University Hospitals Dorset NHS Foundation Trust

Poole Hospital

Inspection report

Longfleet Road
Poole
BH15 2JB
Tel:

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Ratings

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

Our findings

Overall summary of services at Poole Hospital

Requires Improvement 

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

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

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

Maternity services at Poole Hospital are provided by University Hospitals Dorset NHS Foundation trust. This was the first time we rated maternity services at Poole Hospital since Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust merged on 1 October 2020. The maternity ratings inherited from the previous provider at the last inspection in January 2020 was good overall.

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

Maternity

Inadequate ↓↓

We inspected the maternity services at Poole Hospital which include antenatal, intrapartum (care during labour and delivery), and postnatal maternity care.

The maternity unit includes a consultant-led delivery suite, maternity triage, and wards for antenatal, postnatal and transitional care. The alongside midwifery-led birth centre, Haven birthing suite provides intrapartum care for women and birthing people who met the criteria and were assessed to have lower risk pregnancies. The Haven birthing suite has 5 birthing rooms, all of which have ensuite facilities and 3 included access to a birthing pool

In the calendar year January to December 2021 there were 3903 deliveries at Poole Hospital. The home birth rate was 1%.

The rating for this service went down. We rated maternity services as inadequate for safe and well led because:

- The service did not always have enough midwifery or medical staff to keep women and babies safe. Systems and processes for assessing and responding to risk in maternity were not always effective, especially in maternity triage. The maintenance of the environment especially in relation to the emergency call bell systems were not sufficient to maintain patient safety. Managers did not always investigate incidents thoroughly or in a timely way.
- The delivery of high-quality care was not assured by the governance and risk management processes. The maternity leadership team were newly formed so there was not always sufficient capacity or experience in the team. Not all risks identified during the inspection had been identified by the service and mitigated effectively.

However:

- Staff understood how to protect women and children from abuse, the environment was visibly clean, and staff managed medicines safely.

Following the inspection, the trust was served a warning notice under Section 29A of the Health and Social Care Act 2008 requiring them to make significant improvements to the safety of the service in relation to processes for staff to summon help in an emergency by 5 December 2022.

The trust wrote to CQC on 1 December 2022 to submit an action plan and confirm the immediate actions taken to improve the safety of the service. The trust has kept CQC informed of progress on improvements.

Is the service safe?

Inadequate ↓

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

Mandatory training

The service provided mandatory training in key skills to all staff but not all staff were up to date with regular updates to training.

Maternity

Staff received but were not always up to date with their mandatory training. Overall, compliance with mandatory training was 83%. This did not meet the trust target of 90%.

As of September 2022, 100% of staff had completed resuscitation level 1 and 66% of staff had completed resuscitation level 2. Basic life support training was completed every year and midwives working in higher risk areas could access advanced life support training.

The mandatory training was comprehensive and met the needs of staff. Staff completed 'professional obstetric multi-professional training' (PROMPT) once a year. Data showed as of September 2022 compliance was above 90% for midwives and consultant obstetricians. However, compliance was low for other staff groups. For example, 30% of maternity support workers, 47% of theatre staff, 52% obstetric trainees and 58% obstetric anaesthetists had completed PROMPT training.

Staff completed but were not always up to date with training in fetal monitoring. As of October 2022, 86% of staff had completed fetal monitoring training and competency tests. This did not meet the trust target of 90%.

Newborn life support training was included in the 'professional obstetric multi-professional training' day. Data from the monthly maternity quality and safety champions report showed midwife compliance with this training was between 68% and 100%, 58% for midwifery support workers, 61% for consultant obstetricians and 43% for obstetric registrars. This did not meet the trust target of 90%.

Staff did not always complete regular skills and drills training. Although staff had access to a training video on waterbirth and evacuation of the birth pool, staff did not complete birth pool evacuation drills on Haven birthing suite.

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.

Staff received training specific for their role on how to recognise and report abuse. As of September 2022, 100% of staff had completed safeguarding adults level 1 training, 78% had completed safeguarding adults level 2 training, 100% had completed safeguarding children level 2, 100% had completed safeguarding children level 3 and 100% of the midwifery management team had completed safeguarding children level 4.

