpretation support and ensured staff had the training to successfully implement into practice.

The service had introduced a multidisciplinary team (MDT) post partem haemorrhage (PPH) panel at the beginning of August to review cases, share learning and best practice. This was a new initiative. Staff reported that it was working well but there were no measured outcomes available at this early stage.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We reviewed meeting minutes and saw that the meetings were well attended. Minutes were shared via email and outcomes shared via closed social media sites, newsletters and daily huddles.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

We observed that there was positive multidisciplinary team (MDT) working. Staff told us MDT working relationships were positive. Conversations were respectful and inclusive. We heard that doctors were very supportive of midwifery staff and were available to support midwives when required.

Staff held regular and effective MDT meetings to discuss patients and used these as an opportunity to improve care. We observed a morning MDT hand over meeting. This was well attended, including a consultant, an anaesthetist, midwife, delivery suit coordinator and junior doctors. There was clear discussion about the mornings planned caseload and anything pending.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. Staff described referring women to the perinatal midwife for support with mental wellbeing.

Maternity outpatients' departments had specialist clinics held in conjunction with other services, such as diabetes and safeguarding teams.

Staff could access the neonatal unit directly from the labour ward when a baby required transfer.

Maternity

Is the service responsive?

Inspected but not rated

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were not always in line with national standards.

Managers monitored waiting times. However, women could not always access services when needed and did not always receive treatment within agreed timeframes and national targets.

The Birmingham Symptom-specific Obstetric Triage System (BSOTS) was developed to better assess and treat pregnant women who attend hospital with pregnancy related complications or concerns. The service had recently introduced this. BSOTS audit data for August 2022 showed 76% of women were triaged within 15 minutes of arrival, and 98% saw a doctor within the appropriate time frame for their rating. Staff escalated their concern around the initial triage wait times for women. The reason sited was due to staffing, and that triage was not always staffed appropriately due to shortages of staff within the service. We escalated this at the time of our inspection and leaders told us they were aware of the challenges and that there was appropriate escalation in place. Staff incident reported when there was a breach of triage times, or they did not have enough staff to triage within BSOTS guidance. Maternity triage was on the risk register.

There were concerns around the flow of women in the maternity unit due to capacity on the post-natal ward. There were 20 beds on the post-natal ward, 4 of which were being used for transitional care on the day of our inspection. Staff told us that lack of beds on the ward led to delays in care with inductions of labour and caesarean sections being delayed. Data provided by the trust showed that in the 6 months prior to our inspection 1 patient experienced a delay and was waiting in the waiting room due to beds not being available. The caesarean was performed later that day. Four patients were unable to have their caesareans on their original planned dates due to the unavailability of beds. These were all rebooked and completed on the following day.

Managers and staff started planning each woman's discharge as early as possible. Staff communicated with the community midwife team through the electronic record and a written book when women were about to be discharged. This enabled community midwives to follow on the woman’s care in a timely way.

Staff recorded the woman’s discharge plan in a workflow in the electronic care records. Most women had midwife led discharge. Other women received a medical review before discharge.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. We spoke with one woman and her partner who told us they were aware of how to make a complaint.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff escalated concerns to the midwife in charge, senior midwife or a matron when an issue was raised. This meant that where possible concerns could be addressed and managed immediately.

Managers investigated complaints and identified themes. There were 16 open complaints at the time of our inspection, 5 of which were overdue. The main themes of complaints were concerns around communication, diagnosis and delays in care.

Staff told us learning from complaints was shared at daily handover and by email, daily themes of the week and through closed social media groups.

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 understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.

Women's and children's services, which included maternity services had become a stand alone care group since the 1 September 2022 and was now care group 5. This change had been put in place to strengthen the leadership of the women's and children's services

The maternity service was led by a multidisciplinary triumvirate leadership team consisting of a site based head of midwifery (HOM), a site based clinical lead obstetrician and a trust wide deputy director of operations for maternity and neonatal services.

The HOM had recently joined the trust in a substantive role. This was following a period of interim leadership. This period of uncertainty had impacted on staff and the service. The HOM had previous experience in the role and could describe the risks and challenges faced by the service.

Staff on the ward and on the delivery unit told us the senior leadership team were not visible. The HOM and DOM acknowledged that due to other demands this had been the case and that they had plans in place to engage further with staff.

There had been several recent appointments to senior midwife posts. Senior midwives told us the leadership was visible, and they felt supported by the leaders in the service.

Service leaders described feeling supported by the DOM.

The DOM did not have a seat at the trust board meetings. However, the DOM confirmed they did attend board meetings by invitation and when they needed to escalate to board level.

Maternity

All the medical staff we spoke with spoke positively about their managers, colleagues and local leadership team saying they were visible and approachable.

The leadership at all levels was knowledgeable about the issues and priorities for the service and understood the challenges and had action plans in place to address the concerns.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action.

Service leaders told us there was no local strategy and vision in favour of the development of the trust wide maternity improvement plan which HOMs and matrons had been engaged in developing. At the time of our inspection other staff had not been involved in the process.

The plan brought together improvements the service needed to make that had been identified by the CQC inspection, the Ockenden report and the clinical negligence scheme for trusts (CNST).

Culture

The service had an open culture where staff could raise concerns without fear. Staff told us they felt supported by their managers; however, a prolonged period of interim leadership had impacted on morale. Staff reported feeling tired and that morale was low.

We saw positive interactions and working relationships between medical and midwifery staff. They reported collaborative and effective team working, which was evident during our inspection**.**

Leaders were taking action to address some of the concerns raised by staff. There was a cross site culture work stream in place attended by the HOM with actions in place to support work improving culture across the service.

Some actions had been put in place. An offsite training day had been run for band 7 midwives supporting working collaboratively and communication. The service was providing civility training which aims to create, model and support a high standard of behaviour and promote dignity and respect between employees. The culture supported duty of candour. Where incidents had caused harm, and met the requirement for duty of candour, we saw that the appropriate action was taken. Staff also described a working environment in which any errors in a patient's care or treatment were investigated and discussed with the woman and her family.

All the staff we spoke with told us they were encouraged to report incidents. Staff said they felt they could raise concerns with service leaders and colleagues.

Governance

Leaders operated governance processes throughout the service but this was not fully embedded. 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.

The service had recently established a local site-specific governance structure. The HOM told us that since joining the trust the establishment of a robust local governance process had been a priority. They told us that in these early days they felt positive that the structure provided the necessary governance to provide a safe and effective service.

The service had a meeting structure in place support the delivery of the service and enabled escalation of issues from ward to board.

The service held a monthly women's health governance meeting chaired by the clinical lead. We reviewed 3 sets of meeting minutes and saw that they were well attended and had a set agenda including patient safety, risk and compliance, incidents and lesson learned and audit.

The DAU and labour ward held monthly staff meeting. Minutes demonstrated staffing and quality were regularly discussed.

The operations manager, clinical lead for the service, HOM and DOM met formally weekly, however, the HOM told us that they were in regular contact with the DOM daily. The site-specific risk and governance team met once each month to discuss local issues and the dashboard and met with the wider trust risk team the following week.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, but this was not always effective. They identified and escalated identified risks and issues and identified actions to reduce their impact.

The service had a maternity risk register which included a red, amber green (RAG) rating, description of risk, action taken, risk owner and review date. The risk register included the risks that we had been informed of as part of the inspection including staffing levels, incident backlog and triage. The service risks described by senior service leads reflected those on the service risk register

The local governance meetings identified risks and action taken or in progress. Review of meeting minutes indicated risk was discussed and shared at the trust governance meetings, and included updates from governance, finance and human resources.

The oversight of local risk was not robust in all areas. For example, the risk associated with the concerns we escalated relating to the safe storage and distribution of breast milk had not been identified.

The service had an electronic incident reporting system. All staff were encouraged to report incidents and risks on the system. All incidents were graded daily at the safety huddle. The service had a backlog of 450 incidents of which 24 were serious incidents, over 20-day KPI. All the incidents had been harm reviewed and the service had an action plan in place to address the backlog.

The service had a trust wide board level safety champion and a local midwife safety champion.

