Wye Valley NHS Trust

The County Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at The County Hospital

Requires Improvement ➔➔

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

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

The County Hospital is a district general hospital located near Hereford town centre. It provides a full range of maternity services including a mixed antenatal and postnatal ward with 17 beds including three single rooms. There are 5 ensuite rooms on the delivery suite and an obstetric operating theatre located within the footprint of the maternity services. The hospital has a special baby care unit with 12 cots, but we did not inspect this as part of this inspection. There are approximately 1600 deliveries each year.

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

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

The rating of this hospital stayed the same. The County Hospital ratings remains as requires improvement.

Our reports are here: https://www.cqc.org.uk/provider/RLQ

How we carried out the inspection

We provided the service with 48 hours' notice of our inspection.

During our inspection of maternity services at Wye Valley NHS Trust we spoke with 4 women and birthing people, 36 staff including leaders, obstetricians, midwives, and maternity support workers.

We visited all areas of the unit including the pregnancy assessment unit, triage bay, the delivery suite and the maternity ward. We reviewed the environment, maternity policies while on site as well as reviewing 6 maternity records. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

We ran a poster campaign and asked the service to send text messages to women and birthing people who had used the service to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We did not receive any feedback from women and birthing people in response to this campaign.

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

Good ↑

Our rating of this service improved. We rated it as good because:

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vison and values, and how to apply them in their work. Managers monitored the effectiveness of the service. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services. People could access the service when they needed it. Staff were committed to improving services continually.

- Staff morale was good. Staff felt respected, supported and valued.

- The service engaged well with women and birthing people and the community to plan and manage services. Women and birthing people we spoke with during the inspection were positive about their experience of maternity services.

- Leaders were focused on improving outcomes for women and birthing people receiving care.

However:

- Not all staff had training in key skills or had been trained in how to protect women and birthing people from abuse. Staff did not always carry out daily safety checks of specialist equipment. Planned and actual staffing numbers did not always match.

- The service could not be assured that cardiotocography (CTG) monitoring was reviewed in line with guidance.

- Leaders could not be assured staff assessed risks to women and birthing people or acted on them because policies were not always up to date, nor were they aligned to current and evidence-based practice.

- The role of the surgical assistant had not been risk assessed to ensure the role was carried out by staff with the right level of qualification and additional training.

- Leaders had not fully assessed the risks associated with the delivery of level 1 care for women and birthing people who were acutely ill and required enhanced care and monitoring.

Is the service safe?

Requires Improvement →←

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

Mandatory training

Maternity

The service provided mandatory training in key skills to all staff. However, not all staff were up to date with all their mandatory training.

Staff were not up-to-date with their mandatory training. The service had undertaken a training needs analysis for all clinical staff working within the maternity department. The documents defined mandatory training as including both statutory and mandatory training. 'Specialist' training applied to staff working within the maternity department only.

The trust had an 85% training compliance target. Training records showed this target had not been achieved in over half of identified mandatory training for staff. For example: Moving and Handling Training Levels 1 and 2. Ninety-six percent of required staff had completed Level 1 but only 61% of required staff had completed level 2. For Adult Basic Life Support (Level 2) training, the compliance rates at the service for both medical and nursing and midwifery staff compliance was 44%. This meant the service could not be assured staff had the necessary skills and competence to provide lifesaving treatment to women and birthing people in their care. Training compliance for all staff for medicine management was at 79% which was below the trust target. However, further information sent to us following this inspection showed an improving compliance rate with most training compliance meeting trust targets. Adult basic life support and moving and handling remained below trust target at 50.2 and 79.3 % respectively.

The service provided multi-professional simulated obstetric emergency training (PROMPT) and 'clinical drills training' which included pool evacuation training, baby abduction training and clinical emergencies. The service monitored attendance for maternity specific training. Training was allocated by the training team, to individuals and they were allocated via the staff roster. We asked for training compliance data for pool evacuation, however the service was unable to provide this. We were told drill-based pool evacuation training took place monthly and was facilitated by the practice education midwives.