Staff we spoke with could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

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 how to make a safeguarding referral and who to inform if they had concerns. Staff had access to the 'oasis' maternity safeguarding team to support with safeguarding women and children. The 'oasis' maternity safeguarding team was staffed by 9 midwives and two support workers. Managers ensured staff receive safeguarding supervision on at least on a quarterly basis.

Staff followed the baby abduction policy and completed baby abduction drills. The safeguarding lead midwife told us there had been a recent baby abduction drill and staff were reminded of the process to inform security within the maternity unit before calling the police.

Maternity

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. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE) most of the time. Managers did not complete hand hygiene audits in all maternity areas. Between August and October 2022 overall compliance was between 98% and 100% but not all areas submitted monthly hand hygiene audits including antenatal day assessment, antenatal and post-natal wards and transitional care.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to show equipment was clean and ready for use.

Environment and equipment

The design and maintenance of facilities did not always protect women and babies from harm. The emergency call bell system was not fit for purpose.

The call bell system worked intermittently and was a known, but not effectively mitigated risk. An incident in September 2021 on Haven birth unit led to a Health Safety Investigation Branch investigation which was reported in April 2022. At the time of inspection there were three different types of emergency call bell system throughout the maternity unit. Some of these systems only worked intermittently due to issues with the Wi-Fi signal. Action has been taken since our inspection to mitigate the risk.

The electronic baby tagging system was not in use at the time of inspection due to ongoing issues with the functionality of the system and an incident when a tag had caused damage to a baby's skin. As a result, the trust took the decision to ensure staff escorted mothers and babies leaving the unit to the door and the service had 24-hour, 7 day a week security staffing.

The design of the environment followed national guidance. The maternity unit was secure and different areas of the unit could only be accessed through a swipe-card system. The service had two maternity theatres accessible from the central delivery suite. The neonatal intensive care unit was located within the maternity unit. The intensive care unit was on the main hospital site across the road. To access intensive care on the main site women would be transported by ambulance.

Staff did not always carry out daily safety checks of specialist equipment. For example, the neonatal resuscitaire in chamomile room on Haven birth unit should have been checked daily but was not checked on 9 out of 31 days in October 2022 and was not checked on 6 out of 8 days in November 2022 (we visited on 8 November). On the postnatal ward the adult resuscitation trolley was not checked on 3 out of 31 days in October 2022, 5 out of 30 days in September 2022 and 4 out of 31 days in August 2022.

The service had suitable facilities to meet the needs of women's families. However, the postnatal ward had four-bed shared bays and it was therefore not always partners to stay overnight. Staff used rooms on the Haven Birth suite to enable partners to stay on a case by case basis when this facility was available.

The service had enough suitable equipment to help them to safely care for women and babies.

Maternity

Staff disposed of clinical waste safely. Sharps bins were labelled correctly most of the time, but we found sharps bins were not dated on the postnatal ward.

Midwifery Staffing

Midwifery staffing levels impacted negatively on the safety of the maternity unit. Managers regularly reviewed and adjusted staffing levels and skill mix but midwifery shifts were not always filled.

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.

Data showed staffing shortages, and the availability of maternity beds, impacted on the timeliness of induction of labour. In the past six months there were 170 delays in induction of labour. The trust has a system to review the delay to inductions taking into account individual impact risk and safety.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings most of the time. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing.

Staff did not always report all 'red flag' staffing incidents. The minutes of the May 2022 clinical leaders meeting noted staff had been 'under-reporting a few significant issues: induction of labour delays (red flags) and staffing.' Data showed, in the past six months delays to planned procedures included: 3 cancelled planned caesarean sections, 2 delays to caesarean sections (1 cat 2 emergency and 1 planned) and 3 delays to repair of 3rd degree tears.

On the day of inspection midwifery, staffing across the service was short by 5 midwives and 5 maternity support workers during the day, and 4 midwives and 1 maternity support workers short at night. While there were staffing shortages on the day of inspection, we saw the service had effective processes for regular review of staffing and skill mix in all areas. Managers moved staff around the unit to meet the needs of women using the service and to maintain safety.

Registered midwife shifts were not always filled. Between May and October 2022, the average fill rate for registered midwife shifts was 82 % on Haven birth unit, 85% on labour ward and antenatal ward and 87% on postnatal and transitional care unit. The service relied on bank staff and did not use agency midwives. The service offered financial incentives to encourage staff to pick up bank shifts.