The maternity dashboard was routinely discussed at risk and governance meetings held monthly. Women's Health Governance Meeting minutes dated 10 June, 8 July and 5 August 2022, also evidenced regular discussion and oversight of the dashboard.

Minutes of the Trust Board meeting held on 14 July 2022 confirmed the board had oversight of serious incidents which occurred in the service.

Maternity

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. Data or notifications were consistently submitted to external organisations as required.

The service had plans for an integrated IT system across all hospital sites. Managers within maternity services were keen that any electronic system that was used would ensure that the data quality met the needs for reporting internally and externally.

The service had employed a digital midwife to support the integration of electronic records and IT systems into the service.

The trust used paper patient records. The risk associated with tracking and scanning patient notes was on the risk register. The service had plans to move to electronic patient records in the future.

Local and trust service leaders demonstrated that they understood the performance of the maternity service which included women's and staff views, safety and risks. Despite the lack of electronic records managers had a framework to oversee the quality and safety of patient care, which included the maternity dashboard and the regular audit programme.

Engagement

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

The service consistently worked to gain feedback from staff, women and external stakeholders. Managers communicated important messages to staff through hot topics, handovers, staff meetings, closed social media groups and DOM's monthly news newsletter.

The service leaders had recently re-introduced an award scheme for staff called the "maternity star of the month award". Staff would nominate colleagues for the award in recognition of hard work and peer support. We saw posters on the unit showing winners receiving their award.

The national staff survey results of 2021 (published March 2022) showed trust wide, maternity staff consistently scored worse than the overall organisational score. This meant that staff in maternity were less satisfied than staff in other areas of the trust. Senior leaders told us results from Broomfield hospital maternity staff was in line with the trust wide finding.

Service leaders had a good understanding of the populations they served. The area had small pockets of high social deprivation, women with high BMI and increased number of smokers.

The service collected the opinions in relation to user experience of women, their partners, staff and stakeholders and shared them on a display board in the unit.

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.

Maternity

Service leads were committed to stabilising the leadership and developing the service. They were working toward sharing good practice across three trust sites as well as tailoring services to meet local needs.

Southend University Hospital

Prittlewell Chase
Westcliff On Sea
SS0 0RY
Tel: 01702435555
www.southend.nhs.uk

Description of this hospital

Our rating of this location stayed the same. We rated it as requires improvement because:

- The service did not always have enough staff to care for women and keep them safe. Actual staffing levels did not match planned staffing levels throughout the service.
- The department lacked storage space and consumables and equipment were left in corridors. We were concerned this could delay the movement of staff or women in an emergency.
- Staff had not completed their mandatory training in line with the trust target and service leaders did not have a robust plan to address the noncompliance.
- The service had not completed records audits since October 2019 and did not have a robust plan to address this.
- The service was not meeting its target for nursing staff appraisal and did not have a robust plan to address this.
- Leaders did not run services using reliable information systems. Service leaders were unable to extract meaningful data from the new IT system and there were data gaps in performance dashboards.
- Anaesthetists did not attend MDT handover. This was a concern at our previous inspection in 2021.
- The service did not have a local strategy and vision.

However:

- Staff had training in key skills, understood how to protect women from abuse, and managed safety well.
- The service controlled infection risk well.

Diagnostic imaging

Inspected but not rated

Is the service safe?

Requires Improvement

Mandatory training

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

Staff received and kept up to date with their mandatory training. Staff told us they were supported to complete mandatory training and were allocated time to complete it. Data submitted following our inspection showed that 87% of staff had completed mandatory training against the trust target of 85%.

The mandatory training was comprehensive and met the needs of patients and staff.Training was delivered through a combination of online and face to face training. Managers told us that accessing face to face training had been a challenge due to capacity and the ability to release staff for training. This had impacted training compliance for face to face training such as basic life support (BLS) which was at 57% for adult BLS and 55% for paediatric BLS. This had been identified and there was an action plan in place to improve compliance.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The training compliance rate was 77%, which was below the trust target.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept a record of the status of staff training and monitored staff compliance with mandatory training. Staff told us that managers informed them when training was due to be completed.

Safeguarding

Staff understood how to protect patients 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. Staff were trained to level two in both adult and children safeguarding. Data provided following our inspection showed that 96% of staff had completed safeguarding training against a trust target of 85%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew what constituted a safeguarding concern and knew their responsibilities to follow safeguarding policies and procedures. Staff were able to give examples of safeguarding concerns that they had raised.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that they made a referral via the safeguarding team. The team were available through the hospital switchboard. Staff told us that they were very responsive.

The trust had a safeguarding lead. Staff we asked knew how to contact the safeguarding team if they had any concerns and required support. They told us the safeguarding team members were responsive and supportive.

Diagnostic imaging

Staff followed safe procedures for children visiting the department. However, staff were not aware of any policy in place for when children attended the department as a patient or a visitor. Following our inspection, we requested a copy of this policy, but they did not have a policy in place.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.We checked cleaning records in all areas we visited and saw that they were completed appropriately.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand sanitiser was available in all areas we inspected. We observed staff washing their hands before and after patient contact. The service conducted monthly cleaning and handwashing audits. Results showed average compliance of 98% for the 6 months before our inspection. Appropriate PPE including gloves and aprons were available and staff used them when in contact with patients.

Staff cleaned equipment after each patient contact and labelled equipment to show when it was last cleaned. We observed staff cleaning equipment after each patient contact and labelling it with green “I am clean” stickers.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. All radiology equipment within the x-ray department was covered by a current service contract ensuring that equipment was serviced and maintained by specialist engineers. There was a maintenance and service schedule in place for diagnostic imaging equipment. Equipment maintenance was carried out by an external provider overseen by a superintendent radiographer. We checked the service schedule and records and saw that the equipment had been serviced in line with the schedule.

Staff carried out quality assurance (QA) safety checks on specialist equipment. We checked QA records in computed tomography (CT), magnetic-resonance imaging (MRI) and plain x-ray and saw they were completed in line with equipment guidelines.

Non-specialist equipment was maintained and serviced by the trust maintenance team. We checked 5 pieces of equipment and found them to be within their service date and the annual electrical safety checks had been undertaken.

All rooms, where there were ionising radiation exposures were clearly signposted with warning lights. All were in working order. Access to MRI was though a keypad locked door. Patient and staff access was monitored by MRI staff.

The service did not have enough suitable equipment to help them to safely care for patients. There was a capital replacement plan to identify equipment in need of replacement. Staff identified the interventional radiology room was

out of service contract and that there were infrastructure concerns related to this. The risk associated with this room was one of the top risks for the department. A second fluoroscopy room had been decommissioned and was now being used as an ultrasound scanning room following the equipment no longer being safe for use. This impacted the service in terms of capacity to complete diagnostic imaging examination.

Staff separated waste and disposed of clinical waste safely. There were sharps bins available for the safe disposal of sharps. Sharps bins were assembled and labelled correctly.

The service had a business continuity plan, which identified where financial resources were required to enable equipment to be replaced when necessary. An additional CT scanner had recently been installed.

Staff told us that the staff male and female staff changing facilities were not fit for purpose. We observed that they were small, cramped and in poor condition.

In the CT and plain film waiting area the CCTV camera was not working meaning that staff were not sighted on patients waiting. This presented a patient and staff safety risk particularly out of hours. There were no notices in MRI to inform people that CCTV was in operation, so patients were not aware that they were being monitored.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health. All areas we visited had access to resuscitation trolleys. We saw that checks were carried out in line with hospital policy. We checked contents of the resuscitation trolley in MRI and all consumables we checked were in data and tamper proof seals were in place.

Staff shared key information to keep patients safe when handing over their care to others. The service had recently ratified a new policy for the transfer of patients (clinical handover of care) policy for patients attending diagnostic imaging. The policy outlined clear processes and criteria for patients requiring a nurse escort to ensure patients were transported and handed over safely in the department.

Staff knew about and dealt with any specific risk issues. There were signs in the department waiting areas and outside imaging rooms informing people about areas where radiation exposures were taking place.

Pause and check posters were in all imaging areas we visited. They were designed to act as a ready reminder of the checks that needed to be made when any diagnostic imaging examination was being undertaken.