Training data indicated the service had achieved the 90% compliance target for midwifery staff. One hundred percent of active midwives had completed PROMPT training, 83% of midwifery care assistants had completed PROMPT training with skills and drills as a minimum and compliance rate for medical staff ranged from 80% for obstetric consultants through to 87% for other anesthetic doctors contributing to the obstetric rota. One hundred percent of midwives had attended the midwifery update day which included saving babies lives updates and 69% had attended external neonatal life support training within the last 4 years.

The practice education midwives told us more midwives would be trained to be NLS instructors and some would attend this training with a neighbouring trust in order to increase compliance with this mandatory training. Three midwives were already booked on with a December 2023 completion timescale.

Midwifery and obstetric staff were required to attend a cardiotocograph (CTG) fetal wellbeing training day. CTG is used to monitor fetal heart and uterine contractions. Consultant and junior obstetric doctors had achieved the trust target with 91% compliance for junior doctors and 90% for consultants. One hundred percent of midwives had completed the training.

Safeguarding

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

Maternity

Staff received training specific for their role on how to recognise and report abuse. Records showed staff completed level 2 safeguarding adults training. This was not in line with intercollegiate (2019, 2020) guidelines. The overall compliance rate was 92%, although only 73% of medical staff and 82% of maternity leadership and specialist roles had completed this training.

Training records showed that staff had completed safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. Overall compliance rate for level 1 was 75%, for level 2 78% and for level 3 90%. However only 55% of medical staff had completed safeguarding children level 3 training.

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

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The trust had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed the trust’s baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

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

Maternity service areas had suitable furnishings which were mostly clean and well-maintained. Wards had recently been refurbished to the latest national standards.

We found some equipment had dust on them in difficult to reach places and there was visible dirt in one ensuite bathroom on the delivery suite. Cleanliness scores displayed on the delivery suite showed the level of cleaning met 3 stars of 5 possible. The service carried out cleaning audits weekly on the delivery suite, monthly on the maternity ward and bimonthly in antenatal clinic. Cleanliness scores were awarded using a star rating system, 5 being the highest rating. The service told us areas for improvement were actioned and reported to the Divisional Quality Group for monitoring. We saw that the delivery suite had improved their cleanliness rating from 1 star overall for April 2023 to 4 stars overall for June 2023. The maternity ward had decreased to 4 stars overall for June 2023 from 5 stars overall in April and May 2023. The score for antenatal clinic in May 2023 was 2 stars overall. Areas identified for improvement were actioned and reported at monthly divisional quality group meetings.

Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. We looked at the most recent (April 2023) audit for 5 moment hand hygiene which showed 100% compliance across the maternity unit. The service also audited that staff were bare below the elbow and demonstrated 100% compliance across the maternity unit.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic. Staff signed and dated when equipment was cleaned and ready for use.

Environment and equipment

Daily checks of emergency equipment were not always carried out. The design, maintenance and use of facilities, premises and equipment mostly met national standards and kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff did not always carry out daily safety checks of specialist equipment. For example, the obstetric airway trolley in the maternity theatre was only checked on one day in the week commencing 12 June 2023 and the major haemorrhage trolley had only been checked on 4 days the week commencing 15 May 2023.

Processes to ensure all consumables were checked and stored in intact packaging within their expiry date were not always effective. Staff did not record when the seal on the tamper-evidence trolley in the maternity theatre had been broken to check stock items were in date. We found 4 items which had passed their expiry date. Staff took action to replace these items immediately.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

The design of the environment mostly followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. However, the design and use of the anaesthetic room as a second operating theatre did not meet national standards and it was not clearly signposted as a second operating theatre. The anaesthetic room contained the minimal requirements such as anaesthetic equipment, resusciatiare and access to medicines but there was not a separate scrub area, and the airflow did not meet national guidance. It was only used in an emergency when it was assessed to be safer for the patient to have surgery urgently rather than being transferred. Records showed the anaesthetic room had been used on 3 occasions in the 12 months prior to our inspection. The service had completed an environmental risk assessment for the use of the intervention room as an emergency theatre and there was a plan for a new theatre suite to be in use by May 2024.