The service had high vacancy rates. As of October 2022, the overall midwifery vacancy rate was 23% and the overall midwifery support worker rate was 20%. Managers produced updates on midwifery vacancies every month. After the inspection the trust told us the November 2022 data showed the midwifery staffing vacancy rate was 17% and the midwifery support worker vacancy rate had reduced to 11% following recruitment.

As of October 2022, midwifery staffing vacancies in postnatal ward was 10.86 WTE trained midwives. After the inspection the trust told us the November 2022 data showed the midwifery staffing vacancy shortfall had increased to 13.54 WTE on the postnatal ward."

Due to staffing challenges there were four closures of the maternity unit in the past year. When the maternity unit was closed women were diverted to other local units.

Maternity

The service had reducing sickness rates. The sickness absence rate for midwifery staff maternity reached a high of 9% in December 2021. Since April 2022 it has trended downwards and reached a low of 5% in June 2022. Midwifery sickness rates as of September 2022 were higher on labour ward (7%) and postnatal ward and transitional care unit (7%) than on other areas such as Haven birth unit (3%) and antenatal (1%).

Managers supported midwifery staff to develop through regular, constructive clinical supervision of their work. Data showed 60% of staff had received yearly appraisal. Of the 30% of staff who had not had a yearly appraisal 7% were on maternity leave, a career break or long-term sickness.

Managers made sure staff received any specialist training for their role. For example, examination of the newborn, independent prescribing and leadership courses.

Staff could access support from practice educator midwives. The service employed one full-time professional midwifery advocate, and two practice educator midwives.

The service employed a range of specialist midwives including: an audit midwife, fetal monitoring midwife, infant feeding midwife and, bereavement midwives.

Leaders had a midwifery and midwifery support worker action plan dated October 2022. Actions included recruitment of midwives trained internationally with the aim for the recruits to arrive in February 2023. There was a rolling advert for band 6 midwives that was live since August 2022.

Medical staffing

The service did not always have enough medical staff to keep women and babies safe from avoidable harm and to provide the right care and treatment.

Medical staffing shortages in the women's health directorate (across obstetrics and gynaecology) was a recorded risk on the maternity risk register since July 2017. Actions to recruit had been taken but were not fully resolved. The most recent update to the risk in October 2022 stated while staffing was improving there were still 20% gaps in medical rotas due to less than full-time working.

At the time of inspection there was dedicated medical cover for maternity triage between 13:00 and 18:00 Monday to Friday. Outside of these times midwives had to bleep a doctor on labour ward, escalate to an obstetric consultant or to the gynaecology on-call registrar. After the inspection the trust told us they had plans to provide medical cover for triage 08:00 to 20:00, 7 days a week by January 2023.

The service prioritised medical staffing on the labour ward to keep women and babies safe. Data showed consultant cover on the labour ward was consistently 72 hours a week between April and October 2022. This was in line with Royal College of Obstetricians and Gynaecologists Safer Childbirth Guidance on minimum standards for the organisation and delivery of care in labour for maternity units with 2500–4000 births a year.

Consultants completed handovers twice a day on labour ward Monday to Friday at 8am and 8pm. There was six hours consultant cover on Saturdays and Sundays. The service always had a consultant on call during evenings and weekends.

Sickness rates for medical staff were reducing. As of September 2022, the medical staff sickness rate was 4% compared to 9% in the previous 12 months.

Maternity

Maternity theatres were staffed by a theatre team who carried out planned caesarean sections every morning Monday to Friday. An emergency theatre team was also available 24 hours a day, seven days a week to staff the emergency obstetric theatre.

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. However, the records were not audited.

Women's notes were comprehensive, and all staff could access them easily. We reviewed 6 records in relation to the whole maternity pathway and 13 records in relation to maternity triage and found records were complete. When women transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely on an electronic records system.