The service had a radiation protection adviser and medical physics expert. Staff told us they were easily accessible for offering radiation advice. The service had radiation protection supervisors for each clinical area in line with best practice.

There were posters in all areas we inspected advising women to notify the radiographer if they suspected they might be pregnant. Staff checked the pregnancy status of all women of child-bearing age before undertaking a diagnostic imaging examination.

Diagnostic imaging

There was a procedure in place for the collapse of a patient in MRI. The scanning table was detachable and a patient requiring medical attention would be brought out of the scanning room. Although staff in MRI were aware of the procedure for the evacuation of a patient in the event of a patient emergency, this had not been practiced to ensure all staff were aware of their role and to assess the effectiveness of the process.

There was a clear process to escalate unexpected or significant findings both at the time of examination and upon reporting. This process followed Royal College of Radiologists (RCR) guidelines. Learning where necessary was discussed at the monthly discrepancy meeting.

Out of hours cover was provided by an external provider. There was a clear process in place for the requesting, protocoling and reporting of diagnostic imaging examinations required. There was a clear process for the escalation of critical, non-critical significant unexpected findings requiring attention but not immediately life threatening and reporting time frames.

There was a clear process in place for the escalation of time critical or significant unexpected findings during diagnostic reporting.

The service monitored reporting times of the out of hours service. Review of the latest report for the period January to March 2022 showed 93.5% compliance for urgent reports and 90.5% compliance for routine cases.

Although staff had knowledge of processes in place when imaging children, the service did not have policies in place across all imaging modalities to support staff when imaging children. Within MRI there was a paediatric lead and policies and guidance in place, but this was not replicated in other departments.

Paediatric lists in MRI and CT were supported by a paediatric nurse to ensure specialist care was available to children attending the department if required.

Staffing

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

The service did not have enough staff, and this impacted on the number of patients that could attend for diagnostic imaging studies. There was 18 full time equivalent (FTE) radiographer vacancies and 4 admin and clerical vacancies.

Managers calculated and reviewed the number of staff needed for each shift in accordance with national guidance. This meant that staffing levels were safe in the department but impacted on the number of patients that could attend the department for a diagnostic imaging examination.

The service had a reducing vacancy rate. There was a trust wide recruitment plan in place to recruit to diagnostic imaging departments across the 3 hospital sites. Information provided following our inspection showed that over 30 offers had been made to local, regional and international candidates.

The service used bank and agency staff. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Diagnostic imaging

Medical staffing

The service did not have enough radiologists with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not have enough radiologists to keep patients safe. Data provided following the inspection showed that the trust had calculated that the service had a radiologist shortfall of 1 whole time equivalent.

The service accessed additional radiologist reporting capacity through external providers.

The service had a good skill mix of radiologists on each shift and reviewed this regularly.

Records

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

The service had an electronic requesting system for staff to request diagnostic imaging for their patients. We reviewed 8 sets of records and saw that they were completed in full and justified by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) requirements.

Electronic access to diagnostic results were available to authorised staff within the trust.

For patients referred to diagnostic imaging from their GP, their results were sent to their GP by letter.

Records were stored securely. Staff logged out of computers when leaving workstations ensuring that records could not be accessed by unauthorised persons.

Incidents

The service managed patient safety incidents. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and 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.

Staff knew what incidents to report and how to report them. The trust used an electronic reporting system and all staff we spoke with were aware of how to use it.

Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff told us what constituted an incident and the process by which to report and escalate.

Managers shared learning with their staff about incidents that happened elsewhere, for example there had been an increase in incidents of wrong site examinations at another site. Staff were aware of the incidents and the learning and actions that had been implemented across the trust.

Staff we spoke with did not demonstrate that they fully understood the duty of candour. Although they understood the requirement to be open and transparent there was lack of understanding as to when duty of candour should be applied.

Diagnostic imaging

Staff received feedback from the investigation of incidents internally and across the trust. However, we were not assured that learning from incidents was shared externally to the service. For example, we did not see evidence that learning from incidents were shared with the external out of hours provider.

Managers and staff met to discuss the feedback and look at improvements to patient care. Staff told us that they received feedback from incidents that they reported. We reviewed minutes from staff meetings and saw that learning from incidents was a standard agenda item.

There was evidence that changes had been made as a result of feedback. For example, a manager told us that following an incident that occurred out of hours the number of CT radiographers working overnight had been increased to ensure additional support for staff and patients. As a result, the out of hours rota had been increased to 2 CT trained radiographers at night. Staff told us that this had been implemented.

Managers debriefed and supported staff after any serious incident. Staff we spoke with told us they were aware of incidents and learning and changes that had been implemented as a result.

Radiologists attended a learning from discrepancy meeting where cases were reviewed and learning shared. We reviewed minutes from a meeting in July 2022 and saw that 10 cases were discussed and learning points highlighted.

Is the service effective?

Inspected but not rated

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a comprehensive, full induction tailored to their role before they started work. We reviewed the induction programme and saw that it met the requirements. Staff were signed off as competent by senior staff as they progressed through the induction programme. Staff told us that the induction programme was comprehensive, and staff and managers supported them to complete it.

Managers supported staff to develop through yearly, constructive appraisals of their work. Seventy seven % of radiographers and 93% of radiologists has received an appraisal in the last 12 months. All staff we spoke with confirmed that they had a received an appraisal. They told us that they were positive and offered the opportunity to discuss career development and training requirements.

Each diagnostic imaging area had a service lead who worked in the area offering support and supervision for staff. Staff told us there was always someone available to offer help and support.

There was a comprehensive preceptorship programme in place to support newly qualified radiographers that started work in the department. Preceptorship is a structured period of transition whereby the newly qualified radiographer is supported to develop confidence by consolidating the knowledge and skills needed to provide a high level of service and become a competent autonomous professional.

The department held regular meetings and managers made sure staff attended team meetings or had access to minutes when they could not attend.

Managers identified any training needs for all their staff and gave them the time and opportunity to develop their skills and knowledge. The department was proud of the number of radiographers that were undertaking advanced practice. There were 5 reporting radiographers in plain film with 2 in training. There were also 2 reporting radiographers in MRI and an advanced practitioner working in fluoroscopy. Staff told us that there was a proactive approach to training and staff were encouraged to undertake additional training to enhance their roles.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Consultant radiologists attended multidisciplinary meetings to discuss patients and improve their care.

Staff we spoke with in the department told us that consultants and imaging teams worked very well together. We observed staff interacting and saw that staff respected each other and worked together to ensure the best outcomes for patients.

Radiographers we spoke with, told us they had a good working relationship with specialty teams. Staff told us they worked together with clinicians to provide services to patients.

Is the service responsive?

Requires Improvement

Access and flow

People could not access the service when they needed it and did not always receive the right care promptly. Waiting times for treatment were not in line with national standards.

Managers monitored waiting times. However, patients could not access services when needed and did not receive treatment within agreed timeframes and national targets. The service produced a weekly performance dashboard which monitored capacity and activity. It monitored cancer wait times, the number of patients waiting for diagnostic imaging by modality and reporting times. Data showed that week ending 20 June 2022 CT request to appointment for patients on two-week cancer pathway was 10 days and for MRI this figure was 11 days. In the week ending 22 August 2022 this figure had reduced to 9 days for CT but increased to 16 for MRI.

There was a recovery plan in place with actions that the service were taking to address the backlog. Actions included running extra lists when staffing capacity allowed, accessing capacity in the independent sector, accessing independent staffing for scanners, offering enhanced bank rates for staff and working with community providers for ultrasound scanning. The service was working with external auditors to monitor the impact of actions in place.

Diagnostic imaging

Radiologists worked with multidisciplinary teams to conduct harm reviews of patients waiting for treatment. Patients could be prioritised for imaging when required.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. We saw that the service clearly displayed information about how to raise a concern in patient areas and on the website.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with told us that where possible they dealt with patient concerns at the time and tried to resolve any issues for patients.

Is the service well-led?

Requires Improvement

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was strong and inclusive leadership at all levels throughout the service. Leaders were visible, and staff we spoke with told us they were approachable and responsive. Staff told us they felt valued by leaders to deliver a high standard of care to patients and their families.