Following our last inspection of maternity services in 2019, the service had installed a curtain in the small recovery area to provide privacy for women and birthing people, their baby and their partners when they were recovering following a caesarean.

Access to the delivery suite was restricted. All people without swipe card access (staff), had to be let in and let out of the unit by staff.

There was one adult resuscitation trolley shared between the delivery suite and the obstetric theatre. This trolley was located in the main corridor of the delivery suite but not all staff in the maternity theatre knew where it was.

Maternity

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply. The service had two birthing pools, one was an inflatable birthing pool and the other a static pool built into the ensuite bathroom facility. We were concerned that the location of the static birth pool would not allow for sufficient people and equipment to be used in the event of an emergency evacuation. Following the inspection, the service carried out an evacuation drill with their health and safety team. A decision was made to decommission this birth pool until an alternative option could be found because staff were at risk of hurting themselves in the event of a pool evacuation.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. There were small touches in the otherwise clinical delivery rooms that made them cosier and more homely such as battery-operated candles and one room had a large mural on the wall. All delivery rooms had ensuite facilities.

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

The service had identified a lack of space in the triage area as a risk and was in the process of moving triage to a new area with more space to facilitate safer assessment and patient flow.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the delivery there were pool evacuation nets in all rooms with pools and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

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

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration. However, staff did not always use handover tools effectively.

Midwifery staff recognised when women and birthing people deteriorated and escalated concerns to medical staff. Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 6 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. An audit of 10 sets of patient records carried out in May 2023 highlighted good practice but also areas for improvement. MEOWS had been completed for each woman or birthing person, although it was noted in 1 out of the 5 cases that required escalating to a midwife, doctor or senior midwife had not been recorded. The audit concluded that the documentation needed to be improved when escalating to senior colleagues, including recording the action taken, provide a more detailed overview of the patients' physical state and rationalise when a specific observation had been missed. MEOWS audits were discussed at the maternity governance meetings along with any action required if applicable.

The service recognised the potential risk of worse outcomes for women from a Black heritage and other ethnic minority groups. Staff told us there was a lower threshold for escalating concerns and for transferring women and birthing people to a specialist maternity unit if required.

Maternity

The service had identified that triage posed a potential risk to women and birthing people due to the lack of space and current staffing model, and consequently triage had been included on the risk register. The service had a three-bedded triage bay located on the maternity ward as well as a separate one-bedded day assessment unit. Both areas were accessed via the main doors to the maternity ward. Triage was open 24 hours a day 7 days a week and staffed by two midwives, with support from a midwifery support worker during the day.

Women and birthing people were triaged on arrival to the hospital when they were not attending for a planned birth. The service had developed and implemented guidance which included a colour coded triage trigger list to help midwives and medical staff determine the clinical urgency in which women need to be seen.

The service had audited the use of their triage tool over 7 days during July 2022, although the analysis of the information was incomplete. However, the findings indicated that not all women and birthing people were seen within 15 minutes of arrival by a midwife, or within 30 minutes by a doctor. The audit also identified that 91% of attendees did not have a risk assessment completed. The long-term goal was to introduce a nationally recognised evidence-based triage system. A new triage call log had been introduced as an interim measure until data collection around triage arrivals and assessment times could be improved within electronic records. Following this inspection, the trust sent further audit information which showed women and birthing people were seen within 15 minutes of arrival 97.3% of the time and had a completed risk assessment 100% of the time.

Staff knew about and dealt with any specific risk issues. Cardiotocography (CTG) was used during pregnancy to monitor fetal heart rate and uterine contractions. Staff were required to attend a CTG Fetal Wellbeing Study Day and complete a competency test before they were recorded as passing the training. The Fetal Wellbeing Lead Midwife supported staff with CTG training and provided additional one to one support for staff as required. All CTG machines were wireless and linked to the electronic patient records. The service had introduced a centralised CTG monitoring system on the labour ward to support reviews imminently. There was an expectation that staff used a 'fresh eyes' or buddy approach for regular review of CTGs during labour. The recent audit in May 2023 highlighted that 'fresh eyes' had been completed hourly in 73% of cases reviewed. Risk assessments had been completed appropriately in 93% of cases, although only 20% had been updated hourly. However, following our inspection the trust sent us the CTG audit for June 2023. This audit showed improved compliance with 'fresh eyes', completion of risk assessment and hourly updates with compliance rates of 85%. Information and updates around CTGs were shared via the weekly newsletter, meetings and training sessions.