Managers completed audits of records, but these were not completed regularly. The last maternity record keeping audit was completed in April 2022 and included a sample of 30 records completed between May 2020 and April 2022. Overall compliance was with records being 'complete and informative' was 84%. However, no action to improve compliance was identified where compliance with completion of records or risk assessments was low. For example:

- Assessment 2 Feeding Practice form completed - Day 1, 47% compliance against a target of 80% (17 applicable episodes in the audit)
- VTE completed at 20-30 weeks gestation 57% compliance against a target of 80% (14 applicable episodes in the audit)
- If BMI>30 the women is told about the increased dose in folic acid 60% compliance against a target of 80% (5 applicable episodes in the audit)
- Documented postnatal plan of care recorded 74% compliance against a target of 80% (19 applicable episodes in the audit)

Assessing and responding to patient risk

Systems for responding to risk in maternity triage did not always keep people safe. The service did not audit key maternity safety tools to ensure these were being used effectively to identify risk.

At the time of inspection, the service had ineffective processes for staff to summon help in an emergency. The service had three call bell systems in use across the unit. Some of these call bell systems were wireless and worked intermittently due to issues with the wireless signal. Following our inspection, the trust produced a standard operating procedure for call bell management in maternity.

At the time of inspection, staff used an evidence-based, standardised risk assessment tool for maternity triage. This tool rates the urgency of obstetric review needed from red, the most urgent (immediate transfer to labour ward and obstetric review) to green the least urgent (junior obstetric review needed in 4 hours).

We reviewed a sample of 13 maternity triage records for women seen between 10 October 2022 to 8 November 2022 and found three records showed women were not recorded as triaged within 15 minutes, in line with trust policy and the standardised maternity triage tool being used. Of these three records, records showed the wait for initial triage was between 18 and 42 minutes.

Maternity

Women in maternity triage were not always seen in a timely way by medical staff and the service did not monitor waiting times. Following initial midwife-led triage, 12 of the 13 records reviewed found women were graded as a 'yellow' priority and so should have been seen by a doctor within one hour. This standard was recorded to have only been met in 6 out of 12 cases. Where women had experienced a delay to doctor review, they had presented with symptoms including reduced fetal movements, abdominal pain and high blood pressure.

Maternity triage was limited to 07:00 to 01:00 daily. For women arriving between 01:01 and 06:59 it was unclear how women were initially triaged when arriving at the maternity unit in early labour. There was a risk of delay for women needing assessment and transfer to the correct maternity area. For example, in July 2022 a woman was not triaged effectively and was inappropriately admitted to the antenatal ward before being moved to central delivery suite.

At the time of inspection, the service had not been auditing maternity triage times. The service began auditing maternity triage times following the inspection.

Staffing in maternity triage was not sufficient to fully implement an evidence-based, standardised risk-assessment tool for triage effectively as maternity triage was staff by only 1 midwife and there was no dedicated medical cover. This was not in line with the national recommendation for all maternity units to implement a system to assess women in triage, to identify women needing immediate obstetric review. Staff told us they would escalate clinical concerns when needed and there were times when consultants would review patients in the day assessment unit.

After the inspection the trust submitted a maternity triage action plan which included actions to improve midwifery and medical staffing of triage in the short and long term with a plan to recruit staff to cover a 24/7 triage service.

Staff did not always complete risk assessments for each woman antenatally, on admission arrival, using a recognised tool, and reviewed this regularly, including after any incident. Ensuring staff risk assess women at each contact throughout the maternity pathway was not audited by the trust.

Women could access specialist antenatal clinics such as pre-term birth, diabetes and twin pregnancy clinics. The consultant midwife ran a birth choices clinic with the obstetric lead.

Staff monitored fetal wellbeing using a cardiotocograph (CTG) machine. Staff used a 'fresh eyes' approach to review CTG progress, and the trust had appointed a fetal wellbeing midwife to support staff training and decision making. In 6 out of the 6 records we reviewed staff used the fresh eyes' approach to CTG monitoring. However, managers had not completed CTG audits in 2022 as the last recorded audit was in 2021. The trust told us CTG audits were due to be completed in the next three months.

If women and birthing people had concerns about their pregnancy or thought, they were going into labour they could call 'labour line' and speak with a midwife. The 'labour line' telephone service was available 24 hours a day, 7 days a week. If staff identified concerns following an initial call woman were asked to attend day maternity triage or the labour ward.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff screened women for depression using the 'Whooley questions.'