Leaders at all levels demonstrated the skills and capability to support staff to deliver good care.

Managers had an open-door policy and staff confirmed that managers were always accessible. Managers treated staff with respect and all staff we spoke with told us that they felt supported to deliver a good service to their patients.

Leaders demonstrated an understanding of issues, challenges and priorities in the service and beyond. Local leaders within each imaging modality demonstrated a good understanding of the service they delivered and escalated to the trust's senior leadership team

Vision and Strategy

The service had a draft vision for what it wanted to achieve and a draft 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.

Service leaders had developed the vision and strategy to align with the trust vision and strategy. The draft was to be shared with staff for consultation before being formalised and adopted by the service.

Diagnostic imaging

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.

All staff we spoke with told us they felt positive and proud to work for the department. They told us that the best thing about working in organisation was the team they worked with. They were patient focused with delivering a high level of care to patients the priority of all staff we spoke with.

There was a culture of staff development driven by an appraisal and career development conversations. There were 7 radiographers working in extended roles and 3 more in training. All advanced practitioners we spoke with told us that radiologists and managers were very encouraging and supportive of training. Radiology assistant practitioners had been supported to qualify as radiographers. The paediatric lead radiographer in MRI had started their career at Southend as a radiology support worker.

Staff told us that they felt supported, respected and valued by their managers and colleagues. They felt able to raise concerns. Staff at all levels respected each other and the role they played in the department. For example, radiographer support workers told us that they felt valued by the team and particularly felt supported and valued by the consultant radiologists and enjoyed working with them.

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.

There were effective processes and systems of accountability within diagnostic imaging. Governance systems were in place to support the functions of diagnostic imaging services. Monthly meetings were conducted to allow oversight of the service which fed into divisional governance meetings. All senior managers, clinical managers and section heads were encouraged to attend these meetings. Meetings had a set agenda and we saw this was followed during each meeting.

There was an effective process to share governance systems and updates with staff. Monthly staff meetings were held within diagnostic imaging. We reviewed 3 sets of meeting minutes and saw that they had a formal agenda where governance was included. The department produced a monthly newsletter that also included information relating to governance.

Staff of all grades we spoke with were clear about their roles and what they were accountable for and to whom.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The radiology department had a risk register in place. Each risk was rated and had a named responsible manager attached to it. The risk register was reviewed and updated monthly. We reviewed the risk register and saw the top three risks were the same as those that managers described to us at the time of inspection. These were staffing, delayed diagnosis due to capacity and demand and environmental and infrastructure concerns related to the first-floor interventional room.

Diagnostic imaging

There was an action log in place that monitored actions against identified risks, and this was discussed and updated at the diagnostic monthly imaging governance meeting.

Radiologists attended a monthly discrepancy meeting where reporting discrepancies were reviewed and learning shared.

There was an audit programme in place to audit practice against guidelines and monitor outcomes. All staff were encouraged to be involved in audit in the department although staffing capacity had impacted on staff ability to participate.

Senior staff shared information from meetings with staff at departmental meetings. We reviewed 3 sets of departmental meeting minutes and saw that governance issues were discussed.

The service held regular service review meetings with the external out of hours service provider. We reviewed minutes from these meetings and saw they followed a standard agenda. The meeting reviewed the service being delivered but we did not see evidence that there was a sharing of learning from incidents to improve the service for patients.

The service had a business continuity plan in place to cope with unexpected events that may disrupt the service.

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.

Information and data was collated and presented so that information was clear and enabled staff and managers to see where improvements were required.

Information such as patient records, diagnostic images and reports were stored securely, and was easily accessible to all staff and presented in a format that was easy to understand and interpret.

Policies, protocols, standard operating procedures and audit were in final stages of being standardised across the trust. Files were stored centrally and were easily accessible to all staff.

Engagement

Leaders and staff actively and openly engaged with, staff, to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers engaged with staff at regular team meetings in all the areas that we visited. Meeting minutes showed discussion of incidents, complaints and staffing.

Staff told us that local leaders were visible and offered opportunities to listen and feedback to staff. Local leaders told us they felt very supported by the senior leadership team and were involved in decisions about their service.

Senior leaders told us there was positive cross site working across the 3 hospital sites. A divisional leader told us the radiology service was working well operationally across sites and plans were in place to further improve the integration of the services.

Diagnostic imaging

Radiology had carried out a staff survey to gain feedback from the radiography staff members. Staffing, working environment and access to continued professional development (CPD) were the top 3 areas staff rated as important with the greatest gap to needs being met. Actions had been taken in response including the re-introduction of monthly audit afternoons to support staff to engage in CPD.

There was a radiology newsletter that had been introduced to improve staff engagement and to keep staff across sites up to date with news and developments within radiology.

Leaders worked with the integrated care system and the radiology network in planning how to deliver sustainable radiology services.

Learning, continuous improvement and innovation

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

The service was involved in innovative pilot studies exploring the use of technology and artificial intelligence (AI) in radiology. For example, a study that used algorithms to triage head CT for head injury and a study to determine whether the use of AI can increase the accuracy and efficiency of lung cancer diagnosis by flagging positive cases on chest X-rays for priority reporting.

Maternity

Requires Improvement ● →←

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, however not everyone had completed it.

Nursing and midwifery staff received but did not always keep up to date with their mandatory training. Mandatory training data provided by the trust showed an overall compliance rate of 75%, as of 31 August 2022, against the trust target of 90%.

Medical staff received but did not keep up to date with their mandatory training. Mandatory training data provided by the trust showed an overall compliance rate of 74%, as of 31 August 2022 against the trust target of 90%.

This was a slight improvement on the compliance rate of 69% at our previous inspection, where we issued the trust with a requirement notice for poor completion of mandatory training.

Managers told us that, although staff were allocated time to complete the online training, staff had been required to work clinically due to reduced midwifery staff during the recent months.

The mandatory training was comprehensive and met the needs of women and staff. Midwifery staff received mandatory training in line with their role. Depending on the topic, training was provided either in person or online. For example, basic life support and manual handling training was completed in person whilst equality and diversity training was completed online.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff training needs were recorded centrally, and managers prompted staff to complete training or booked sessions for them when staffing enabled this. Midwifery staff told us managers monitored mandatory training, alerted them when they needed to update their training and booked training onto their off-rota days.

Safeguarding

Staff understood how to protect women 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 however, not all staff had completed the training

The service had clear safeguarding policies which described escalation and reporting processes. The trust also had a policy called care of pregnant teenagers and young people. The policy was version controlled and was in date for review.

Maternity

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Medical staff safeguarding adults level 2 training compliance was 90% and nursing and midwifery staff safeguarding adults level 2 training compliance was 85% compared to the trust target of 90%. Medical staff and nursing and midwifery staff safeguarding children level 3 training compliance was 59% compared to the trust target of 90%.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to describe the trust's process for raising a safeguarding concern and knew how to contact the safeguarding lead for support and advice.

Managers told us that, although staff were allocated time to complete safeguarding training, staff had been required to work clinically due to reduced midwifery staff during the recent months, but the service had safeguarding midwives who were available and supported staff with any concerns.

Staff followed the baby abduction policy and undertook baby abduction drills. There were processes in place to protect babies and prevent abduction. Staff reported they had completed a baby abduction drill to test the efficiency of the process within the last six months.

Access to the maternity unit was secure. Staff used swipe cards and visitors reported to a receptionist who opened the door where appropriate.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All the areas we inspected, were visibly clean.

The service generally performed well for cleanliness. Cleaning audits were completed monthly and reviewed by service leads to ensure standards were maintained. Cleaning audits for August 2022 showed that compliance across all areas exceeded the trust target of 95%.

This was an improvement from our previous inspection where we issued the trust with a requirement notice in relation to the completion of cleaning records. Staff followed infection control principles including the use of personal protective equipment (PPE) and handwashing. Staff were bare below their elbows.

PPE was available throughout the department and staff used it appropriately in line with trust policy. Hand sanitiser was available on entry to clinical areas and across all units we inspected. Staff were prompted to maintain good hand hygiene and visitors were encouraged to sanitise their hands on arrival to the departments.