Staff completed surgical safety checklists in accordance with national guidance (World Health Organization: Safe Surgery) (WHO). Staff used an electronic patient care platform to record this. However, this platform was separate from women and birthing people's other electronic medical records and there was no paper copy completed and added to individual paper-based records. Leaders audited compliance with WHO checklists completed for all specialities and found that between January and March 2023 99.5% (707 out of 710) of checklists had been completed correctly.

There were arrangements for emergency transfers to specialist maternity units and the service worked well with the ambulance service to transfer patients in emergencies. It was recognised that it was a small service and there was a low threshold for transferring women and birthing people out.

There were processes to highlight anaesthetic risks such as potential difficult airway management during obstetric operations (caesareans) and if women and birthing partners wished to have a spinal anaesthetic for planned caesareans. This information was entered onto the electronic patient record system.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

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

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

However, shift changes and handovers did not always include all necessary key information to keep women and birthing people and babies safe. Midwifery staff told us they used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. The service audited 15 randomly selected patient records each month, to check all handovers from admission to discharge. We reviewed audits of handovers which identified there had been a decrease in the SBAR handover tool being used at each handover. The SBAR handover tool had been used in 53% of all handovers in the records audited in May 2023. In addition, the SBAR was most frequently missed when transferring between triage to the maternity ward or from change of staff member. The audit identified that staff amended management plans to reflect changes of care recommended by the medical staff but did not always record the name of the responsible clinician for the care.

During the inspection we attended medical staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The medical handover did not use a format which described the situation, background, assessment, recommendation for each person when sharing information, however, each medical handover was followed by a ward round where each patient's needs were discussed.

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

The service provided transitional care for babies who required additional care as part of the overall Special Care Baby Unit (SCBU). Staff told us babies requiring transitional care who could be managed outside of the SCBU environment were cared for on the maternity ward with input from paediatric and SCBU team.

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

Midwifery Staffing

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

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Staffing on the delivery suite on the day of inspection, did not meet the planned staffing. There were 3 midwives working with no maternity support worker when there should have been 1 on duty in accordance with planned staffing levels. Staffing on the maternity ward and triage usually met planned staffing of 2 midwives and 2 maternity support workers on the ward, and 2 midwives and 1 maternity support worker in triage. However, there were multiple times the

triage area did not have a midwifery support worker and the second midwife was moved to another area when acuity was low. The day assessment unit was closed due to a lack of staff. One woman attending for a routine appointment had to be seen in triage, they had been waiting for several hours and said they had the same experience at a previous appointment.

The maternity theatre was staffed by staff from the main surgical theatres. There was a designated team on call for emergency caesareans and a separate team on days when women and birthing people were booked in for elective (planned) caesareans.

The role of the surgical assistant to assist consultants during caesareans was carried out by staff who were not suitably qualified in accordance with national guidance. We discussed this with leaders of the service following this inspection. They made the decision to continue this arrangement as it had been in place for a number of years and there had not been any recorded incidents as a result of this practice.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. In May 2023 there were 11 red flag incidents, these included delays in induction of labour of more than 2 hours and movement of midwifery staff to cover other areas. All red flag incidents were discussed at safety champion and governance meetings along with causative factors and action plans to reduce further risk.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance. Planned and actual staffing numbers were closely monitored. For the weeks 27 March 2023 to 15 May 2023, the service was up to 1.75 midwives short for 12% of shifts and more than 1.75 midwives short for 2% of shifts. From December 2022 to May 2023, 5841planned hours were not fulfilled. Staffing shortages were identified as a risk and were on the risk register. Staff said told us staffing numbers were improving. The service had recruited 12 new midwifes commencing employment in September 2023. International recruitment was also ongoing.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

There was a clear escalation policy and process with identified priority rated triggers. This included collaboration with the wider local maternity services when required. Community escalation where community midwives were brought in to support inpatient areas had been used 3 times in the last quarter, additional measures to reduce the risk of staff working when they were tired had been introduced so staff did not work any more than 6 hours before having a break.