Staff shared key information to keep women safe when handing over or receiving their care to others. Staff used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information.

Maternity

At the time of inspection, managers did not audit the effectiveness of use of the SBAR tool within the maternity unit, only in relation to safeguarding where women were booked for maternity care at other units other than Poole Hospital. Data from the SBAR audit completed on a sample of 20 records between 1 January 2022 and 30 June 2022 showed handover was carried out using the SBAR format in 75% of cases reviewed. No actions had been identified by the audit lead to improve performance in this audit.

The trust told us the new electronic maternity records system would support them to audit use of SBAR and this would be completed within the next three months.

Staff in maternity theatres used the World Health Organisation (WHO) surgical safety checklist. Data showed staff completed monthly audits of WHO checklist compliance in maternity theatres. Data showed between for the past three months August to October 2022 average compliance with the WHO sign in process was 92% and 89% for the sign out process. It was not clear from the data submitted if the trust had a target for compliance.

On the postnatal ward staff used an electronic system to record newborn early warning score (NEWS).

The service monitored compliance with timeliness standards for completion of newborn infant physical examination screening (NIPE). Leaders monitored performance against the NIPE standards through the monthly maternity quality and safety champions report. Data showed for quarter 1 of 2022 96% of newborn screening assessments were completed within 72 hours.

Medicines

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

Staff stored and managed all medicines and prescribing documents safely. We reviewed the storage and management of medicines on labour ward and found all medicines were in date for use.

Staff followed systems and processes to prescribe and administer medicines safely. As of September 2022, 83% of staff had completed medicines management training.

Staff completed medicines records accurately and kept them up to date. We reviewed 6 medicines charts, and all were fully completed, legible and had women's allergies clearly recorded where relevant.

Staff learned from safety alerts and incidents to improve practice. There had been a recent serious incident where a medication error had let to an avoidable admission to intensive care. Staff we spoke with were aware of the learning from this recent incident including the importance of clarity when requesting medicines for administration in a clinical emergency.

Incidents

Managers did not always investigate incidents thoroughly or in a timely way. There was little evidence of learning from events or action to improve safety.

Staff knew what incidents to report and how to report them. However, staff did not always report incidents due to low staffing levels. Staff we spoke with told us they did not always receive feedback from investigation of incidents they reported.

Maternity

Managers shared learning from incidents in monthly 'key safety and learning messages' posters. These posters included learning from incidents such as ongoing issues with call bells and baby tagging. Staff we spoke with were aware of learning from recent incidents for example, ensuring placentas were sent to histology where relevant.

Staff reported serious incidents clearly and in line with trust policy. Data showed the trust reported one maternity serious incident between 1 March 2022 and 17 August 2022 which related to an unplanned admission to the neonatal intensive care unit.

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. We saw evidence in the three serious incident investigations we reviewed that women were involved in investigations and sent copies of the final investigation report.

Managers did not always investigate incidents thoroughly. For example, we reviewed the investigation process for an incident where a woman had sepsis and there may have been opportunities to the risk of sepsis earlier. Care issues not considered in the final investigation report that were relevant to the case included: the use of maternity early obstetric warning scores (MEOWs) and escalation, the quality of situation, background, assessment, recommendation (SBAR) handover and unconscious bias.

Managers did not always investigate incidents in a timely way. For example, a serious incident investigation following an incident in May 2021 was not finalised until May 2022. Leaders monitored incidents open over 60 days, but data showed incidents were not always reviewed and closed in this time frame. The trust approach was as there was not a regulatory or contractual requirement to complete an investigation within a particular period the length of time of review was not important to them. The trust informed us of the 25 incidents, 24 were rated minor or no harm. Only one incident was rated as moderate.

Data showed in the past six months as of 9 November 2022, 25 incidents were open over 60 days. There were no incidents that met the criteria for referral to referred to the Healthcare Safety Investigation Branch (HSIB) between April and September 2022.

Serious incident action plans were not always monitored to ensure learning was embedded. For example, the final investigation report for an incident relating to the management of women with abnormally invasive placenta had actions that were open 5 months beyond the target date and the revised policy had not been completed at the time of inspection

Managers did not always grade incidents appropriately. For example, a post-partum haemorrhage incident led to a woman having an emergency hysterectomy was graded as a minor, low harm incident.