Staff cleaned equipment after each patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Maternity

The design of the environment followed national guidance. The maternity department was located on level 2 and consisted of a fetal medicine unit (Kypros Nicolaides), an antenatal ward (Margaret Broom 1 (MB1)), post-natal ward (Margaret Broom 2, (MB2)), central delivery suit (CDS) with extended care area, midwife led birthing unit (MLBU) and bereavement suit. Rooms were sufficiently sized to enable treatment and any adjustments such as the introduction of a birthing pool.

On arrival to the department, visitors reported to a central reception and were signposted to the relevant clinical area. All departments were accessed by secure access only.

The fetal medicine unit consisted of 6 individual scanning rooms, 2 counselling rooms and 2 clinic rooms.

At the time of our inspection, the service had combined the antenatal and postnatal wards (MB1 and MB2) and was providing 7 antenatal beds and 18 postnatal beds in MB2. Staff told us the bed ratio could be flexed in each direction when required.

The triage service was being provided in the 13 bedded former prenatal area (MB1).

The CDS consisted of 6 individual rooms, with a 5 bedded extended care area for higher risk women and 2 adjacent dedicated theatres.

The MLBU provided 4 delivery rooms however, due to low staff numbers, the MLBU service had closed 2 delivery rooms and reduced the service to 2 rooms in order to keep safe staffing levels.

Staff carried out safety checks of specialist equipment. Records confirmed staff carried out daily, weekly and monthly checks of emergency response equipment such as resuscitation and post-partum haemorrhage (PPH) equipment in line with trust policy. However, staff stored the PPH trolley behind a locked door. We were concerned this could delay accessing the trolley in an emergency. Following our inspection, the chief nurse told us the keypad access code had been shared with all staff when working in the ward area and staff were familiar with this access code. This meant there would be no delay in accessing the trolley if it was required. The service had also undertaken live drills to identify any risks and to date none had been identified.

The emergency trolleys were secured with tamper proof tags. We checked a random sample of consumables stored in the emergency trolleys, these were in good condition and in date.

Electrical equipment had been portable appliance tested (PAT), had been regularly serviced and conformed to relevant safety standards.

The service had enough equipment to safely care for women and babies. We reviewed the service record for 8 pieces of equipment including observation machines, weighing scales, ultrasound machines and cardiotocography (CTG) machines. All of them had been serviced and calibrated in line with trust policy. This was an improvement since our previous inspection where we issued the trust with a requirement notice for not completing equipment checks in line with trust policy.

The service lacked storage space and corridors were cluttered with consumables and equipment. Staff told us this was because there was a lack of storage space and sometimes deliveries arrived all at once. We were concerned this could pose a risk to staff and women as they moved through the department in an emergency. Following our inspection, the trust service leaders told us the cluttered corridors was because there had been a stock delivery.

Staff disposed of clinical waste safely. Staff segregated waste appropriately and disposed of it appropriately. Staff labelled and did not overfill sharps waste containers.

Staff ensured women could reach their call bell. We spoke with 3 women and saw their call bells were within easy reach.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used the modified early obstetric warning score (MEOWS) tool to monitor women for signs of deterioration of their health.

In the labour ward, staff completed the MEOWS on an electronic handheld device which automatically alerted the medical team and the clinical outreach team if a critical score was recorded.

During antenatal care episodes, staff completed MEOWS manually and recorded the score in the woman's electronic record. We reviewed 3 electronic care records that showed staff calculated MEOWS correctly and escalated critical scores appropriately.

The service had a policy for the monitoring of fetal growth rates (FGRs). The trust shared the saving babies lives care bundle dashboard with staff and visitors to the unit. Data on the dashboard showed staff carried out risk assessments for FGRs in 95%, 100%, 100% and 90% of pregnancies from January to April 2022 respectively in line with the policy. The trust did not report any data for May to July 2022. Staff told us this was because it was difficult to draw data out of the new electronic reporting system.

Triage was completed by a midwife in line with the Birmingham Symptom Specific Obstetric Triage System (BSOTS). There were 2 ledgers for the triage area, 1 for elective (booked) admissions and another for self-referrals or urgent attendances. Women were prioritised according to their symptoms, as either red, amber, or green priority. Women risk assessed as red were seen immediately in labour ward. Three entries in the ledger for the day of our inspection confirmed those women risk assessed as amber saw a midwife within fifteen minutes of arrival. Ward managers monitored the BSOTS performance monthly.

Staff completed risk assessments for each woman on admission / arrival, using nationally recognised tools, and reviewed these regularly. Three care records we reviewed confirmed midwives completed risk assessment for obesity, gestational diabetes and venous thromboembolism (VTE) at the women's booking appointment and throughout their antenatal care period.

Women were asked routine enquiry questions; this was evident in the 3 sets of records we reviewed. The routine enquiry refers to staff asking all women about their experience of domestic abuse regardless of whether or not there are any indicators or suspicions of abuse.

Staff knew about and dealt with any specific risk issues. Staff ensured risk assessments were completed and acted on in a timely way at every contact with the woman. This was evident in the 3 sets of records we reviewed. This meant women were assigned to the appropriate care pathway based on their risk status. Those women identified as high risk were assigned consultant led care and those who were identified as low risk received midwife led care.

Maternity

Staff carried out carbon monoxide (CO) monitoring in line with guidance. This was evident in the 3 sets of records we reviewed. Risks associated with smoking were planned to be recorded at the initial assessment, and at 36 weeks. Saving babies lives care bundle data from July 2022 confirmed CO monitoring had been carried out at booking and at 36 weeks in 99.7% and 85% of pregnancies respectively.

The service had a policy in place for the care of women with diabetes in pregnancy. The policy stated from 36 weeks gestation women should attend for weekly review. We spoke with 1 woman who was following the diabetes in pregnancy pathway and they confirmed their attendance for weekly blood glucose checks.

The service used the World Health Organisation (WHO); five steps to safer surgery checklist for all theatre procedures. Two members of staff counted and signed swab counts post caesarean section (CS). This was evident in the 3 sets of records we reviewed. This ensured all swabs were accounted for at the end of the surgery.

Staff completed a CTG assessment tool sticker and inserted this in the paper care record at the start and end of each CTG trace. Two midwives reviewed the CTG and confirmed this by signing and dating the sticker. This was evident in the 3 sets of records we reviewed. This was in line with national guidelines and confirmed fresh eyes reviews of the trace had been completed.

Paper care records we reviewed were legible and orderly. Staff had signed and dated prescription charts and recorded the woman's allergy status.

There were clear processes for doctors to call for support from consultants in and out of hours. For example, conditions such as pre-eclampsia, maternal collapse, post-partum haemorrhage or concerns relating to MEOWS with a score over 6.

Staff had access to interpreters for women who did not speak or understand English. One set of care records we reviewed for a woman who did not speak English confirmed an interpreter had been present for the woman's booking appointment. The appointment had also been extended to 2 hours long. This was in line with trust policy.

Shift changes and handovers included all necessary key information to keep women and babies safe. Midwives completed detailed records of women's' situation, background, assessment, recommendation (SBAR). Staff used stickers inserted in the woman's care record at each shift handover which ensured a complete handover of relevant care information was completed.

The service had 24-hour access to mental health liaison and specialist mental health support. There was a dedicated mental health midwife who was accessible to staff offering advice and support where necessary.

Staff completed or arranged psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff followed the local guideline in place for mental health referrals if staff were concerned that a woman had deteriorating mental health concerns.

Women carried a "maternity passport" during their pregnancy. This was a booklet that contained information relating to their appointments. It also had contact details for access to the triage service, what to do if fetal movements were reduced, and advice on where to get support for stopping smoking, domestic abuse and alcohol during pregnancy.

Notice boards throughout the triage area displayed information for women on healthy eating and maintaining a healthy body weight during pregnancy and where to get additional support and advice.

Maternity

Midwife staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience. However, managers regularly reviewed staffing levels and skill mix and moved staff within the department regularly in order to keep women safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. The trust had challenges with the recruitment of midwives due to a national shortage in this staff group. Managers told us they had a recruitment plan which included international recruitment, return to practice midwives and increasing the number of student midwives.