The service mostly 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.

Maternity

There were systems and processes for managers to support staff to develop through yearly, constructive appraisals for their role. However, not all staff were up to date with their annual appraisal. The figures ranged from 56% for staff working in antenatal clinic, 70% for staff who worked in leadership and specialist roles through to 95% of staff working on the maternity ward / delivery suite. However, information supplied by the trust following our inspection showed improving compliance rates with staff appraisals. Appraisal rates for leadership and specialist roles had improved to 100% with an overall staff appraisal rate of 82%.

A practice development team supported midwives. The team included 2 practice development lead midwives. There was a team of specialist midwifes to provide additional training and support. For example, the bereavement midwife was working on a new package of training for staff, they used an interactive case study during midwifery update days and medical staff training days. The service had recruited to all nationally recommended roles. This included the successful recruitment of the Trust's first consultant midwife.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff.

The service had 10.3 whole time equivalent (WTE) consultants in post, which exceeded minimum requirements in line with national guidance (Royal College of Obstetricians and Gynaecologists, 2010). The service had one vacancy for middle grade medical staff, and 8.5 WTE in post. There were 6 WTE junior grade medical staff in post, with 0.4 WTE vacancy.

There was a designated anaesthetic registrar rostered to cover the emergency maternity theatre. They had no other roles and were protected for maternity services 24 hours a day. They had access to a consultant to assist with emergency caesarean sections or for any other advice 24 hours a day. The anaesthetist consultant was either an anaesthetist consultant covering obstetrics, intensive care or general surgery. The elective caesarean sections were covered by a consultant three days a week.

There were twice daily consultant-led ward rounds which followed on from medical handovers. Medical staff also took part in daily multi-disciplinary team meetings where treatment and care for each woman or birthing person was discussed.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Whenever possible, the service used internal bank staff to cover any gaps in the staffing rota. Figures for May 2023 indicated the service used 121.5 hours of bank middle grade doctors and 50 hours of bank consultant on the delivery unit and maternity ward to fulfil the staffing rota. In June 2023 the hours had increased to 229 hours for middle grade doctors and decreased to 24 hours for consultant cover. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

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

Maternity

The service always had a consultant on call during evenings and weekends.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Some medical staff told us there were limited opportunities for training and development and that they did not always have access to formalised supervision. This was reflected in the General Medical Council National Trainee Survey (GMT NTS) (2021) when only 25.6% felt local training met expectations. This had declined from 33.9% in 2019. There were fewer than 3 doctors that had completed this question in the survey in 2022 so this was not reported in the survey. The 2022 GNC NTS showed results had improved in 11 measures, 'overall satisfaction' increased from 51 to 78%.

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. Wherever possible paper records were scanned into the electronic system. Staff completed surgical safety checklists in accordance with national guidance (World Health Organization: Surgical Safety Checklist). Staff used an electronic patient care platform to record this. However, this platform was separate from women and birthing people's other electronic medical records and there was no paper copy completed and added to individual paper-based records. We reviewed 6 electronic patient records and found records were clear and generally complete.

A digital midwife was employed to oversee and audit records. The trust was an early adopter of electronic record keeping within maternity services. The digital midwife had identified some required staff training and updates regarding functionality and utilisation and was working towards implementation. A maternity services documentation audit dated May 2023 reported 100% compliance with record keeping on the services electronic systems.

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

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, although these were not always used effectively.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 6 prescription charts and found staff had not always recorded when medicines were administered or recorded the reason when medicines were omitted.