Managers did not always discuss learning from recent incidents in governance meetings. We reviewed the last three directorate quality and risk meeting minutes and found while incidents and serious incidents were included as a standard item on the agenda there was no identification of themes or learning in the July, September or October 2022 minutes as part of this agenda item.

Managers debriefed and supported staff following distressing incidents. Managers told us they could access staff trained in trauma risk management methodology (TRiM) to manage debrief sessions.

Maternity

Is the service well-led?

Inadequate ↓↓

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

Leadership

The maternity leadership team was not stable and was recently formed. Leaders were not always visible or approachable within the service.

The resilience and experience of the midwifery leadership team was a recorded risk since September 2021 as half of the leadership team were in interim posts at that time. While the stability of the leadership team was improving, at the time of inspection the labour ward matron had been appointed substantively 2 weeks ago and the outpatient matron post was vacant.

Poole Hospital maternity services were managed as part of the women's health directorate, one of six directorates in the specialities care group.

The specialities care group was led by a group director of nursing, a group medical director, a group director of operations and a deputy group director of operations.

The women's health directorate was led by an interim director of midwifery, a clinical director a general manager.

The director of midwifery led the maternity service with support from a head of midwifery who was supported by a senior outpatient services matron, a community matron, a senior inpatient services matron and a labour ward matron.

The leadership team were recently established and there were some interim posts following the recent merger of two local hospital trusts and to cover sickness absence.

Leaders were working to improve their visibility on the unit. The management offices were on the second floor of the building away from the clinical areas on the ground and first floor. Leaders acknowledged in the June 2022 maternity safety champions that being on a separate floor was a barrier to staff accessing them and reporting their concerns. A proposal was made for a drop-in session for an hour a week booked through the personal assistant of the director of midwifery.

Vision and Strategy

The service did not have a strategy at the time of inspection.

Maternity services did not have their own vision or strategy. Maternity services were referenced in the trust operational plan for 2022/2023 in relation to staffing, funding and ensuring compliance with Ockenden immediate essential actions.

The maternity service had an operational plan with objectives for 2022/2023 which included actions such as improving the smoking cessation service and developing a recruitment and retention strategy. Plans for 2022-2026 included re-locating to a new building on the Bournemouth Hospital site.

Maternity

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service had an open culture where women, their families and staff could raise concerns without fear.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas.

Staff understood the policy on complaints and knew how to handle them. Women could access a birth afterthoughts service to speak with a midwife about their experiences.

Managers investigated complaints and identified themes. Themes from recent complaints included staff communication and delays to induction of labour.

The 2022 General Medical Council national trainee survey showed the trust scored similar to previous years in all areas but the score for local teaching was a negative outlier with a score of 34 compared to 62 the previous year.

University Hospitals Dorset NHS Trust was categorised 'as expected' overall in the 2021 CQC Maternity Survey. In comparison to other trusts, University Hospitals Dorset NHS Foundation Trust scored 'about the same' for 45 questions, 'better than expected' for one question, 'much better than expected' for one question and 'somewhat worse than expected' for three questions. The survey found that mother's experience could improve the most in relation to the information and support given to women by the midwifery and health visiting teams and in relation to support about changes in mental wellbeing after having a baby.

Governance

The governance arrangements and their purpose were not always clear.

Governance processes were overly complex. There were many governance meetings and while these meetings had terms of reference, the purpose of these meetings was not always clear.

Leaders monitored key safety and performance metrics through a range of governance meetings. There were 4 sub-group governance meetings: weekly review of new maternity and neonatal incidents, monthly perinatal mortality review meeting, monthly avoiding term admission into neonatal units (ATAIN) meeting and monthly maternity and neonatal quality governance. The sub-group governance meetings fed into the obstetric directorate quality and risk meeting. These meetings fed into the specialities care group quality and risk meeting every other month. In addition, maternity leaders had monthly meetings with the board level safety champion.