Throughout June, July and August 2022, the midwife to birth ratio was reported to be 1:26, 1:25, and 1:25 respectively. This was slightly higher than the planned 1:24.

Managers calculated and reviewed the number and grade of midwives, healthcare assistants needed for each shift in accordance with national guidance. The service used the birth rate plus acuity tool every 4 hours to ensure staffing was appropriate for each area.

The number of midwives and healthcare assistants did not always match the planned numbers. On the day of our inspection, the service was operating with 2 midwives less than planned. This meant staff who should have been supernumerary were counted in the numbers and were working clinically.

We reviewed the staffing rota for the central delivery suit, it showed actual midwife staffing did not match the planned midwife staffing on 21 days between 15 August to 11 September 2022.

In MB2, actual staffing did not match the planned staffing on 18 days between 15 August to 11 September 2022.

The duty manager reviewed staffing levels versus patient acuity throughout the department regularly during the day. Staff moved between antenatal/postnatal ward and the delivery unit to meet the needs of the women in each area. The community midwives could also be required to cover in the unit to ensure appropriate skill mix and staff numbers in each area.

Managers used bank staff and requested staff familiar with the service. The service did not use agency staff but gaps in the rota were covered by bank staff or community midwives where possible. We were also given examples of where ward managers and specialist midwives worked clinically instead of completing office days or undertaking their other activities.

Staff told us they mostly got their rest breaks during shifts.

The service had reducing vacancy rates. At the time of our inspection, the service had a 17% vacancy rate. The service had recruited 15 new midwives, and these were due to start their employment in the coming weeks.

The service was currently operating on the summer plan which had been developed to mitigate the risks of reduced staff numbers which was compounded due to increased annual leave. MB1 and MB2 (pre and postnatal areas) had been merged and the MLBU had closed 2 delivery rooms to ensure staffing was appropriate in each area.

Maternity

The 25 bedded combined pre and postnatal ward was staffed by 4 midwives and 2 HCAs plus a nursery nurse during the day and 3 midwives and 2 HCAs during the night. There was also a newborn midwife who completed the newborn and infant physical examinations (NIPEs) and supported with the discharge of women.

The 13 bedded triage service was operated from MB1 until midnight daily. After midnight the service was available from the labour ward. The number of staff in the triage area was planned as 3 midwives and 1 health care assistant (HCA) during the day and 2 midwives and 1 HCA until midnight.

The 5 bedded extended care area was staffed by 7 midwives and 2 HCAs during the day and night. Two of the midwives in this area were band 7 and 1 was always supernumerary.

Staffing on the labour ward was planned as 2 band 7s, 1 of which would be supernumerary as the coordinator, 5 midwives and 2 HCAs.

The MLBU was operating with 2 midwives each day and 2 each night.

The community midwifery service was staffed by 8 midwives.

Medical staffing

The service had 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. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep women and babies safe. We reviewed the rota for the 3 week period 29 August 2022 to 18 September 2022, which showed the service had a good skill mix of medical staff on each shift.

The medical staffing rota shared by the trust showed, for the 3 week period 29 August 2022 to 18 September 2022, the number of actual medical staff mostly matched the planned number.

The service had 14 consultants, 4 of which covered gynaecology. The service always had a consultant on call during the evenings and weekends.

The service had reducing vacancy rates for medical staff. The service had recently recruited 2 additional consultants who were due to join the service in November and December 2022.

One consultant was assigned to cover the labour ward during the morning, afternoon and evening 7 days per week. There were no gaps in this cover during the period 29 August 2022 to 18 September 2022.

The maternity dashboards showed that from April to July 2022, consultant presence on delivery suit was 100%.

A minimum of 1 registrar (ST3 -ST7) was assigned to cover labour ward during the morning, afternoon and evening 7 days per week, with 1 registrar overnight. There were no gaps in this cover during the period 29 August 2022 to 18 September 2022.

Managers could access locums when they needed additional medical staff. For the week 29 August to 2 September the night shift was covered by a locum doctor who regularly worked in the service.

Maternity

A minimum of 1 senior house officer (SHO) (FY2 -ST2) was assigned to cover labour ward during the morning, afternoon and evening 7 days per week, with 1 SHO overnight. There were no gaps in this cover during the period 29 August 2022 to 18 September 2022.

There were mostly sufficient numbers of registrars and SHOs to ensure there was medical cover available in all clinical areas between 8am and 8.30pm. On 2 days (29 August and 5 September) during the period 29 August 2022 to 18 September 2022, the service did not have a designated SHO to cover MB1/MB2. Prenatal and gynaecology services shared a registrar and SHO. Staff told us they could always be called to the unit if they were elsewhere.

Doctors reported that the on call rota was 1 in 10, and they were happy with this provision. There were clear escalation processes for consultants to come into the hospital and doctors told us consultants were always responsive.

Records

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

Women's notes were comprehensive and all staff could access them easily. We reviewed 3 sets of patient care records. Prenatal care records were electronic. Records of care delivered during each woman's stay in hospital were paper based. The records we reviewed were clear, legible and comprehensive. Staff signed and dated each entry.

Records were stored securely. Staff stored paper records in closed notes trolleys. Trolleys were located at the nurse station and secured with a coded lock. This was an improvement from our previous inspection where we issued the trust with a requirement notice in relation to the storage of women's records.

We asked the trust to share data relating to records audits. The trust told us there had been no records audits undertaken since October 2019. The trust told us this had been impacted by the introduction of their new paperless Maternity IT system where they needed to set up a record keeping report to be able to assess how effectively this was being used. The service had not been able to achieve this due to issues they had experienced with the electronic system and competing priorities. The service had employed a band 7 digital midwife who started at Southend in July 2022 and this was one of the priorities to be completed.

Medicines

The service used systems and processes to safely store medicines.

Staff stored and managed all medicines safely. Staff stored and managed medicines in line with the provider's policy. Medicines were stored in cupboards in locked rooms and controlled drugs (CDs) stored in a locked CD cabinet.

Staff checked fridge temperatures where medicines were stored. Temperature monitoring charts confirmed staff had checked the temperature in line with policy and there had been no omissions. This was an improvement on our previous inspection where we issued the trust with a requirement notice in relation to the storage of medicines.

Incidents

Staff recognised and reported incidents and near misses, managers investigated incidents and shared lessons learned with the team. However, incidents were not always investigated and closed in line with trust policy.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. The service had an incident reporting policy. The policy was in date and version controlled.

Maternity

Staff reported serious incidents clearly and in line with trust policy. At the time of our inspection, the service had a backlog of 35 open serious incident investigations. Of the 17 incidents undergoing investigation inhouse, 12 (70%) had been open for more than 60 days.

The trust division leads described the process of escalation around incidents; the division leads undertook an Initial Management Review (IMR) to establish the facts known at the time and presented the report to the Executive Review Group (ERG) for a decision on level of investigation. This meant all incidents declared had an initial review which included consideration of any immediate safety concerns and required actions.

Staff knew what incidents to report and how to report them. All the staff we spoke with knew how to report incidents using the online electronic system.

Staff reported serious incidents clearly and in line with the trust policy.

Staff received feedback from investigation of incidents. This was evident in the women's health governance group meeting minutes dated 10 June 2022, 8 July 2022 and 5 August 2022. Learning from incidents was also shared by memo, email and closed social media group on a Friday in a document called the Friday Faux Par.

Two members of staff we spoke with said they received individual feedback from incidents. Staff could describe changes to a process following a previous incident. This confirmed there had been learning from incidents.

Staff met to discuss the feedback and look at improvements to patient care. Staff described "hot" and "cold" feedback which the trust had introduced to help share learning from incidents. Hot feedback happened on the day of the incident to try to identify any immediate learning. Cold feedback happened after the investigation to share any learning.

The service had no never events on any wards in the 6 months March 2022 to August 2022. The service reported 5 serious incidents during the same period.

Staff understood duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Two medical staff members we spoke with knew about duty of candour but had never had to carry it out.

Minutes of the Trust Board meeting held on 14 July 2022, confirmed the board had oversight of serious incidents which had occurred in the service.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Maternity

Staff followed 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, which were in date and followed national guidance for example Resuscitation Council UK and Practical Obstetric Multi Professional Training (PrOMPT).