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

Staff completed medicines records accurately and kept them up-to-date. Medicines records were clear and up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

We found medicines were managed safely. Staff monitored fridge temperatures to ensure medicines were stored under the correct conditions. Pharmacy department check medicines every day Monday to Friday.

Two staff checked controlled drugs twice a day. Two registered staff checked and signed when controlled drugs were administered. Medicine cupboards were locked and there was a separate key for the controlled drugs cupboard. However, the fridge in theatres was not always kept locked.

Oxygen cylinders were not always stored safely. We observed one oxygen cylinder which was stored on the floor and without being secured, in the recovery area of the obstetric theatres.

We found medicines were managed safely on the maternity ward and staff monitored fridge temperatures to ensure medicines were stored under the correct conditions. However, we noted there were gaps in the fridge temperature records, one in June 2023, 2 in May 2023, one in April 2023 and 2 in March 2023.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems for the10 sets of records we looked at were fully completed, accurate and up-to-date.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 3 incidents reported in the 3 months before inspection and found them to be reported correctly.

The service had no 'never' events on any wards.

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

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. Where appropriate to do so, managers shared duty of candour and draft reports with the families for comment.

Maternity

Managers did not review incidents potentially related to health inequalities. Although the trust's incident reporting policy required an equality impact assessment to be carried out. There was no record of this taking place in the 3 incident investigations we reviewed.

All incidents were a standing agenda item at safety champion and governance meetings. Incidents were discussed along with required action plans.

Managers shared learning with their staff about never events that happened elsewhere. Staff met to discuss the feedback and look at improvements to the care of women and birthing people. The service used handover sessions to communicate incidents. Incidents were featured in 'theme of the month' learning for staff. Incidents were also discussed at monthly governance meetings along with action taken and action required to improve safety.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medication incident. Case reviews also took place and explored what the team did well along with any learning to be shared with staff.

Managers debriefed and supported staff after any serious incident.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

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 women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons.

Maternity

The service was supported by maternity safety champions and non-executive directors. The board safety champion and non-executive director completed a monthly walk around and produced a written report. Safety champions were encouraged to attend these walk rounds, and time was taken to speak with women, birthing people and partners as well as members of staff.

Not all staff were aware of who the non-executive director supporting maternity services were or any direct route of escalating concerns if this was required.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress. Following a change in leadership and governance and management review, further specialist roles had been developed with new teams and additional matrons appointed.

A preceptorship programme was in place to support band 5 midwives with basic competencies and specific skills such as suturing.

All midwives completed enhanced care training about the management of arterial lines and had their competency assessed, this meant women and birthing people who required enhanced care could remain on the delivery suite with their baby where possible. However, not all risks associated with women and birthing people requiring level 1 care on the delivery suite were assessed.

Vision and Strategy

The service was developing a vision and strategy for maternity and neonatal services. Leaders told us although the trust had developed a strategy which included the vision and values, this did not include maternity services. They told us work was underway to develop the vision and strategy, including away days to enable consultation with staff.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services. An Ockenden assurance visit took place in April 2023. The service was working towards meeting all essential actions and had an action plan in place. For example, changes were being made so that serious incidents were reported to the board monthly rather than every 3 months and work was underway to increase the accessibility of information for women and birthing people.

Culture

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

Staff felt respected, supported, and valued. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

Staff told us there was a good atmosphere in the service and staff worked well together. There were arrangements for debriefing all staff involved with stressful or traumatic deliveries. Leaders told us they were proud of their staff and how they supported each other.

Maternity

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

The results of the Maternity Survey 2022 showed similar results when compared to other trusts. A small number of questions showed a decrease in satisfaction and covered all aspects of the service. The survey found that women and birthing people's experience could be improved through better communication throughout their journey. The service had reviewed the results of the survey and developed an action plan. Each action was rated in accordance with priority, had a responsible person and a completion date. All actions were added to, and progress tracked via the Quality Improvement action plan.