We reviewed the last six maternity safety champions meetings and found issues discussed included: staffing, Ockenden recommendations response, risks such as call bells, baby tags and ambulance response times impacting the homebirth service. While these meetings were minuted it was not clear what actions came out of these meetings and how they were monitored. For example, the risk of women choosing to have an unassisted birth at times when the trust had to suspend the homebirth service was discussed at a safety champions meeting, and an agreement was made to add this to the risk register. However, the risk of increased instances of unassisted birth was not on the current version of the risk register we reviewed.

We reviewed minutes of the last 3, women's health directorate quality and risk meetings and found a standard agenda was used to discuss safety, effectiveness, patient experience, finance, workforce, performance, estates and external visits. Staff minuted these meetings and actions were tracked through use of an action log for each meeting.

Maternity

Leaders used an online perinatal mortality tool to report serious incidents trust wide. Leaders monitored stillbirths, fetal loss, neonatal and post-neonatal deaths and produced a biannual perinatal mortality reviews summary report (PMRT). The most recent Perinatal Mortality Reviews Summary Report from 1 July 2022 to 30 September 2022 recorded 1 stillbirth, 0 late fetal losses and 0 neonatal deaths. The review panel concluded that in the one case of still birth there were no care issues identified that may have made a difference to the outcome for the baby.

Maternity incentive scheme (MIS) compliance was last reported to trust board in July 2021 as fully compliant with the ten requirements.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Staff had access to policies and standard operating procedures on the electronic records system. We reviewed seven clinical guidelines policies including those relating to sepsis, caesarean sections and pre-eclampsia these were all in date for review and in line with national guidance. Staff told us about recent improvements to the hypoglycaemic pathway.

Management of risk, issues and performance

Risk issues were not always dealt with appropriately or quickly enough. Leaders and staff did not always receive information to enable them to challenge and improve performance. Internal audit processes were inconsistent in their impact.

The top-rated risks on the maternity risk register included: maternity staffing, medical staffing and carbon monoxide monitoring. The service was updating the maternity risk strategy at the time of inspection.

While maternity staffing was one of the top risks, the service had not reported on midwifery staffing establishment using a midwifery acuity tool at board level in the past six months before the inspection period. This is a requirement of the Maternity Incentive Scheme and an Ockenden essential action. The trust told us they planned to report to board on maternity staffing in September 2022, but this was delayed to 30 November 2022 due to issues with the quality of staffing data.

The last maternity staffing and acuity tool review was completed in June 2021. This review recommended 220.69 WTE midwives' band 3 to 8 were needed against the current funded staffing of 211.9 WTE, a shortfall of 8.99 WTE staff. An update to the workforce strategy committee was delivered in October 2022 which included a midwifery staffing update. At the time of inspection, the director of midwifery was reviewing midwifery staffing and completing new roster templates and creating an action plan to address recruitment, retention and staff development. The service had made a successful funding bid to recruit 12 internationally trained midwives in 2023.

Maternity leaders had recently produced a maternity workforce action plan in October 2022. The workforce action leaders planned to purchase and use a nationally recognised maternity acuity tool to produce accurate data for six monthly board reports. This action was due to be completed by December 2022. The workforce action plan also included an action to review the maternity triage service to staff a 24/7 service by December 2022. Leaders planned to have monthly maternity workforce meetings.

Managers did not have an effective local audit programme at the time of inspection. There was limited evidence in governance meeting minutes of managers sharing information from audits to improve care. Managers did not audit compliance with key maternity safety metrics including use of maternity early obstetric warning score (MEOWS), situation background assessment recommendation (SBAR), cardiotocography (CTG) or maternity triage audits. After the inspection the trust submitted an updated local audit plan.

Maternity

The maternity service audits completed included but were not limited to the latent phase of labour, carbon monoxide readings, staff breaks, caesarean wound infections and postnatal sepsis.

Leaders monitored compliance with the Ockenden review mandatory actions to improve safety of maternity units regularly at board level. The last Ockenden review update to trust board in August 2022 showed the trust was fully compliant with three out of 7 immediate essential actions and partially compliance with four of the immediate essential actions relating to enhanced safety, managing complex pregnancy, risk assessment throughout pregnancy and informed consent.

The maternity integrated performance report to board was presented in an updated format in October 2022. Data included in the maternity perinatal quality surveillance scorecard included: 3rd and 4th degree tear rate, obstetric haemorrhage over 1.5 litres, term admissions to the neonatal care unit, Apgar scores less than 7 at 5 minutes and the stillbirth rate.

Data from the national maternity and perinatal audit, last published in June 2022, showed the trust scored higher than expected or the metric 'term babies with a 5-minute Apgar score of less than 7' (an Apgar score is a score between 0 and 10 that is the result of a simple test to quickly assess the health of babies immediately after birth, the higher the number, the healthier the baby.) Data showed between April 2022 and September 2022 this metric had not improved and ranged between 1.4% and 3.2%.

Outcomes for women were positive, consistent and met expectations such as national standards. Leaders monitored outcomes for mothers and babies through the maternity dashboard. The maternity dashboard showed in the past 6 months there were 9 neonatal readmissions, 5 maternal readmissions, 3 neonatal deaths (all of which were reported to MBRRACE) and three stillbirths of babies over 22 weeks gestation (all reported to MBRRACE, 2 MTOP twins, 1 PMRT review)

Leaders had assessed compliance against the Saving Babies Lives Care Bundle 2 and found themselves to be compliant in all areas. The audit noted some issues with carbon monoxide monitoring as the service was doing virtual booking appointments. For example, staff completed carbon monoxide monitoring as part of the Saving Babies Lives version 2 care bundle. In 3 out of the 6 records we reviewed women were not offered carbon monoxide monitoring.

Data from May 2022 showed the trust was in the upper 25% nationally for the metric 'women who were current smokers at delivery' was 16.7% compared to the national average of 9.9%.

Information Management

Leaders and staff do not always receive information, such as local audits to enable them to challenge and improve performance. Information is used mainly for assurance and rarely for improvement.

The trust was not able to provide accurate data on maternity clinical quality improvement metrics for the NHS Digital maternity dashboard. In June 2022 out of the 12 measures, data quality failed for three measures and was suppressed for one measure. No data was supplied for 8 measures.

The local maternity system region had recently developed a regional dashboard at the time of inspection. The region had a draft regional maternity dashboard, but it was not at a stage to be shared at the time of inspection.

Maternity

The service did not have a digital maternity strategy or digital lead midwife at the time of inspection. The September 2022 directorate quality and risk meeting minutes showed this had been highlighted as a risk and work was in progress with the Dorset local maternity and neonatal system (LMNS). Following the inspection the trust told us two digital midwives had been employed by the LMNS and the maternity data strategy was presented to trust board on 30 November 2022.

The service used a maternity electronic system. This system was introduced in March 2022 and 'superusers' were trained to support staff.

Engagement

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

The maternity service's relationship with the local maternity voices partnership (MVP) was in its early stages. The first meeting with the service and the MVP was in November 2022 which was attended by 50 people. Going forward the trust planned to have quarterly meetings with the MVP. The Dorset MVP chair or volunteers completed monthly '15 steps' walkabouts of the unit since August 2022.

The maternity voices partnership survey report 2022 completed between April and June 2022 by 242 respondents showed local women wanted the MVP to focus on improving continuity of carer, better staffing on postnatal wards, the quality of information available and improved mental health support.

Learning, continuous improvement and innovation

There was minimal evidence of learning and continuous improvement.

The trust supported 5 midwives to attend the Royal College of Midwives conference in October 2022.

The service started a trial of use of Oxytocin in water births in October 2022.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

MUSTS

Maternity

- The trust must ensure that there are effective systems and processes for staff to summon help in an emergency. 12(1)(2)
- The trust must ensure that all staff complete yearly professional obstetric multi-professional training (PROMPT) training. Regulation 12(1)(2)
- The trust must ensure that staff complete daily checks on emergency equipment. Regulation 12(1)(2)

Maternity

- The trust must ensure that leaders have an effective local audit programme to assess, monitor and improve the quality and safety of services. This must include cardiotocography, maternal early obstetric warning scores and use of the handover tool. Regulation 17 (1)(2)
- The trust must ensure that incidents are investigated thoroughly. Regulation 17 (1)(2)

SHOULDS

Maternity

- The trust should ensure that regular hand hygiene audits are completed in all maternity areas.
- The trust should consider completing live birth pool evacuation drills.

Our inspection team

The inspection team included 2 CQC inspectors and 3 specialist advisors with expertise in midwifery. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.