Staff showed us that they could easily access policies and guidelines which were held centrally and available through their intranet system.

The trust had processes in place to monitor and assess women with additional needs for example reduced fetal movements and gestational diabetes.

A review of women's notes indicated the fetal growth was plotted on the fetal growth chart in line with national guidance.

Policies and procedures relating to emergency care were also available in paper format stored in folders outside women's rooms, this was to ensure easy and speedy access. Staff told us these were replaced any time there was an updated version.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. The trust had a dedicated mental health midwife and the community perinatal mental health midwife. Staff completed mental health training as part of the mandatory training programme.

Staff referred women for mental health assessments when they showed signs of mental ill health, such as depression. Staff described referring women to the perinatal midwife for support with mental wellbeing. Two women we spoke with told us they had met with the perinatal midwife for ongoing support with their anxiety and depression once they had left hospital with their newborn baby.

The service had not undertaken any audits of women's records since 2019. This meant they were not assured staff were delivering care in line with national guidance.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers made sure staff received any specialist training for their role. For example, staff took part in Practical Obstetric Multi Professional Training (PrOMPT) as part of a monthly programme.

Consultant and midwife PrOMPT training was reported as being compliant with trust target. Service leads told us anaesthetic consultants did not have good compliance because of difficulties in attending due to clinical responsibilities. Lack of anaesthetist attendance was also recorded on the service risk register.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The trust continued to develop staff skills and knowledge despite the pandemic. The service had implemented physiological Cardiotocography (CTG) interpretation and ensured staff had the training and support to successfully implement into practice.

Cardiotocography (CTG) training had been completed by 100% of midwives and 100% of doctors (July 2022) which was better than the trust target of 90%. Trust data showed that 55 staff were trained in new-born screening. One trained staff member was available on shift Monday to Friday.

Data provided by the trust as part of the saving babies lives care bundle dashboard showed 100% of nursing and midwifery and medical staff were trained in effective fetal monitoring during labour.

The trust confirmed 100% of band 7 labour ward coordinators (band 7 midwife) were trained to provided high dependency unit (HDU) care. There was 1 band 7 on every shift, 7 days per week, 365 days per year.

Managers did not always support nursing staff to develop through yearly, constructive appraisals of their work. Only 54% of nursing and midwifery staff had received an annual appraisal (target 85%). The division leaders told us this was due to staff having to work clinically during the summer months due to midwife staff shortages. Senior leaders told us it was a priority to address the appraisals but did not have a robust plan to improve appraisal compliance. Two members of staff told us they had received their annual appraisals and that they were useful and helpful. Staff described being able to obtain external training if appropriate.

Ninety six percent of medical staff had received an annual appraisal, this was better than the trust target of 85%.

Before the COVID-19 pandemic, staff rotated through all areas of maternity service. Due to staffing issues and the need to keep teams separate for COVID -19 precautions, this had not been the case recently. Service leaders told us once staffing improved after the summer annual leave period they were looking to reintroduce rotation within the department.

There were processes in place to protect babies and prevent abduction. Staff reported that they had completed a baby abduction drill recently to test the efficiency of the process.

The clinical educators and practice development leads supported the learning and development needs of new and junior staff and the service had recently introduced a legacy midwife. This was a retired and returned to work experienced midwife. The aim of the role was to support new midwives who had completed training during the pandemic and therefore possibly felt less confident in their new roles. The trust also provided a preceptorship scheme for newly qualified midwives.

Staff carried out live skills drills. The most recent one (July 2022) was a post-partum haemorrhage (PPH) and was based on an actual PPH which had occurred in the department recently.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff reported, and we saw, that there was positive multidisciplinary team (MDT) working. Conversations were respectful and inclusive. We heard that doctors were very supportive of midwifery staff and acted accordingly when there were staffing pressures, taking on additional tasks.

Maternity

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. We observed a mid-day MDT. The MDT was well attended, and included a consultant, an anaesthetist, midwife, delivery suit coordinator and a number of junior doctors. There was clear discussion about the afternoon's planned caseload and anything pending.

The trust shared the MDT handover register for 8am and 6pm. The register showed that the anaesthetist was present on 9 of a possible 22 occasions (41%). Reasons for non-attendance were "with a patient/ epidural". Staff explained how anaesthetists held their own anaesthetist to anaesthetist hand over to ensure the relevant patient information was shared.

Women who needed diabetic antenatal care received care for the diabetes specialist midwife.

The community midwife service was based in the department and community midwives attended the unit every morning for handover. This ensured good communication between the community staff and the hospital staff.

Staff could access the neonatal unit directly from the labour ward when a baby required transfer. If the baby required transfer to a tertiary service the neonatal team would arrange this.

Is the service responsive?

Inspected but not rated

We inspected but did not rate this service.

Access and flow

Mostly, people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment of women were in line with national standards.

Managers monitored waiting times and made sure women could access services when needed and received treatment within agreed timeframes and national targets. The service had introduced the Birmingham Symptom-specific Obstetric Triage System (BSOTS). BSOTS is a maternity triage system, which improves the safety of mothers, babies, and the management of the department

Audit data showed a trend of improving service. Audit data for August 2022 showed 89% of women were triaged within 15 minutes of arrival, and 84% saw a doctor within the appropriate time frame for their rating. This was an improvement on June where 77% of women were triaged within 15 minutes and 74% saw a doctor within the appropriate time frame for their rating and July where the data showed 84% and 81% of women were triaged and seen by a doctor respectively.

When women had their appointments cancelled at short notice, managers made sure they were rearranged as soon as possible and within national targets and guidance. On the day of our inspection, the service was at capacity for inductions of labour. This meant that women who were due to attend the unit for planned inductions needed to be to postponed. All these women were asked to come to the unit for a review including a CTG and observations. Midwives prioritised those women who had to be induced that day and those that could safely wait until the next day based on clinical priorities.

Maternity

At the time of our inspection, due to summer staffing pressures, the service had merged the antenatal and postnatal care areas. Most postnatal women were cared for in a separate area of the ward to prenatal women. However, on the day of our inspection, 3 women receiving antenatal care were being cared for in the same area as postnatal women. Staff told us this was due to an increased number of deliveries on the day. We spoke with the women receiving antenatal care, who told us they were happy with the care they were receiving.

The maternity dashboard confirmed that for the 4-month period April to July 2022, the number of home deliveries exceeded the trust target of 3%. At the time of our inspection, the home birth rate was 5%. This exceeded the national target.

Data displayed in the midwife led birth unit (MLBU) confirmed there had been 33 babies born in the unit in August.

Managers and staff started planning each woman's discharge as early as possible. Staff communicated with the community midwife team through the electronic record and a written book when women were about to be discharged. This enabled community midwives to follow on each woman's care in a timely way.

Staff recorded each woman's discharge plan through a workflow in the electronic care records. Most women had a midwife led discharge. Other women received a medical review before discharge.

Staff planned each woman's discharge carefully, particularly for those with complex mental health and social care needs. One woman we spoke with told us they suffered from anxiety and depression and confirmed they had been given the contact details of the perinatal community mental health support midwife to support them once they were discharged.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Staff understood the policy on complaints and knew how to handle them. Where possible concerns were addressed at the time. Staff escalated to the midwife in charge or matron when issues arose, enabling concerns to be addressed immediately.

Managers investigated complaints and identified themes. Concern themes were usually around treatment plans and communication.

Staff told us that the number of complaints had reduced since the introduction of local resolution. This involved ward managers addressing the complaint immediately rather than waiting for a formal complaint to be received. However, the service still had approximately 12 formal complaints in progress.

Staff told us learning from complaints was shared at daily handover and by email called the "Friday faux par" or closed social media group.

On the midwife led birthing unit (MLBU), staff encouraged women to leave feedback in a book. All the entries we read were positive and included the words "amazing experience", "supported", "calming" and "cared for".

Maternity

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 understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The maternity service was led by a multidisciplinary triumvirate leadership team consisting of a site based head of midwifery, a site based clinical lead obstetrician and a trust wide deputy director of operations for maternity and neonatal services.

Staff were experienced in their respective roles and the triumvirate was well established. The team were supported by matrons and ward managers and reported to the director of midwifery (DOM).

Service leaders were experienced in their roles and could describe the risks and challenges faced by the service.

Service leaders described feeling supported by the executive leaders and the trust board.

The DOM was not routinely present at the trust board meetings. Trust Board held on 12 May 2022 showed the DOM was present at the meeting for a specific item only. Meeting minutes of the trust board held on 14 July 2022 showed the DOM was not present and not in the list of apologies, maternity services were represented for a specific item on the agenda only.

All the medical, nursing and midwifery staff we spoke with spoke positively about their managers, colleagues and local leadership team and told us they were visible and approachable.

Vision and Strategy

The service did not have a local vision for what it wanted to achieve and a strategy to turn it into action.

Service leaders told us there was no local strategy and vision in favour of the development of the trust wide maternity improvement plan which the HOMs and matrons had been engaged in developing. The plan brought together improvements the service needed to make that had been identified by the CQC inspection, the Ockenden report and the clinical negligence scheme for trusts (CNST).

At the time of our inspection, service leads were not able to describe how the service monitored the progress of the improvement plan. The first review meeting was scheduled for October 2022.

Culture

The service had an open culture where staff could raise concerns without fear.

Staff said they felt they could raise concerns with service leaders and colleagues. However, a number of staff contacted CQC prior to the inspection and told us that concerns were not always addressed appropriately by local managers.

Staff were aware of the freedom to speak up guardian (FTSUG) and how to access them if they wanted to. None of the staff we spoke with had used the service.

All the staff we spoke with told us they were encouraged to report incidents. Staff were aware of duty of candour but none of the staff we spoke with had been involved in discharging this regulation.

The service displayed its values and behaviours at the entrance to the unit and encouraged staff to challenge any colleagues who were not demonstrating those behaviours.

Staff spoke positively about their local teams and said they felt well supported by colleagues. Staff told us it was a friendly place to work and teams worked well together.

Governance

Leaders did not consistently operate effective governance processes, throughout the service. There was little evidence of monitoring and reviewing the performance of the service. Staff at all levels did not have regular opportunities to meet, discuss and learn from the performance of the service.

Staff development was not always given sufficient priority. Staff did not have time to complete their annual mandatory training.

Staff appraisals had not been carried out in line with trust target. Only 54% of nursing and midwifery staff had received an annual appraisal (target 85%), this meant staff had not been given the opportunity to discuss their own performance.

Clinical and internal audit processes are inconsistent in their implementation and impact. Completion of audits had not been undertaken, for example records audits since 2019. Data records on the saving babies lives dashboard were incomplete.

Women's and children's services, which included maternity services had become a standalone care group since the 1 September 2022 and was now care group 5. Prior to this date women's and children's services had been part of care group 4. This change had been implemented in order to strengthen the leadership of Women's and Children's services.

The service had recently established a local site-specific governance structure which consisted of a band 8A lead midwife for maternity safety, supported by 2 band 7 midwives. The band 8A reported to the trust wide band 8B deputy head of maternity governance. Service leaders told us that in these early days they felt positive this was the right thing to do and would provide the necessary governance to provide an effective service. The structure was not yet embedded.

The service had a meeting structure in place to support the delivery of the service and enable escalation of issues from ward to board.

Ward managers meetings were held every other week. Meetings were chaired by matrons and the HOM was present. Meeting minutes dated 13 July 2022 and 6 September 2022 demonstrated staffing and quality and safety were regularly discussed.

The Women's Health Governance Group meeting (site based) had a standard agenda which included a review of incidents, risk and quality. Meeting minutes dated 10 June 2022, 8 July 2022 and 5 August 2022 confirmed the group met monthly chaired by the HOM.

The operations manager, clinical lead for the service, HOM and DOM met formally on a weekly basis, however, the HOM communicated with the DOM on a daily basis.

The site-specific risk and governance team met once each month to discuss local issues and the dashboard and met with the wider trust risk team the following week.

The service had 2 safety champions, 1 midwife and 1 consultant obstetrician. Safety champions met weekly and escalated concerns through the risk and governance team to the board.

Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. However, they did not always use systems to manage performance effectively.

The service had a risk register. We reviewed the service risk register. There were 20 open risks. All risks were rated red, amber or green (RAG rated) depending on their risk score. All risks had named owners and review dates.

The service risks described by senior service leads reflected those on the service risk register; for example, staffing, out of date guidelines and governance among others.

Staff displayed the saving babies lives dashboard in the delivery suit. This meant all staff could be aware of performance of the service. However, data was missing for the 3 months May, June and July. This meant we could not be assured the service leads had oversight of performance for those months.

The service had not completed records audits since October 2019, this meant we were not assured leaders had oversight of the quality of records staff were keeping.

The service had a maternity improvement plan which pulled together all the areas of improvement required as identified by the Ockenden report, clinical negligence scheme for trusts (CNST) and CQC's previous inspection (December 2021). Service leaders met on alternate weeks to review each area of improvement.

July 2022 data displayed in the delivery suit showed the service was rated amber for compliance with all actions from the Ockenden report and 4 of the 10 CNST actions were green with the remaining 6 rated amber.

Minutes of the Trust Board held on 12 May 2022 confirmed the board had oversight of performance in relation to the Ockenden actions to be implemented.

The service had a trust wide board level safety champion and a local midwife safety champion.

The multi disciplinary team (MDT) safety champion meeting was held monthly and included heads of midwifery (HOMS) ward safety champion, matrons, CNST lead and midwives. The meeting was chaired by the Director of midwifery (DOM)

Two medical staff we spoke with could describe how they had completed scenario training for post partum haemorrhage (PPH).

The maternity dashboard was routinely discussed at risk and governance meetings held monthly. Women's Health Governance Meeting minutes dated 10 June, 8 July and 5 August 2022, also evidenced regular discussion and oversight of the dashboard.

Minutes of the Trust Board meeting held on 14 July 2022 confirmed the board had oversight of serious incidents which occurred in the service.

Incidents were reviewed every 24 hours in the presence of the risk and governance lead for the service and harm rated. Any immediate actions or learning were shared with the midwives at handover.

Information Management

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had recently introduced electronic patient records. This had left staff unable to access some data they had previously used for monitoring. For example, records audits. The service had recently employed an IT digital midwife who was tasked with developing the process for downloading the data and analysing it.

Problems with connectivity for electronic patient records in some rural areas of the community. This meant midwives had to complete paper records and copy the information onto the electronic record information at a later date.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had established a patient experience midwife in order to improve friends and family feedback scores and patient experience.

The service leaders had recently introduced (July 2022) an award scheme for staff called the “maternity star of the month award”. Staff could nominate colleagues for the award in recognition of hard work and peer support.

The national staff survey results of 2021 (published March 2022) showed that trust wide, maternity staff consistently scored worse than the overall organisational score. This meant that staff in maternity were less satisfied than staff in other areas of the trust. Senior leaders told us this was a true reflection of how maternity staff at Southend University hospital felt.

In response to the staff survey, each division developed a local staff experience improvement plan. The leadership team told us they had improved communication to staff by introducing a monthly briefing and had increased awareness of sources of support for staff such as FTSUG, professional midwifery advisors and safety champions.

The service had a poster at the entrance to the unit which said “hello” in multiple languages.

Service leaders had a good understanding of the populations they served. The area had pockets of high social deprivation, women with high BMI and increased number of smokers. The service cared for an increased number of teenage mothers and a large Jewish community.

The service had a longstanding relationship with the Jewish women and a good understanding of their needs and cultures. Less than 10% of the women cared for came from black and minority ethnic communities. The service was reviewing Better Births recommendations and engaging with maternity voices partnership (MPV) and the public health midwife to ensure they were liaising with hard to reach communities.

Maternity

Learning, continuous improvement and innovation

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

Nursing staff told us they were able to access additional external training if they wanted it.

Medical staff told us they were only eligible for additional external training if they were compliant with their mandatory training.

Service leaders told us they had a “desire to be proactive” in relation to improving the service but were restricted by low nursing staff numbers.

Service leads would like to introduce a discharge booklet to provide all relevant information in one place to the women being discharged from the ward.