The service provided an overview of the main themes from the most recent local staff survey in 2022. The survey focused on staff wellbeing and culture. Staff were asked about how they felt their work week was going and if they accessed any wellbeing support provided by the trust. The survey identified that almost 20% of staff did not feel able to escalate concerns and 22% of staff did not feel the service was a good place to work. In addition, more than half of the respondents felt that they were not able to give the care they wanted to some or all of the time. The main themes were around staffing levels impacting on safety, and not being listened to or action taken when concerns were raised. The service had shared their proposed action plan with staff. Staff we spoke with during the inspection told us they were confident escalating concerns and said The County Hospital was a good place to work.

Staff had an awareness of how health inequalities may affect treatment and outcomes for women and birthing people and babies for ethnic minority and disadvantaged groups in their local population. However, staff were unable to identify specific actions or risk assessments to mitigate risks.

An external midwifery consultant had been commissioned to support demographic profiling. This meant maternity services would have improved information about women and birthing people with complex needs or known vulnerabilities and therefore improve planning to meet these needs.

Staff had access to interpreters if required when caring for women and birthing people for whom English was not their first language.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Staff told us they worked in a fair and inclusive environment.

Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. Safety meeting minutes reported a reduction in complaints since the Matron and Patient Safety Midwife began to spend more time in inpatient areas and offering postnatal debriefs to woman and birthing people.

The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them. Complaints were a fixed agenda item at maternity safety meetings.

Maternity

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. Complaints risks and incidents were displayed in ward areas for staff updates about themes and feedback received. Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Maternity and Neonatal Safety Champions Meetings took place monthly. There was a planned reporting schedule for 2023. Standard agenda items included feedback from the Maternity Voices Partnership, the monthly walk rounds and staff safety concerns. Other agenda items, for example, Avoiding Term Admissions into the Neonatal Unit (ATAIN), Perinatal Quality Surveillance Model update, feedback from assurance visits, Maternity and Neonatal Service Improvement Programme update were reported on in accordance with the reporting schedule. An action plan had been developed in June 2023 to address issues identified in the meeting.

Governance

Leaders operated mostly effective governance processes, throughout the service and with partner organisations. Guidance for staff was not always current and the harm was not always recoded accurately. However, 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.

Guidance available to staff to plan and deliver high quality care was not always reviewed and referenced to demonstrate they were aligned to current and evidence-based practice. Guidance documents were not always reviewed when they should be and did not always show when the guidance was last reviewed to ensure they were compliant with latest evidence-based practice. For example, the Obstetric Haemorrhage Guidance (version 3) should have been reviewed in February 2022 and this guidance was not referenced to demonstrate it was aligned with current national guidance. Emergency drug boxes and guidance for staff about how to respond to emergency situations such as pre-eclampsia and post-partum haemorrhage were not aligned with best practice and guidance. Some medicines required in such an emergency were not available in the clinical area. The service took immediate action to address this. A rapid review took place, all required medicines were made available, and guidelines and algorithms were reviewed by an expert group along with confirmation they were in line with the National Institute for Clinical Excellence and Practical Obstetric Multi-Professional Training guidelines.

The service had a governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

The service reported data quarterly to the Board, ensuring oversight of performance. Quality Committee meetings (a sub board committee) chaired by a non-executive director provided quarterly reports to the board. These reports included safety, risk and successes. Performance measures included how many babies were born (activity), and number of caesarean sections, ante-natal care and ‘midwife to birth ration. However, there was a missed opportunity to report on safety performance measures such as triage within 15 minutes and delayed induction of labour. Other reports shared with the Board included updates on Ockenden assurance progress and compliance with the maternity incentive scheme. The Quality Committee also received the monthly perinatal quality surveillance model report. The Board level safety champion was able to raise anything with the Board at any time.

Maternity

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. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

All risks were recorded and scored in order of severity on the risk register. This was reviewed monthly at governance and speciality directorate meetings. Top risks across maternity services were staffing and triage. Action was planned and underway to mitigate these risks. The Associate Director of Midwifery was supported to make the necessary changes and told us the funding for improvement work had been agreed.

The maternity dashboard compared outcomes to national averages. Data showed improving outcomes for the months April May and June 2023. In particular, the number of women and birthing people asked about domestic violence had increased. The number of mothers and birthing people with a smoking status at delivery was above the national standard in April and May 2023 but had reduced to below the national average in June 2023. Post-partum haemorrhage of over 1500ml rate was at 5.6% in May and 3.1 in June 2023 against a national average of 3%. Incidents of post-partum haemorrhages were not reported with the correct harm grading in accordance with national guidance.

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

They shared perinatal mortality review meetings with a neighbouring NHS trust every month. This meant that learning should be shared, and they could identify if service improvement could be made. These meetings were embedded and had been running for 2 years. Perinatal mortality reviews were holistic reviews of the patient care and pathway and would include specific discussion around those risk factors relating to heritage or social deprivation.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

The trust had declared compliance with all ten safety actions required by the maternity incentive scheme.

Information Management

Maternity

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.

The service collected reliable data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

The information systems were integrated and secure.

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

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. There were 2 MVP chairs, both were positive about the relationship they had with leaders and staff. They felt supported and involved. Monthly meetings were held to discuss any issues raised by women and birthing people. Examples of a quick and thorough response to any concerns raised by the MVP's were shared.

The MVP were involved in the Equality and Equity strategy, they were working towards improving engagement with harder to reach communities.

The trust has been using QR codes for the family/friend's test, these were displayed in clinical settings. The response rate had been poor, so a plan was in place to use text messaging to obtain feedback from women and birthing people. Feedback from women and birthing people was discussed and reviewed at governance and safety champion meetings.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. Antenatal education has been made available in multiple languages that had been assessed and based on local population needs.

Leaders were improving systems so the needs of the local population could be better understood.

The bereavement midwife worked with other organisations such as charities to support people after baby loss. Home visits were offered, and information was available in different languages. Staff had an awareness of meeting the needs of people from different cultures and religions.

Staff were engaged through staff meetings and newsletters. Weekly check in handover's took place at ward level to communicate changes or current themes.

A staff consultation period had commenced regarding staff rotation within maternity services. The 2021 NHS staff survey results showed a higher proportion of Black and Minority ethnic staff experienced harassment, bullying and abuse from patients, relatives or the public and staff in the previous 12 months.

Maternity

Results for disabled staff showed results were comparable to the average or showed positive results when compared to the average.

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 was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement forum, a multi-disciplinary group responsible for monitoring the progress of action plans and making collective decisions.

Changes were being made to the triage environment and a nationally recognised tool for risk assessments in triage was being introduced. Centralised CTG monitoring was almost ready to go live.

A new theatre suite was planned for May 2024.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. The service was involved in the Giant Panda Trial for the evaluation of antihypertensive drugs used in pregnancy.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure 'fresh eyes' checks of cardiotocography (fetal heart rate) monitoring are carried out hourly. (Regulation 12 (2) (a) (b))

- Systems or processes must be established and operated effectively to monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. These must include the checking of emergency equipment, auditing of triage processes, ensuring all guidance meets national standards and reviewing grading of harm reported in incidents in accordance with national guidance. (Regulation 12 (2) (d))

- The service must ensure staff training compliance with mandatory training, including safeguarding training and specific maternity training to meet the local training compliance requirements. All staff must receive annual appraisals. (Regulation 12 (2) (c))

- The service must be assured that the role of the surgical assistant is risk assessed to ensure that the role is carried out by staff with the right level of qualification and additional training. (Regulation 12 (2) (c))

Maternity

- The service must ensure all risks associated with women and birthing people requiring level 1 care are fully assessed. (Regulation 12 (2) (a) (b))

- The service must ensure staff caring for those with an arterial line are trained and competent for the additional observation and care required. (Regulation 12 (2) (c))

Action the trust SHOULD take to improve:

Maternity

- The service should ensure effective communication tools are used when handovers take place at all shift changes and handovers between different areas.

- The service should continue to audit cleanliness in line with national standards and improve compliance.

- The service should ensure all staff are aware of the location of emergency equipment.

- The service should ensure an equality impact assessment is included within incident reviews.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a second CQC inspector, a CQC operations manager and 2 midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment