Bedfordshire Hospitals NHS Foundation Trust

Inspection report

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Ratings

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

When a trust acquires another trust in order to improve the quality and safety of care, we do not aggregate ratings from the previously separate trust at trust level for up to two years. Our normal practice following an acquisition would be to inspect all services run by the enlarged trust.

At the time of our inspection, the new entity of Bedford Hospitals Foundation Trust had not yet been fully inspected. This means that some core services at Bedford Hospital location do not yet have ratings. All core services at Luton and Dunstable Hospital location retain their previous ratings.

The ratings for the trust in this report are therefore based only on the ratings for Luton and Dunstable University Hospital and our rating of leadership at the trust level. At Bedford Hospital we inspected only those services where we were aware of current risks. We did not rate Bedford Hospital overall.

Due to the significant concerns within the maternity service we undertook enforcement to enable the improvement of safety within the service at both locations; Bedford Hospital, and Luton and Dunstable Hospital. We issued a warning notice under Section 29A of the Health and Social Care Act 2008 on the 20 December 2024 and told the trust it must improve. We reviewed representations against the warning notice and on 13 May 2024 we wrote to the trust to not uphold representations.

Outstanding practice

We found the following outstanding practice:

- The service applied to partake and passionately participated in the HOPE box project. This initiative aimed to promote an ongoing connection between mothers and babies going through separation through care, a group of women who are often forgotten. The hope boxes helped parents grieve their immediate loss and acknowledge their maternal identity.

Our findings

Areas for improvement

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

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

Bedford Hospital - maternity

- The service must ensure the triage unit has enough staff to manage all the functions included safely. (Regulation 18 (1))
- The service must ensure that medical staff completion of training is in line with the trust target. (Regulation 18 (2)(a))
- The service must demonstrate it supports its staff by challenging unacceptable behaviours and language. This includes, but is not limited to, racism and discrimination. (Regulation 18 (2) (a))
- The service must ensure incidents are managed appropriately. (Regulation 17(2)(b))

Luton and Dunstable Hospital - maternity

- The service must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced midwives to provide safe care and treatment across the service and reduce delays in provision of safe care to reduce the risk of harm for women, birthing people and babies. (Regulation 18 (1))
- The trust must ensure staff complete mandatory training in line with the Trust's own target. Regulation 12(1)(2) (a)(c)
- The trust must ensure equipment is checked in line with Trust policy and documented clearly. Regulation 15 (1) (2) (c)(d) (e)
- The trust must ensure it supports all staff, including those with particular equality characteristics, to feel respected and valued and support an environment where staff are encouraged to speak up and raise concerns without fear of blame or reprisal. Regulation 18 (2)(a).
- The trust must demonstrate it supports its staff by challenging unacceptable behaviours and language. This includes, but is not limited to, racism. Regulation 18 (2)(a).
- The trust must ensure that internationally recruited staff receive appropriate and ongoing support to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a).
- The trust must ensure that clinical waste is stored securely.

Action the trust SHOULD take to improve:

Bedford Hospital - maternity

Our findings

- The service should ensure the maternity triage area is suitable to meet the service's needs.
- The service should ensure that junior midwives are able to get appropriate experience in all clinical areas.
- The service should ensure that safety huddles are structured and confidential.
- The service should ensure medicines are managed and stored appropriately.
- The service should ensure all women's risk assessments are completed and recorded at each contact.
- The trust should ensure that incidents are reviewed in a timely manner to ensure that themes and trends are identified
- The service should improve on triage processes and monitoring through audit.

Following our inspection, we served a warning notice asking the trust to make significant improvements on staffing and governance and oversight of the service. The service was required to submit an action plan, and we will continue to monitor progress in relation to this.

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

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

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Luton and Dunstable Hospital	Requires Improvement → ← Jul 2024	Good → ← Jul 2024	Good → ← Jul 2024	Good → ← Jul 2024	Requires Improvement ↓ Jul 2024	Requires Improvement ↓ Jul 2024
Bedford Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires improvement Dec 2022	Good Dec 2022	Good Dec 2022	Good Dec 2022	Good Dec 2022	Good Dec 2022

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

Rating for Luton and Dunstable Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Dec 2022	Good Dec 2022	Good Dec 2022	Good Dec 2022	Good Dec 2022	Good Dec 2022
Services for children & young people	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Outstanding Dec 2018	Good Dec 2018
Critical care	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
End of life care	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Surgery	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Urgent and emergency services	Requires improvement Dec 2022	Good Jun 2016	Good Jun 2016	Good Dec 2022	Good Dec 2022	Good Dec 2022
Maternity	Inadequate ↓ Jul 2024	Requires Improvement ↓ Jul 2024	Good Jul 2024	Requires Improvement Jul 2024	Inadequate ↓ Jul 2024	Inadequate ↓ Jul 2024
Overall	Requires Improvement → ← Jul 2024	Good → ← Jul 2024	Good → ← Jul 2024	Good → ← Jul 2024	Requires Improvement ↓ Jul 2024	Requires Improvement ↓ Jul 2024

Rating for Bedford Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Dec 2022	Good Dec 2022	Good Dec 2022	Good Dec 2022	Requires improvement Dec 2022	Requires improvement Dec 2022
Chemotherapy	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Services for children & young people	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Urgent and emergency services	Requires improvement Dec 2022	Requires improvement Dec 2018	Good Dec 2018	Requires improvement Dec 2022	Requires improvement Dec 2018	Requires improvement Dec 2018
Maternity	Inadequate ↓ Jul 2024	Requires Improvement → ← Jul 2024	Good → ← Jul 2024	Requires Improvement ↓ Jul 2024	Inadequate ↓ Jul 2024	Inadequate ↓ Jul 2024
Outpatients	Good Dec 2018	Not rated	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Luton and Dunstable Hospital

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Description of this hospital

Bedfordshire Hospitals NHS Foundation Trust (BHFT) formed as a new entity in April 2020 as a result of a merger of Luton and Dunstable Hospital NHS Foundation Trust and Bedford Hospitals NHS Trust. Both sites provide maternity services.

Bedfordshire Hospital NHS Foundation Trust provides maternity and midwifery services at Luton and Dunstable Hospital. The hospital has an eleven-bedded consultant-led maternity unit as well as a four-bedded midwifery-led birthing unit (MLBU) with birthing pool. There is an antenatal clinic in the hospital as well as an early pregnancy unit and a day assessment unit (DAU). Between January 2023 and December 2023 there were 5409 women and birthing people who delivered at Luton and Dunstable Hospital.

We spoke with 48 members of staff at all levels of the organisation across various specialities and including administrative staff, consultants, doctors, healthcare assistants, midwives, nurses, pharmacy staff and senior leaders. We also contacted the Maternity and Neonatal Voices Partnership and Healthwatch.

We also spoke with 5 women and birthing people and 2 birthing partners. We observed care and reviewed 5 sets of care records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, risk assessments, training records and audit results.

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

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

- The service did not always have enough staff to care for women and keep them safe.
- Staff did not always check emergency equipment in line with policy to ensure this was ready, safe and fit for purpose.
- Staff did not always feel respected, supported and valued. The service did not effectively manage cultural issues raised by staff
- There was a lack of learning from incidents. The incidents investigation backlog impacted on risk management. Action plans could not always be translated to learning as they were not embedded, therefore there was a risk of recurrence of incidents. There was a backlog of incidents which had not been reviewed, investigated and action plans had not been developed to mitigate risks of recurrence.
- Infection risk was not managed consistently

Our findings

- The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards. Staff did not always manage clinical waste well.
- Leaders did not always understand and manage the priorities and issues the service faced. Staff did not always understand the service's vision and values, and how to apply them in their work.

However;

- Staff treated women with compassion and kindness.
- Staff were responsive and worked hard, with limited resources, to meet the needs of women and their families.
- The service engaged with the local community and local Maternity and Neonatal Voices Partnership.

Maternity

Inadequate ↓

Is the service safe?

Inadequate ↓

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

Mandatory training

The service provided mandatory training in key skills to all staff. However not all staff had completed training in line with trust target.

Staff received but were not always up to date with their mandatory training. The maternity services training was comprehensive and met the needs of women and birthing people. Training was divided into trust mandatory training (core skills), and essential for role which included maternity specific modules and multi-professional obstetric simulated emergency training. Training included a mixture of online courses and face to face multi-professional simulated training. However, staff were not always completing training in line within the Trust target of 90%. Following the inspection, we reviewed data for training compliance. Data showed that for October 2023 66.75% of maternity staff had completed adult basic life support and 78.55% of maternity staff had completed level 2 newborn basic life support. There was also a low compliance for infection prevention and control (IPC) level 2 as 75.68% of staff had completed this training. The overall compliance training rate at the time of this inspection for midwives was 84% and for medical staff 83%. The risk of low life support and IPC training meant that the trust could not assure staff were trained to respond to patient deterioration on a responsive way.

The mandatory training was comprehensive and met the needs of women and staff.

Cardiotocography (CTG) is a continuous recording of the fetal heart rate obtained via an ultrasound transducer placed on the mother's abdomen. CTG is widely used in pregnancy as a method of assessing fetal well-being, predominantly in pregnancies with increased risk of complications. The service provided cardiotocography (CTG) study days and assessment between September and November 2023. These were attended by 91% of midwives and 94% of doctors. According to data submitted by the trust 95% of staff had passed the competency assessment.

CTG was covered in PROMPT (practical obstetric multi-professional training) training. This was evidence-based training and 93% of midwives had completed PROMPT against the trust target of 90%. The service also provided a two-day maternity update day to cover maternity specific topics such as smoking cessation, antenatal screening, reducing pre-term births and infant feeding which was to be attended by midwives, maternity care assistants and nurses

Staff attended a multi disciplinary team fetal monitoring study day with a competency assessment with a minimum pass mark of 90%. Between September and November, 2023, more than 90% of midwives and obstetric doctors attended the multi disciplinary Fetal Monitoring Study Day.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training compliance was monitored by managers and staff were encouraged to complete training before it had expired. Managers we spoke with confirmed that booking training venues was a challenge and also frequent staff shortages impacted on training completion. Staff told us they received emails about training which was due.

Maternity

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.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. The trust had a target of 90%. The Trust reported 94% midwives had completed safeguarding level 3 in October 2023 and that 84% of obstetricians had completed safeguarding level 3.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff we spoke with understood how to identify any concerns about harassment and discrimination and were able to describe the process of escalation. Equality, diversity and human rights was part of the core mandatory training programme.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had safeguarding policies in place for both adults and children. Maternity services had additional policies in place for female genital mutilation (FGM).

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, a colour coded flag was used to identify and highlight a safeguarding concern on the trust electronic system to ensure staff were aware and the support to provide. Staff knew how to make a safeguarding referral and who to report to if they had concerns.

Staff told us they felt confident to inform the safeguarding leads if they had any concerns. The service had specialist safeguarding midwives with designated roles in areas including female genital mutilation (FGM), mental health, young mothers, domestic abuse and substance misuse.

The safeguarding lead and midwives attended safeguarding strategy meetings with other agencies including the local authority to plan and support women and birthing people, when required. The team demonstrated a commitment to protect and maintain the security and well-being of women, birthing people, and their families,

Staff followed the baby abduction policy and undertook baby abduction drills. We were told that there had been 2 baby abduction drills performed in the last year however some staff could not describe learning outcomes. We were told that there had been no emergency obstetric drills performed on the post-natal ward.

Cleanliness, infection control and hygiene

Some areas which could not be cleaned effectively posed an infection risk. Infection risk was not managed consistently.

Staff were not always complying with their infection prevention and control policy for cleaning standards, to keep mothers and babies safe. The trust conducted infection prevention and control audits however performance was not clear as the data for the trust had been merged. Information on audits did not give a clear indication of performance in line with trust targets.

Maternity

Ward areas had suitable furnishings however not all areas were clean and well maintained. On inspection we saw a shower room that had mould. We flagged this on inspection and were told that the trust were planning on removing the mould. Other ward areas in the maternity unit were generally clean and well maintained by the hospitals contracted domestic cleaning team. During our inspection, we observed domestic staff regularly cleaning the floor, bathrooms and birthing rooms.

Ward areas were generally clean and had suitable furnishings which were clean and maintained. Ward areas in the maternity unit were generally clean and well maintained by the hospitals contracted domestic cleaning team. During our inspection, we observed domestic staff regularly cleaning the floor, bathrooms and birthing rooms.

We observed storage boxes on the floor which meant the floor could not be cleaned effectively. We also observed a blood gas analyser, used to record infant blood glucose levels being stored in a clean utility room. Traces of blood were seen on nearby storage boxes and posed an infection prevention and control risk.

Staff followed infection control principles including the use of personal protective equipment (PPE). All areas had a good supply of PPE for staff to use and we observed staff appropriately wearing items when completing clinical care.

Staff cleaned equipment after patient contact. However, the use of 'I am clean' labels was inconsistent, so it was not clear when equipment was last cleaned. We saw I am clean stickers used in some areas however this was not used consistently across the maternity unit.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards. Staff did not always manage clinical waste well.

The design of the environment did not follow national guidance. The environment layout was not in line with health building notes best practice guidance HBN 09-02 for maternity care facilities. There were 4 labour rooms that were not large enough to store life saving equipment. In the case of a baby requiring emergency medical treatment they would need to be carried out of the room and onto life saving equipment. This was placed directly outside the labour room.

Following the inspection, we asked the trust to take urgent action relating to the safety of women and babies within the midwife led unit because neonatal resuscitation equipment was not available for bedside use. In response the trust provided an action plan that meant that resuscitation equipment would be moved into rooms when needed. We asked the trust how they were assured that they had a safe ratio of infant resuscitaires to labour rooms. Senior staff confirmed the number of available resuscitaires had never been a cause for concern and the trust considered they were able to provide a safe service with the number available. The trust had procured additional smaller more mobile neonatal resuscitation equipment. However these were not in use at the time of the inspection. Following the inspection the Trust explained training was being rolled out to ensure staff were competent to use the new equipment is in use.

During the inspection a new building was being constructed to accommodate parts of the maternity service. The building work is expected to open in 2025.The new block would consist of:

- Maternity services – delivery suite, 3 operating theatres, midwifery led birthing unit, triage, bereavement
- NICU – intensive care, high dependency care, special care, transitional care, parental accommodation
- Critical Care – a 22 bed critical care floor

- Surgical arrivals and recovery
- Operating theatres – 8 new operating theatres, including two hybrid theatres
- A maternity ward block with maternity wards (antenatal and postnatal) and pre-operative lounge.

Women could reach call bells however there were delays in responding when called. On inspection we observed that call bells were attended to but staffing pressures meant responses were not timely. The trust did not audit response times for call bells.

Staff did not always carry out daily safety checks of specialist equipment. On the delivery suite resuscitation trolley checks were missing on 4 days out of 31 days in October 2023 without an explanation. There were also missing ECG checks for 6 days within a month. Information provided by the trust indicated that resuscitaires checks with completion rate of 47% in August 2023, 41% in September 2023 and 91% in October 2023. On inspection we spoke to senior leaders who were aware of low compliance and were working with staff to prioritise equipment checks.

There service had a range of equipment to monitor women and their babies. Following the inspection data submitted by the trust showed that equipment was not always checked. Of 309 items of electrical equipment, 14 were overdue including 6 air/oxygen blenders, 1 CTG, 1 infusion pump and 2 general purpose ultrasound imaging systems. There was a risk that the lack of a comprehensive audit of equipment meant that faulty equipment could be used.

Staff did not always dispose clinical waste safely. Sharp bins were labelled correctly on the wards however the clinical waste was not always stored securely. Clinical waste was taken off the maternity unit and stored for collection. This storage area was near the entrance of the maternity unit and was accessible to the public. This area was not secure and on inspection there were clinical waste in bins that were not locked.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each woman and took action to remove or minimise risks.

Staff did not know about specific risk issues. On inspection, staff were unaware of ligature risk assessment in line with NHS England National Patient Safety Alert/2020/001/NHSPS for each ward. Following the inspection, the trust had completed assessments for each ward.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used Maternity Early Obstetric Warning System (MEOWS) to detect patient deterioration during pregnancy, delivery and postnatal. The service used Newborn Early Warning Trigger and Track for infants. MEOWS had been completed in the 5 records reviewed.

Staff completed risk assessments for each woman on admission and flagged women to consultant-led care if risks were identified. The Royal College of Obstetricians and Gynaecologists recommend that maternity triage departments implement the Birmingham Symptom-specific Obstetric Triage System (BSOTS), which is the recommended triage system in England. Using this system offers standardised initial assessment and symptom-specific algorithms to identify those women who require more urgent attention in a busy clinical setting.

On the day of inspection, the service was not operating in line with BSOTS due to challenges with staffing within triage. There had been a review of the BSOTS model and was planned to be relaunched in the next few weeks, although we were not provided with a plan. The service had a system in place for the midwives and clinicians to review the risk assessments during each appointment or episode of care. There had not been an audit of the triage service.

Staff completed individual risk assessments on admission to the delivery unit. These included venous thromboembolism (VTE), which we saw staff had completed in the medical records.

A review of 5 sets of women's notes showed that carbon monoxide monitoring was being completed. Risk assessments were being completed to identify high risk women although labelling was not always clear.

Staff used a 'fresh eyes' approach to fetal monitoring. 'Fresh eyes' is a checking system that uses peer review to give a second opinion on CTGs. However, the process was not consistent, with fresh eyes stickers being used in different ways. Some notes stated just 'yes' for fresh eyes, and some midwives used a separate sticker for their fresh eyes assessment.

Safety huddles took place in each ward or area and included all necessary information to keep women and babies safe. There was an overview of antenatal women who were in-patients. Some safeguarding issues were highlighted which could be clinically relevant. The midwife in charge shared safeguarding and birth plans and was able to handover events from previous days. The handover also included a discussion about high-risk women. Staff were encouraged to contribute, and there was effective communication and shared learning.

Maternity services had a day assessment unit. The day unit worked on a booked appointment system and the responsibilities included compiling monitoring checks on mothers and observations.

Shift changes and handovers included all necessary key information to keep women and babies safe.

Maternity theatres completed the World Health Organisation 5 steps to safer surgery checklists for all surgeries. Patient records we reviewed for women who had caesarean section deliveries demonstrated that staff had completed the checklist. The service completed monthly compliance audits for the completion of the WHO checklist. We reviewed the audit results from August 2023 to October 2023 which demonstrated that the maternity theatres had achieved a compliance of over 90% which was the trust target.

There had been 3 pool evacuation drills since the last inspection in March, May and July 2023.

Midwifery Staffing

The service did not always have enough nursing and midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers did not accurately review and adjust staffing levels.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. On the first day of inspection 6th November 2023 the hospital was at capacity and staffing pressures had contributed towards the trust decision to go on divert.

Staffing levels did not always match the planned numbers, putting the safety of service users at risk. The delivery suite was understaffed during the inspection and there was not enough staff in triage. On the first day of inspection the antenatal and postnatal wards were at capacity. This impacted on women in a variety of ways, for example, triage was often used as an overflow which was not always appropriate.

In the community, staff told us day to day staffing was often difficult to manage due to frequent on-call cover. Community staff were pulled to cover the labour wards which impacted on the service because midwives were not available for their planned work in the community the following day.

Maternity

Managers reviewed the number and grade of midwives, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. This included midwives dedicated to the triage area. On the first day of inspection the midwife allocated to the triage phone was redeployed due to short staffing. This created additional pressure on triage who were caring for women waiting to be induced. Managers told us maternity staffing levels were discussed at all situation reports (sitreps) meetings. Following the inspection, we requested evidence of sitreps for 6 and 7 November to evidence how the escalation process was managed. There was a variance between the local and trust level sitreps for delivery suite and the midwife led birthing unit (MLBU). This meant that leaders did not have assurance of accurate account of staffing requirements on the wards. The trust was unable to provide evidence sitreps for 0400, 0800, 1200 and 2000 hrs. The maternity unit went on divert on 6 November at 1120 however this escalation was not on the 1130 cross site sit rep. There was not an effective escalation which resulted in patient delay in treatment of women who were waiting to be induced.

Senior leaders described how they mitigated risk when staffing did not meet acuity levels. Leaders explained the service escalation process which was detailed in their escalation policy. The policy detailed the minimum number of midwives needed on the ward areas and that escalation should go through the services supernumerary bleep holder. They would redeploy midwives not engaged in clinical duties to ensure cover.

On the day of inspection midwifery staffing across the service was short by 8 midwives and 4 maternity support workers. For the night shift the service was short by 8 midwives and 1 maternity care assistant. Records we reviewed showed, low staffing resulted in significant delays in admitting and transferring patients onto wards.

A midwifery red flag event is a warning that there may be an issue with staffing. Red flag events are situations such as missed or delayed care, delay between admission for induction and beginning of process, and the coordinator being unable to remain supernumerary. Once a red flag event is highlighted, the midwife in charge should be alerted and if staffing is identified as the cause, action should be taken. There were 102 red flag events within maternity for November 2023 reported at Luton and Dunstable Hospital. During the inspection there were 6 red flag events for delayed induction of labour and 1 red flag for a delayed artificial rupture of membrane.

At the Luton and Dunstable Hospital the staffing level on delivery suite was met for 41% of time in September 2023.

In September 2023, at Luton and Dunstable Hospital the day registered midwives (RM) fill rate was 75.83% and night fill rate was 79.44. The unregistered day fill rate was 62.67% and night fill rate was 71.76%. This meant that staffing was not always at the planned level.

The midwife allocated to the triage phone in the morning was reassigned due to staffing shortages. Staff we spoke to said that they would often be pulled from the ward they were assigned to. Staff also said that they would often struggle to take breaks and would frequently work long shifts.

On the second day of the inspection the day assessment unit was reallocated onto an inpatient ward because there were not enough staff to run the service.

The hospital conducted a workforce planning review in January 2022. The generic casemix at the hospital has increased since the previous assessment and 69.7% of women are in the 2 higher categories which is significantly higher than the 58% average for England. On inspection leaders spoke about the correlation between casemix and maternity outcomes especially in relation to induction rates, delivery method, post-delivery problems and obstetric and medical complexity.

Maternity

The overall birth to midwife ratios has changed to 21.1 births to 1 whole time equivalent (WTE) clinical midwife for Luton and Dunstable University Hospital (1:21.1), this is a reflection in the change in casemix. The ratio is calculated by dividing total births by the total clinical midwives. Ratios are dependent on demographics; case mix, models of care, total number of community cases and the differing needs of women, but most usually range between 1:26 at the higher end and 1:34 at the lower end. This means that for every 26 births, 1 clinical WTE midwife is required.

On inspection Leaders said the trust is not compliant with the funded establishment based on the January staffing review. We were told a case is being developed by the midwifery leadership team and deputy director of finance to improve staffing and comply with the Maternity Incentive Scheme Year 5. Staff told us that the recruitment of internationally recruited midwives had helped improve numbers of staff, however the skill mix did not always match the higher acuity on the wards.

The supernumerary status for Band 7 Delivery Suite Coordinators (not providing 1:1 care) was 100% in September 2023.

The service had a vacancy rate of 13.1% (30.71 WTE) for registered midwives (RM). This was an improvement since our last inspection.

There has been a small increase in sickness from 5.4% in August to 5.7% in September.

Staff said monthly sickness absence management meetings are held with matrons and ward managers to ensure compliance with sickness absence policy, along with return to work interviews following sickness absence. Maternity leave accounts for 10.4 WTE in September 2023 and no themes have been identified around sickness.

Managers primarily used bank staff to try and fill shifts however there were many unfilled shifts. In September 2023 there were 5436 hours unfilled. Of these hours 2784 were filled by bank staff and 25 hours filled by agency staff. This meant that most shifts were unfilled.

At Luton and Dunstable Hospital the day registered midwife fill rate in September 2023 decreased to 75.83% and night fill rate decreased to 79.44%.

The hospital went on divert for one occasion during September 2023 due to low staffing.

Medical staffing

The service generally 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 reviewed and adjusted staffing levels and skill mix and offered locum staff an induction.

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

Staff on Triage and Day Assessment Unit (DAU) told us women would benefit from access to a dedicated doctor, particularly at peak activity. Midwives had to bleep the delivery suite doctors to attend when needed, this frequently led to delays if the doctors were treating patients in the delivery suite. At the time of inspection the Trust had approved a business case for a junior doctor to support the triage units during peak periods.

Maternity

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There was a consultant led ward round twice daily on the delivery suite. There are 2 consultants one for obstetrics and one for gynaecology, independent of any other elective activity cover. Both consultants physically present in hospital from 0830 to 1700.

Consultants completed rounds and were supported by a team of speciality registrars and junior doctors. There was always an anaesthetist available for the delivery suite. The critical care outreach team and intensive therapy unit (ITU) provided support when requested. The service always had a consultant on call during evenings and weekends.

Out of hours triage was covered by the on-call team, which covered all areas of the service. This meant doctors may be busy in other areas when people needed to be seen in triage. On inspection staff told us there were delays in doctors seeing triage patients within the required time frames and could often be waiting for many hours.

The trust completed an audit of consultant attendance for the Royal College of Clinical Gynaecologists (RCOG) Clinical Situations for the time period of 1st May 2023 to 30th June 2023. Audits showed that in May, there was 1 mandatory condition where consultants needed to be present and they attended. There were 47 non-mandatory conditions of which consultants were present in 44 cases (93.6%). In the remaining 3 cases (all outside normal working hours), the registrars were signed off as competent.

In June, there were 3 mandatory conditions where consultants needed to be present and adhered with all cases (100%). There were 44 non-mandatory conditions and consultants were present in 40 cases (90%) and 4 cases were out of office hours where registrars were deemed competent to manage them.

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

An obstetrics and gynaecology consultant had recently joined the service in October 2023.

Following the inspection we were told 2 consultants were joining in November 2023 for early pregnancy and obstetrics and gynaecology. Gaps of resident consultants' slots would be covered by the new team arriving to fulfil the planned consultant cover. In addition 2 junior doctors would be appointed to cover twilight and second junior overnight.

There was a low sickness rate for medical staff. Sickness rate was 1.74% in October 2023.

Records

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

Women's notes were completed, and all staff could access them easily. We reviewed 5 sets of maternity records, all records included mental health assessments, fetal movements, risk factors such as high BMI, MEOWS, and entries were signed and dated. This meant that information about women accessing care was available to staff. The women had 2 sets of paper records. The women held one set of records and the service the other, this ensured the women always had a copy of their notes available.

The service had different information technology platforms for recording women's data for audit and assessment purposes. On the inspection staff told us the two platforms did not always effectively transfer data between the two systems which meant that some data was not accessible.

When women transferred to a new team, there were no delays in staff accessing their records, as the women took their hand-held notes to all clinical appointments or when accessing care from other services.

Records were stored securely.

Medicines

The service did not have effective systems and processes to safely prescribe and administer medicines. The discharge process and monitoring of prescriptions were not always effective. The service did not always store medicines safely.

Staff followed systems and processes to prescribe and administer medicines safely. Patient medicines charts and prescriptions were paper records. We looked at 9 medicines charts and none contained a documented patient weight. The impact of this are potential mistakes leading to poor outcomes for women and birthing people.

Staff did not always complete medicines records and kept them up-to-date. A review of 9 patient records who had a record of an omitted medication and did not have a reason documented.

Staff did not always store all medicines safely. On inspection we found take home medications were not stored securely on ward 33. This was escalated to the deputy head of midwifery. The medications were removed but not stored securely and remained in the ward office.

The pharmacy team completed regular checks of the medications cupboard however these were not always effective. On ward 33 we found that oral solutions did not have a date opened recorded. There was also 3 injectable medication solutions that had been labelled for women who had been discharged from the ward.

Incidents

Most staff recognised and reported the majority of incidents and near misses. However, we found there was not an open culture of incident reporting in relation to all types of incident, particularly in regards to those relating to racism and discrimination. When things went wrong, staff apologised and gave patients honest information and suitable support. However, the service did not always correctly grade incidents or manage them in a timely manner.

Staff did not feel able to report instances of racism when this had been experienced on the ward and between midwifery staff, including managers. We spoke to leaders who acknowledged that some parts of maternity had a challenging culture and were working on increasing their visibility on the ward. Staff were concerned that incidents of racism they reported to the trust would not be investigated in line with the trust's values. Following the inspection, we raised concerns about racism within maternity services and how incidents could be managed in a culturally competent way. The trust set up a task and finish group made up of senior leaders to undertake an engagement programme to further investigate these issues.

On inspection we were told that lack of staffing and increased acuity on the wards had meant that staff were working in challenging situations when women and birthing people were at the point of delivering a baby and that a learning culture was not encouraged when things went wrong. Staff did not feel able to report instances of racism when this had

been experienced on the ward and between midwife staff, including managers. We spoke to leaders who acknowledged that some parts of maternity had a challenging culture and were working on increasing visibility on the ward. Staff were concerned that incidents of racism would not be investigated in line with the trust's values. Following the inspection, we raised concerns about racism within maternity and how incidents could be managed in a culturally competent way.

During the period of 1 July 2023 to 30 September 2023 there were a total of 11 deaths; 1 neonatal death and 10 stillbirths reported. Between 17 October 2022 and 31 October 2023 there had been 1582 incidents.

On inspection ward 32 showed information on incidents open across the whole of maternity. This meant that staff would not be aware of ward specific risks and incidents. The impact of open incidents had meant that staff were not kept up to date with learning in a timely manner. The service had 534 open incidents, these incidents were either awaiting investigation, currently being investigated, or awaiting final approval. There were 44 incidents that were low harm or no harm that dated back to 2022. These incidents had not been closed in line with trust timeframe.

A review of open incidents showed that 102 incidents categorised as staffing incidents, 67 of these relate to midwifery shortage. All incidents are low or no harm. There were 15 staffing incidents reported related to triage. This included 11 incidents where only 1 midwife was working in triage.

There had been 18 incidents relating to home birth services trust wide. There were 3 incidents relating to the home birth service being suspended at this location.

Health Services Safety Investigations Body (HSIB) investigate patient safety concerns across the NHS in England and in independent healthcare settings where safety learning could also help to improve NHS care. There have been 9 cases reported to HSIB between 1st April 2023 and 30th September 2023.

Staff could not always meet to discuss the feedback and look at improvements to the care of women and birthing people. Staff told us there were weekly CTG sessions with the fetal monitoring lead consultant by video link, however they said it was difficult to attend these when at work. Staff told us that they found it difficult to find the time to attend these sessions. The provider could not be assured the CTG learning from cases was effective.

The service had no never events on any wards. Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Staff understood the duty of candour (DoC). They were open and gave women and families an explanation if and when things went wrong. Staff were able to describe their legal obligations under DoC and were aware of then they would be required to act upon this. For example, 1 member of staff told us of a medication error which had previously happened in the service.

Staff said they did not always receive feedback from investigation of incidents. Staff told us they did not always have responses about the incident reports which they had submitted. Although when they did receive feedback, learning from incidents was shared at handovers and huddles in all clinical areas.

Women and their families were involved in serious incident investigations. We reviewed minutes of the learning from deaths board. This showed that parents were informed of the review of deaths and that their perspective and concerns were sought.

Maternity

Mangers did not collect data on health inequalities in relation to incidents. The service could not be assured that it was measuring its impact in reducing health inequalities.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance.

The service had a structured audit programme to ensure practice was reviewed and audits were completed to ensure staff followed local and national guidance.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. Where appropriate, staff would refer or signpost women for further support. The service also had specialist midwives to cover a variety of holistic needs and would also be involved with a woman's care if required.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We observed shift change handovers and individual patient handovers between staff. We saw staff discussed women's mental health needs when they required additional support.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. The clinical areas had a refreshment area for women and relatives. Women could make hot drinks and had access to beverages and biscuits. This was in addition to the main meals served. Women told us that the food was good.

Women in the triage area had access to a drinks station and biscuits. As women could wait for several hours depending on staffing, staff told us they had organised delivery of more substantial food, such as sandwiches.

Staff fully and accurately completed women's fluid and nutrition charts where needed. We reviewed women and baby records and saw fluid and food charts were completed. Staff used a nationally recognised screening tool to monitor women at risk of malnutrition. Specialist support from staff, such as dietitians and speech and language therapists was available for women who needed it.

There was a breast feeding midwife who was able to support women to breastfeed. The hospital helped 80% of mothers to breastfeed their newborns in November 2023.

Pain Relief

Staff assessed and monitored women to see if they were in pain however, they did not have assurance give pain relief was administered in a timely way.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Women received pain relief soon after requesting it. Women we asked did not have any concerns with timeliness of pain relief. Pharmacological methods of pain relief were readily available and included nitrous oxide (gas and air), opioids, and epidural anaesthesia, which was available 24-hours a day. Non-pharmacological methods of pain relief were also available.

We reviewed audit data of epidurals that showed how its medical effectiveness was being monitored. The data did not show the timeliness of pain relief administration at the point of request. The hospital is not able to provide assurance that pain relief was administered in a timely way.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain relief such as nitrous oxide, oral pain relief and an epidural were available to women. Epidurals (an injection of anaesthetic into the spinal area) were available 24 hours a day. The service had a duty anaesthetist available on the unit 24 hours a day. The hospital reported to board compliance against Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1. This standard requires that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits including the national report for perinatal mortality for births: Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) 2021 audit. The result showed the still birth rate was 3.7 and the neonatal death rate was 1.7 (per 1000 live births) which were both slightly higher than the England averages of 3.5 and 1.7 respectively. The hospital had an action plan in place to improve outcomes. This included independent external reviews from LMNS (local maternity and neonatal system), reviewing trust level data frequently to identify modifiable factors and work with the MNVP (Maternity Neonatal Voices Partnership) team to communicate with women from Black and Asian populations to identify specific needs.

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

The trust was not fully compliant with the Saving Babies Lives Care Bundle Version 3 at this time, and actions are in place to identify and implement the interventions and resources required to address this.

Following the inspection, the trust provided data that 103 elective caesarean section had been postponed and rescheduled between August 2023 and October 2023.

There had been 395 cancelled antenatal clinic appointments.

The service used a LMNS maternity dashboard to monitor and compare various clinical outcomes figures with their peers within the LMNS. This included but was not limited to emergency caesarean sections, vaginal deliveries, third and fourth degree tears, stillbirths, post-partum haemorrhage, maternal deaths and pre-term deliveries. Data was provided by the trust covering September 2022 to September 2023 however, it did not specify what the targets for each clinical outcome was and how the service was performing in comparison to their peers. The service did however monitor clinical outcomes independently which they then measured against various national ambition rates. The clinical outcomes included massive obstetric haemorrhage, third and fourth degree perineal tears, smoking at time of delivery, pre-term birth rate, term admission to the neonatal unit, pre-term administration of magnesium sulphate, pre-term administration of antenatal steroids and women being in the right place of birth. We reviewed data between June 2023 and August 2023 and outcomes for August 2023 50% of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 100% of babies born before 30 weeks of gestation who received magnesium sulphate within the 24 hours prior to birth.

Competent staff

The service made sure staff were competent for their roles however, managers did not always conduct yearly appraisals.

Midwifery staff were supported by band 7 specialist midwife practice development lead. However, we were informed they had to work clinically due to staffing shortages at times of high acuity.

Staff had the right skills and knowledge to meet the needs of women. Newly qualified band 5 midwives all had a preceptorship which was a period of time for them to complete a set list of competencies. These midwives were required to rotate around different areas to ensure they were competent in all settings. On inspection there was a concern that newly registered midwives were not protected when supernumerary and would be tasked with responsibilities

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The service did not always conduct annual appraisals with their staff. Although appraisal rates had improved since the last inspection overall compliance remained low. The trust had a target of 90% compliance and 65.74% had received an appraisal.

The clinical educators supported the learning and development needs of staff. Clinical educators worked did not always have protected time to support midwives and were in post on a substantive basis.

Staff were qualified to meet the needs of women. The trust had recruited a cohort of internationally trained midwives who were being supported to develop their skills and experience within the NHS. The trust were helping to develop ongoing CTG training. Due to staffing constraints at the trust, we were told that supernumerary staff would sometimes be working with less support due to the high acuity on the wards. We saw evidence of incidents where supernumerary staff with 2 patients who were high risk on continuous electronic fetal monitoring (CEFM) had to be allocated to a midwife who should have been supernumerary due to staffing shortages.

All staff that cared for women in labour were required to undertake annual training and competency assessment on cardiotocography (CTG). Staff were assessed through a competency assessment tool and were required to achieve 90% to pass the module. The seven modules include intrapartum CTG, fetal blood sampling and antenatal CTG. Review of

data after the inspection indicates the junior doctors were at 90% in all competencies and the delivery suite midwives at 80% in all competencies and at 100% in intrapartum CTG competency. The service holds monthly CTG study days led by the fetal monitoring midwives, for newly qualified midwives and bespoke CTG training for internationally recruited midwives.

100% of obstetric staff had received an appraisal.

Managers gave all new staff a full induction tailored to their role before they started work. All newly qualified midwives went through a preceptorship programme and were supported to gain skills and experience within their role. The local head of midwifery met with all newly qualified midwives individually as part of their induction. All bank staff had to complete a full trust induction programme and a local induction for each clinical area they worked in.

Doctors completed medical revalidation every five years. Data reviewed after the inspection indicated 100% of doctors were up-to-date.

Multidisciplinary working

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

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

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff in all areas of the maternity service told us they worked closely together to make sure women received person-centred and effective care, this included working with healthcare professionals outside the trust. The patient records we reviewed corroborated this.

We observed all staff working well as a team to ensure women had safe care and treatment. Staff were complimentary about other members of the multidisciplinary team (MDT).

Staff worked across health care disciplines and with other agencies when required to care for women. Staff were aware of how to contact other agencies such as social services.

Seven-day services

Key services were available seven days a week to support timely care.

All women could access maternity care 24 hours a day, 7 days a week. Women over a specific gestation could attend maternity directly by triage, but women could also report to the hospital in an emergency through the accident and emergency (A&E) department. There was also access to an advice line 24 hours a day, 7 days a week.

Consultant obstetricians and anaesthetists were available on-call 24 hours a day, 7 days a week. The service always had a consultant anaesthetist and obstetrician on call along with a full obstetric team who were physically on the unit. Consultants led daily ward rounds on the delivery suite and maternity ward. Women were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests such as MRI and x-rays, 24 hours a day, 7 days a week.

Maternity

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. The service had information available in multiple languages on both the website and leaflet form. Service leaders told us they were keen to develop information available for women in accessible formats to suit the needs of the local population.

Mothers were supported to initiate breastfeeding postnatally in hospital and when discharged home. We saw a large amount of information and literature which women could access in order to promote a healthier lifestyle.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, women were asked about their smoking status at their booking appointment and had carbon monoxide monitoring if they smoked. Women were offered smoking cessation support and could be referred to a smoking cessation service.

The service assessed woman's health needs such as diabetes, smoking and vitamin D deficiency as part of the antenatal checks. Staff were able to give women information and where appropriate refer to specialist services.

Staff told us they followed the 'Saving Babies' Lives Care Bundle'. This was an initiative from NHS England (NHSE) to reduce stillbirths and early neonatal deaths. The four elements of care are: reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movement, and effective fetal monitoring during labour.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff made sure women consented to treatment based on all the information available. All women we spoke with felt they had been given enough information, including risks and benefits, to make an informed decision over their care and treatment and that they were able to give informed consent.

Women were able to give us examples of information they had been given and how they were asked for their views and preferences before consent to treatment.

Staff clearly recorded consent in the woman's records. A review of women's records indicated that consent was recorded in line with trust policy.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff we spoke with were able to explain the procedure if there were concerns over the woman's capacity to consent. Staff were supported by a dedicated mental health midwife.

Staff took verbal consent at the antenatal booking appointment for blood testing, for example for blood screening and human immunodeficiency testing. Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Maternity

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. At the time of our inspection, there were no patients who were detained under the Mental Health Act 1983 (amended 2007) and none who were subject to a Deprivation of Liberty Safeguards) authorisation under the Mental Capacity Act 2005

It was unclear whether staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as the service did not provide any data on this. However, there is not usually a regular need for MCA and DoLs in maternity.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Staff took time to interact with women and those close to them in a respectful and considerate way. Curtains were drawn around the beds when there was an episode of care.

Women said staff treated them well and with kindness.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff introduced themselves to women when they provided care. Women were informed of care that was being provided and what to expect next, for example we saw a patient being guided through triage and having their medical observations explained to them.

Staff followed policy to keep women's care and treatment confidential. We observed staff handovers, which were held away from where women or their families could hear their discussions.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Staff we spoke with presented as non-judgemental and open towards all patients regardless of their personal, cultural, social, or religious needs.

Emotional support

Staff could not always provide emotional support to women, families and carers to minimise their distress. Staff understood women's personal, cultural and religious needs.

Maternity

Staff gave women and those close to them help, emotional support and advice when they needed it. However, staff had not considered the emotional impact of removing babies requiring emergency care from the labour rooms to resuscitaires and the anxiety this would cause women to be separated from their babies Following the inspection we fed our concerns back to the trust who in turn reviewed their procedures to bring emergency resuscitation equipment into the room where care was being delivered. On inspection staff said that they were working at capacity on most shifts and therefore found it difficult to provide the level of emotional and wellbeing support that they had been trained to deliver.

Midwives involved the support of specialist midwives where additional support was required. For women and those close to them who required support following the loss of a baby, the bereavement midwife provided support to them in a designated bereavement suite.

Women were supported to access psychological, and the mental health team as needed. Women who had known mental ill health had support from a mental health specialist midwife.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff told us they were also able to request support from faith leaders for women who required support. Staff told us they had access to a range of faith leaders. Staff had also had support from them when they had experienced a challenging and emotional situation.

Understanding and involvement of women and those close to them

Staff supported and involved women to understand their condition. The service was working to ensure women made informed decisions about their care and treatment.

The service encouraged the women who used the service to engage with other organisations such as the maternity voices partnership (MVP). We spoke with the local MVP service who told us they had a strong relationships with the trust. The trust told us that the local MVP allowed the service to engage with the local community.

The service had developed specialist roles such as the patient experience midwife. This enabled the service to engage with community groups and cultural workshops.

The service also worked closely with Maternity Neonatal Voices Partnership (MNVP). The MNVP helps the NHS to hear the diverse voices of service users, they have done this by hosting listening events at baby groups, children's centres, and libraries. This information is then fed back to the trust to improve women's experiences using the service.

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service did not always plan or provide care in a way that met the needs of all local people and the communities served.

Maternity

At the time of our inspection the maternity unit was put on divert due to insufficient midwifery staff and a shortage of beds which meant that women, and birthing people, who had planned to attend the day assessment unit were asked to attend Ward 32 instead. The triage phone was diverted to the delivery suite. As part of the escalation process the home birth service had been suspended.

The service worked closely with local stakeholders and neighbouring trusts to establish the local maternity system to improve the maternal and neonatal safety across the clinical network.

Facilities and premises were not always appropriate for the services being delivered. Leaders were aware of most of constraints of the current premises and were developing plans for the new maternity unit that was under construction.

The trust's website contained a dedicated maternity section. The maternity pages provided basic information about antenatal care and services, labour, and postnatal care and support. Not all pages were up to date for example the trust offered a home waterbirth was encouraged on the website but is no longer offered by the hospital..

The service had systems to help care for women in need of additional support or specialist intervention. The safeguarding team had piloted a HOPE box. The HOPE Boxes are an intervention to help support women who are separated from their baby close to birth due to safeguarding concerns.

Managers monitored and took action to minimise missed appointments. Managers ensured that women who did not attend (DNA) appointments were contacted. Staff sent text reminders to reduce DNAs.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff made sure women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

The service had a 24-hour access to mental health liaison and specialist mental health support. The mental health provision was provided by a different trust and a policy was in place to support access. The service had a specialist mental health midwifery team available for support and guidance for both clinical staff and women. All women underwent 'Whooley' assessments to assist in screening for depression. This identified if there were concerns with a woman's mental health and enabled staff to escalate their concerns. We found all women had this assessment documented within their records.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Staff had access to 24-hour language interpretation services, this service could be via telephone, video, or face to face. BSL sign language interpreters were available for face-to-face appointments or via video link.

The service had information leaflets available in languages spoken by the women and local communities. We saw leaflets available on the wards in a range of languages. The trust website also had an accessibility tool called 'Recite Me' that was able to translate web pages to a range of languages.

Women were given a choice of food and drink to meet their cultural and religious preferences. This included Halal, vegetarian, and vegan options for patients. Menus were available in pictorial and braille versions (translated by the royal national institute of the blind) too.

Maternity

Access and flow

People could not always access the service when they needed it.

Managers monitored waiting times and made sure women could access services when needed however treatment was not always delivered within agreed timeframes and national targets.

Not all women could access the service within agreed timeframes. On the first day of the inspection the hospital went on 'divert' which meant there was no capacity. Ward 32 was at capacity and had no available beds. Due to antenatal clinic capacity women/pregnant people were sent to triage for scan reviews which meant they had to wait a long time before being reviewed by a consultant. There was no dedicated doctor within triage. The doctor was on call and this resulted in delays. Staff reported frequent delays for a doctor review that meant patients could wait 4-6 hours.

The maternity unit had an escalation policy to support staff during peaks in activity however on inspection we found that there was no record of situation report (Sitrep) until 4pm on 6 November. The maternity unit went on divert at 11.20am on 6 November. Following the inspection, we wrote to the trust about the lack of evidence that the escalation policy had been followed. The trust submitted evidence that demonstrated that relevant processes were in place when the unit went onto divert and when the service had reopened.

We heard there were delays when women were being transferred to a different ward for example from triage.

Following the inspection, we requested data on delayed discharges. The trust was in the process of moving to an electronic bed management system. The trust were not able to provide an assurance that action was being taken to reduce delayed discharges at the hospital.

The hospital monitored the number of missed hospital appointments. The hospital had a policy that clearly gave a direction for staff to follow up missed appointments. There were 559 people who did not attend their antenatal clinic appointment during the 3 months August – October 2023. Staff sent text reminders to reduce DNAs. There was no process for the service to audit if the service was following the policy. There was a risk that missed appointments were not being followed up in line with the policy.

Learning from complaints and concerns

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

Women, relatives and carers knew how to complain or raise concerns.

There were processes in place for responding to complaints and information was available to women and their families of how to complain. Leaflets informing patients how to make a complaint or how to contact the patient advice and liaison service (PALS) were available in all areas of the maternity service.

The service clearly displayed information about how to raise a concern in patient areas. Patient feedback boards were displayed clearly throughout the maternity unit. This included information about how to raise concerns or make a complaint and also provided information about changes that have been made as a result of feedback.

Managers debriefed and supported staff after any serious incident.

Maternity

Is the service well-led?

Inadequate  

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

Leadership

Leaders demonstrated that they understood some of the issues the service faced, however, they were not always managed and prioritised effectively.

Leaders had not understood all the issues the service faced in terms of safety and quality. For example, there was no risk assessment for placing resuscitation equipment on corridors that would require a baby to be handled in an emergency and carried to a corridor for treatment. The trust was working towards transitioning to a new medical unit that was being built at the time of inspection. The building was expected to open at the end of 2024. We found that ligature risk assessments had not been completed on the wards and were submitted following our inspection.

The trust was reliant on escalation processes where there were staffing shortages. Staff felt unsettled as they were not always working on the shift they had been allocated to do. Specialist and community midwives told us they were often required to work clinically to support where there were staff shortages, and this took them away from their roles in supporting women within their field. Leaders had recognised the need for managers to help in times of staffing pressures, however this was to the detriment of their specialist roles.

The leadership team comprised of the Director of Midwifery, General manager and Clinical director of gynaecology and obstetrics providing cross site oversight of Bedford and Luton and Dunstable Hospitals. The Luton site had a triumvirate that included the head of midwifery, a deputy general manager and clinical leads for obstetrics and a separate lead for gynaecology. The Director of midwifery was supported by a Head of Midwifery and three midwifery matrons for:

- wards and the day assessment unit,
- delivery suite
- community/ antenatal care
- and a named midwife for safeguarding.

The director of midwifery (DOM) had a strategic role and was supported by a head of midwifery (HOM) who would took ownership of the operational aspects. The DOM was visible throughout the service and was providing clinical support when there were staffing pressures.

The Director of Midwifery confirmed that they had access to the trust board and felt supported. They were also the local maternity safety champion and responsible for reporting updates to the board.

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. For example, 40 internationally recruited midwives had been trained at the Luton site and many were moving from band 5 to band 6 following preceptorship periods.

Maternity

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, however not all staff were aware.

Some staff were not aware of the vision and strategy for the service. Staff we spoke with said they had not been consulted in the design of the new building that the maternity service would relocate to. At the time of the inspection, matrons had started to be involved in some aspects of the layout.

The trust had been engaging with stakeholders through forums in 2023 to produce a strategy that was due to be presented at the Trust clinical validation committee in January 2024. We saw evidence of staff engagement and involvement of local community groups such as Luton Maternity Voices Partnership (MVP), public body representatives and partners from the local maternity and neonatal system (LMNS).

The service had a set of values which were described by the acronym THRIVE: Teamwork, Honesty and openness, Respect, Inclusivity, Valuing people, Excellence.

Culture

Not all staff felt respected, supported and valued at a local level. Staff were not always focussed on the needs of women receiving care. The service provided opportunities for career development. However, the service faced challenges with promoting equality and diversity in its daily work. The service was working towards an open culture where patients, their families and staff could raise concerns without fear.

The trust participated in the nationally mandated Workforce Race Equality Standard (WRES) data collection. The data at trust level (rather than for the maternity service) as of March 2022 showed disparity for staff from ethnic minority groups for the following indicators:

- Indicator 1: representation of staff from ethnic minority groups in the workforce by pay band: there was disparity of representation for every level of staff apart from non-clinical staff lower to upper bands
- Indicator 2: likelihood of appointment from shortlisting: The likelihood ratio was 1.73. Specifically, 8.3% of White
- candidates were appointed from shortlisting compared to 4.8% of candidates from ethnic minority groups. The trust performed better than 34% of trusts and worse than 66% of trusts.
- Indicator 4: relative likelihood of White staff accessing non–mandatory training and continuing professional development (CPD) compared to staff from ethnic minority groups. The likelihood ratio was 0.85. The trust performed better than 43% of trusts and worse than 57% of trusts.
- Indicator 7: belief that the trust provides equal opportunities for career progression or promotion: This was significantly lower for staff from ethnic minority groups (46.2%), than for White staff (59.5%). The trust performed better than 58% of trusts and worse than 42% of trusts.
- Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months: This was significantly higher for staff from ethnic minority groups (17.2%), than for White staff (7.1%). The trust performed better than 41% of trusts and worse than 59% of trusts.
- Indicator 9: BME representation on the board minus BME representation in the workforce: the difference between representation of people from ethnic minority groups on the board and in the workforce was -40.1%. Staff from ethnic minority groups were underrepresented on the board by eight members in terms of a headcount, this was worse than 99% of other Trusts.

For other WRES indicators, trust level data did not show significant disparity, as follows:

- Indicator 3: The relative likelihood of staff from ethnic minority groups entering the formal disciplinary process compared to White staff. The likelihood ratio was 1.20. The trust performed better than 83% of trusts and worse than 17% of trusts
- Indicator 5: The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. This was similar for both White staff and staff from ethnic minority groups. the trust performed better than 56% of trusts and worse than 44% of trusts.
- Indicator 6: The percentage of staff who experienced harassment, bullying or abuse from other staff in the last 12 months. This was similar for both White staff and staff from ethnic minority groups. the trust performed better than 68% of trusts and worse than 32% of trusts.

In the 2022 NHS Staff Survey results, a quarter of Trust's midwives reported experiencing at least one incident of bullying, harassment or abuse from managers in the last 12 months, compared to 18% of midwives across all Acute and Community trusts nationally.

In addition, almost a third of Trust's midwives reported experiencing at least one incident of bullying, harassment or abuse from colleagues, compared to about a quarter of midwives at all Acute and Community trusts.

The trust level data described above indicated areas of disparity at trust level, which determined some areas of focus whilst undertaking the maternity level inspection. During the inspection, a number of midwives came forward and described a culture in which it was normalised for people from ethnic minority groups to tolerate discrimination from their colleagues and felt they were not able to bring their whole selves to work. Midwives and other staff we spoke to reported incidents of racism that had occurred towards the internationally recruited cohort of staff, alongside more subtle microaggressions that reflected racial stereotypes and a lack of cultural awareness. A microaggression is a form of discrimination that can be intentional or accidental, targeting a marginalised group or individual. The internationally recruited midwives reported that these microaggressions and other subtle forms of behaviour contributed to them feeling a sense of exclusion from the wider team. Some of these instances had been reported formally as incidents, but we were unable to establish what meaningful action had been taken as a result.

Due to high acuity on the wards and the training of internationally recruited midwives amidst these staffing shortages, it was not always possible for staff to be supported in their learning, further adding to the strain of these working relationships and putting further pressure on this cohort of staff. Staff that were responsible for the pastoral support for internationally recruited midwives were not clear on their future within the trust as their seconded posts were due to end in December 2023. However since raising this concern the Trust has extended the role of these midwives.

Most staff felt they were encouraged to be open and honest with service users and staff when things went wrong, although some staff did not feel safe to report concerns without fear of reprisal.

Staff were aware there was a Freedom to Speak up Guardian (FTSUG), and their contact details were clearly displayed in staff rooms and staff toilets. All NHS trusts are required to nominate FTSUG. Their role is to support staff who wished to speak up about a concern or issue. They ensure any issue raised is listened to and feedback is provided to them on any actions or inactions because of them raising an issue. The trust had 92 FTSUG cases reported for quarter 1 2023/24, this was higher than the peer average of 25. The trust also had a high number of bullying and harassment cases reported to FTSUG for the same period – the trust had 21 and the peer average was 4. It was not possible to break down these figures at a hospital level however the evidence does support concerns that were raised on inspection.

Leaders understood the importance of staff being able to raise concerns without fear of retribution and told us they operated an 'open door' policy. Most staff told us they felt able to raise concerns without fear. However, there were cohorts of staff who felt that action would not be taken when they reported racism and other poor behaviour from staff on the ward. Some staff talked about a lack of professional curiosity to address instances of poor behaviour and racism as described above.

Midwives we spoke to reported that they found themselves having to act as educators about racism and routinely explain aspects of cultural difference. Leadership was aware of the cultural issues within the service, but we were not assured that this was being treated as a priority as we did not see any evidence of it being discussed at relevant meetings. We raised this with the practice development team and the triumvirate who informed us that they were aware of the cultural issues and as a result had introduced cultural safety and competency workshops. The workshop was open to all obstetric and maternity staff and had multiple dates to choose from throughout the year. However, the workshop was not compulsory for staff to attend, and we were unclear as to whether these sessions would meaningfully address the concerns raised by this cohort of staff.

Governance

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

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. There was a quality governance manager who supported the director of midwifery and head of midwifery across both sites.

We reviewed the monthly maternity safety and governance meeting minutes led by the chief nurse who was board level maternity and perinatal safety champion and also a non -executive director who was also a board level maternity and perinatal safety champ. This meeting had a standard agenda which included updates and compliance and were attended by the local MVP. These meetings were starting to incorporate cross site working however this process had not been embedded.

Each month the Trust Quality Committee received a detailed Perinatal Quality Surveillance Report. In line with national reporting requirements this report summarises, for the Trust Board the key safety intelligence and initiatives.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed and discussed during clinical governance meetings.

The service also had regular monthly triumvirate meetings which has a rolling action log. The log included comments, actions, deadlines and updates. Items on the log included staffing challenges.

Each person had a defined role and were in general clear about what was expected of them. Although staff expressed concerns about the size of their workload and responsibilities and how it was a struggle to complete work in their agreed allocated time.

Maternity

From November 2022 to November 2023 a total of 4 cases were reported to the national perinatal mortality review tool (PMRT); 3 stillbirths and 1 late fetal loss. 100% of the cases were reported within the required timeframes to MBRRACE-UK. Themes and learning identified relate to the completion of documentation including risk assessments, partograms and observation charts

The quality and governance manager was supported by staff in bank and agency roles. At the time of the inspection there was a vacant patient safety and risk manager.

BSOTS is a maternity triage system. It consists of a prompt and brief assessment (triage) of women when they present with unexpected problems or concerns, and then a standardised way of determining the clinical urgency in which they need to be seen. The service had a BSOTS audit conducted on 18 October 2023. The report recommended an audit to understand the activity within triage. The hospital had not conducted the audit at the time of the inspection due to staffing constraints. The lack of audit meant that the service was unable to benchmark its performance and focus on aspects of the service that required support. This meant that the service could not focus on areas of improvement and women and birthing people did not receive the best service available.

A recent situation, background, assessment, recommendation (SBAR) audit had identified lower compliance rates of staff completing (SBAR) at 64%. The service had an action plan increase training to promote use of SBAR at handovers.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify relevant risks and issues along and actions to reduce their impact.

We reviewed the risk register following the inspection. Not all risks we identified were included such as the discontinuation of support for internationally trained midwives and the cultural issues between the UK trained and internationally trained midwives, lack of ligature risk assessments, and lack of resus equipment availability in labouring rooms. Risks on the risk register were listed with a risk identification number, a description, a RAG rating and a date when it had been opened and when it was last reviewed. The service lacked effective oversight of assurance measures in place to mitigate risk. The risk register was generally high level risk such as 'Introduction of Inphase risk management reporting and management has caused delays in managing clinical incidents and risks' that was created on 16 Feb and had not been reviewed. Following the inspection, we were told that risks were logged on the incident reporting system and that information relating to controls and actions could not be extracted into a report.

The trust were monitoring performance and compliance with the NHS resolution maternity incentive scheme (MIS). Progress was being reviewed monthly through governance meetings with mitigations listed.

Information Management

The service did not always collect reliable data. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical area KPIs.

The service told us there were issues identified with the data transfer within the Maternity Information Systems and the data did not always pull through between the two systems used. This was a risk that had been raised in various governance meetings however there did not appear to be a timeline for compliance.

The trust was starting to analyse data on dashboards to have an overview of performance for infection prevention and control. The dashboards were being formulated to provide an overview at trust level however data issues meant there was not a clear overview of performance.

The service had plans for an integrated IT system across the trust. Managers within maternity services were keen that any electronic system that was used would ensure that the data quality met the needs for reporting internally and externally. The service used paper patient records, one set of records was held by the woman and the other by the service. The risk associated with dual documentation is on the risk register. The service did have electronic prescription and medicine management system. The service had plans to move to electronic patient records in the future.

Local and trust service leaders demonstrated that they understood the performance of the maternity service which included women's and staff views, safety and risks. Managers had a framework to oversee the quality and safety of patient care, which included the maternity dashboard however the programme for audit had not been embedded and staff we spoke with were not always aware of how the ward was performing.

The service consistently submitted data to external organisations when required such as Healthcare Safety Investigation Branch (HSIB). The service also participated in national audit programmes which required regular, accurate data notifications.

Engagement

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

Friends and Family Test response rate in January 2022 was 108. In October 2023 the response rate was 430. Themes included communications, waiting times and staffing. We were told that the Trust were developing action plans to address these concerns.

The service hosted regular staff engagement sessions to promote mental, physical, and nutritional well-being. These sessions were disseminated by email and social media to ensure all staff had the opportunity to attend.

The trust had 3 formal staff networks which were the black, Asian and minority ethnic (BAME), lesbian, gay, bisexual, transgender and queer (LGBTQ+) and Allies, Disabilities and Allies Staff Networks. The aim of these staff networks was to ensure the needs of all staff were met.

The service engaged well with stakeholders such as the Care Quality Commission (CQC), NHS England and Healthcare Safety Investigation Branch (HSIB). The service was also actively involved with the Local Maternity Neonatal System group (LMNS).

The trust proactively engaged with the Luton Maternity Voices Partnership (MVP) as a mechanism to reach the local community.

The maternity service was active on the trust social media account and provided updates on engagement events and used these platforms to celebrate success and embrace its diverse workforce.

Managers engaged with staff through newsletters, social media, display boards and during learning forums. The head of midwifery also held listening events to enable open conversation with staff at all levels.

Some staff felt they were not actively engaged with and their views were not reflected in the planning and delivery of services. For example, providing input in the design and layout of the new acute maternity unit.

The service had feedback mechanisms in place to gain the views of women including feedback forms, formal complaints and the friends and family test. The latest friends and family test results we saw displayed on the postnatal ward (Ward 33) notice board reported 98% satisfaction.

Learning, continuous improvement and innovation

Staff told us they were committed to learning and improving services

The service was not always committed to improving services by learning when things went well or not so well. For example, maternity was below the service target for mandatory training. Staff did not feel like they could improve services as staff shortages meant they were not always working in their usual role. Specialist midwives were often required to work on the ward which took them away from their specialist role.

Specialist midwives were working with the local MVP to produce a friends and family survey to offer bereaved families in relation to the care they received.

Bedford Hospital

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Description of this hospital

Bedfordshire Hospitals NHS Foundation Trust (BHFT) formed as a new entity in April 2020 as a result of a merger of Luton and Dunstable Hospital NHS Foundation Trust and Bedford Hospitals NHS Trust. Both sites provide maternity services.

Bedford Hospital maternity unit comprises of a joint consultant led and midwife led birthing unit, a joint antenatal ward and postnatal ward, and community services. Outpatient services are also provided in antenatal clinics, a day assessment unit and a triage unit.

From January to December 2023 there were 2629 babies born at the hospital.

We last inspected maternity services at Bedford Hospital on 2-3 August and 20-21 September 2022. We previously only inspected safe, responsive and well led domains. We rated both safe and well-led domains as requires improvement, the responsive domain was not rated. The main concerns we found were around safeguarding and mandatory training completion figures and infection prevention and control.

We carried out this unannounced focused inspection of the maternity services following emerging concerns regarding safety, culture, and governance. Between August and September 2023, we received 3 concerns raised by whistleblowers.

During this inspection we visited all areas of the maternity unit, spoke with 32 members of staff both during and following our inspection. This included consultants, registrars, junior doctors, anaesthetists, midwives, student midwives, specialist midwives, matrons, and members of the senior leadership team. We observed procedures, handovers, safety huddles, reviewed policies and looked at 9 maternity care records.

We rated maternity as inadequate because:

- The service did not always have enough staff to care for women and keep them safe.
- The service provided mandatory training in key skills to all staff but did not always ensure that medical staff had completed it.
- The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards. Some equipment safety checks were out of date and daily checks were not always completed.
- Staff did not always assess risks to women. They did not always store medicines securely. The service did not always manage safety incidents well.

Our findings

- Staff did not always feel respected, supported and valued. The service did not manage cultural issues raised by staff effectively.
- Serious incidents were not always reviewed in a timely manner and lessons were not always learned and embedded from serious incidents and external investigation when there were poor outcomes for women and birthing people, to reduce reoccurrence.
- There was a lack of operational oversight and management of risk. Governance systems and processes to assess, monitor and manage risks within maternity services were not robust.

However:

- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- Staff provided good care and treatment and gave women enough to eat and drink. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it.

As we only inspected maternity services at Bedford hospital, we did not rate the hospital overall.

Maternity

Inadequate 

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.

Medical staff did not always receive and keep up to date with their maternity specific training. Compliance for PROMPT was 98%.

Nursing and midwifery kept up to date with maternity specific training. Maternity specific training included but was not limited to practical obstetric multidisciplinary training (PROMPT) and fetal monitoring. Compliance for PROMPT was 90% and compliance for fetal monitoring was 92% which exceeded the trust target of 90%. The service also provided a two-day maternity update day to cover maternity specific topics such as smoking cessation, antenatal screening, reducing pre-term births and infant feeding which was to be attended by midwives, maternity care assistants and nurses. Information provided by the service showed 91% compliance for midwives, 100% compliance formaternity care assistants and 75% compliance for nurses which gave an overall compliance of 93.3% which did meet the trust target.

The mandatory training was comprehensive and met the needs of women and staff. The training included, but was not limited to equality, diversity and human rights, fire safety, infection prevention and control, NHS conflict resolution, moving and handling and safeguarding level 2. The service also provided advanced mandatory training for appropriate staff this included, preventing radicalisation and safeguarding level 3. The overall compliance rate for midwives at the time of our inspection was 91% which exceeded the trust target of 90%. This was an improvement since our last inspection. Medical staff did not always keep up to date with their mandatory training. The overall compliance rate for both mandatory and advanced mandatory training was 87% which did not meet the trust target of 90%.

Clinical staff completed training on recognising and responding to women with mental health needs and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. The practice development team monitored training compliance and booked staff on as appropriate. Nursing and midwifery compliance has improved since our last inspection with staff reporting that the trust has allocated them 3-4 days a year for training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, not all staff had completed mandatory safeguarding training.

Maternity

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. The trust provided adult and children's safeguarding training at levels 2 and 3. Nursing and midwifery staff had a compliance rate of 93% for safeguarding children level 2 and 91% for level 3. The figures were similar for safeguarding adults which were 94% for safeguarding adults' level 2 and 90% for level 3 which was in line with the trust target of 90%.

Medical staff did not always complete training specific for their role. Data provided by the trust showed that compliance for safeguarding adults level 2 was 89% and 79% for level 3. Compliance for safeguarding children level 2 was 88% and 91% for level 3. This did not meet the trust target of 90% overall. This was an ongoing concern from our last inspection.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to explain the safeguarding process and informed us that the safeguarding team were visible and very accessible by email, phone or the bleep system.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We reviewed 9 sets of notes and found that staff had asked all women about domestic abuse. This was highlighted discreetly in women's handheld notes and further information could be found on the trust's electronic system for safeguarding information. All staff we spoke with had access to this system and were aware to check it for all women in their care.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act (2010).

Staff followed the baby abduction policy and undertook baby abduction drills. The policy set out staff roles and responsibilities in the lockdown of the maternity department and was within the review date of June 2024. The unit was secure, and doors were monitored. The service had practised what would happen if a baby was abducted and identified an action plan to improve management of a baby abduction going forward.

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 also clean and well-maintained. All areas of the unit had dedicated domestic staff who were aware of their daily role. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All areas across the unit had daily cleaning schedules which were completed by domestic staff and maternity support workers which was an improvement from the last inspection. Records we reviewed showed that this was completed daily unless the room was being occupied. Staff on the maternity unit were clear which rooms had been cleaned and those that were ready for use.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed the use of green 'I am clean' stickers throughout the unit, which are used to indicate what equipment had been cleaned and when on all equipment.

Maternity

The service generally performed well for cleanliness. The service performed regular cleaning audits throughout the month which checked all areas in the unit to ensure they were clean and fit for purpose. A breakdown of the cleaning audit data for delivery suite and the maternity wards for August to October 2023 showed the delivery suite scored an average of 99% for cleanliness which exceeded the target of 98%. The maternity wards scored an average of 98% between August and October 2023, which exceeded the target score of 95% for this area.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand sanitising gel dispensers were available at all entrances, exits and throughout the clinical areas for staff, women, and visitors to use. We observed staff bare below the elbow, wearing appropriate PPE when handling specimens, using hand sanitiser when entering clinical areas and washing their hands in between patient contact. The trust provided hand hygiene audit data from July to September 2023. The results showed 97% compliance in July, 92% compliance in August and 97% compliance in September overall for all areas in the unit. The service target was 95% which was not met in the month of August. However, the service provided evidence of an action plan to improve hand hygiene figures particularly for doctors, who had the lowest compliance rates amongst staff.

Women who were booked for elective caesarean sections were screened for methicillin- resistant staphylococcus aureus (MRSA) during their pre-operative assessment appointment. MRSA is a type of bacteria that is resistant to many antibiotics and can cause life threatening infections as a result.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards. Equipment safety checks were out of date and daily checks were not always completed.

The maternity services at the hospital consisted of a consultant- led delivery suite with a midwife led birthing unit and triage attached, bereavement suite, a joint antenatal and postnatal ward, and a day assessment unit. The maternity unit was open 24-hours a day, 7 days a week. The premises were secure; access to all areas was by swipe card only. All doors were closed, and we observed staff asking for identification before admission into areas. The corridors in all areas were brightly lit and clutter free. The design of the environment generally supported the number of women who arrived and had suitable facilities to meet the needs of women and families. The unit consisted of a 10-bedded delivery suite with 2 birthing pools available, a private bereavement room, a fully operational operating theatre, a 3 bedded recovery area, and a separate triage. There was also a 24 bedded maternity ward, a 4-bedded day assessment unit and an antenatal clinic for outpatient appointments.

Triage was a dedicated area on delivery suite. The trust invested in increasing the size of triage from 1 room on delivery suite to a dedicated area with 3 beds and a private room since our last inspection. However, even with the increased space the triage area could not always support the number of women who arrived. Due to space constraints within triage and lack of a waiting area, women who were awaiting review had to wait outside of triage near the entrance to the delivery suite and sometimes outside of the delivery suite doors. This meant that midwives did not always have oversight of these women. We raised this with midwives working in triage and they assured us that only women who were low risk waited outside of delivery suite.

The service had carried out ligature risk assessments of the environment in line with NHS England National Patient Safety Alert/2020/001/NHSPS.

Staff regularly checked the birthing pools cleanliness. All water outlets were flushed daily by the domestic staff to prevent the spread of legionella.

The service did not always have enough suitable equipment to help them safely care for women and babies. The delivery suite did not have a portable ultrasound scanner to scan for the presenting part or fetal heart rate on the unit. This had been identified on the risk register and staff were able to use the portable ultrasound scanner in theatre if this was available. Across the unit we found equipment such as blood pressure machines, cardiotocograph (CTG) machines, suction units, weighing scales had been serviced and/or portable appliance tested. Following the inspection the trust provided evidence that a new scanner came into service in March 2023.

We reviewed 8 daily safety checks of neonatal resuscitaires, adult resuscitation trolleys and emergency boxes and found that 2 of the 8 special equipment we reviewed were not checked daily, this included an emergency sepsis box and an adult resuscitation trolley. We found an emergency sepsis box in the clinical room that was last checked in July 2023 with a blood aspirator bottle that expired on 2 November 2023 and a sodium chloride ampoule that expired in July 2023. This could potentially cause a delay in an emergency. This was escalated to the midwife in charge who explained that the emergency sepsis box is not frequently used as all the equipment in the box was also found in each delivery room and is more accessible for midwives. The midwife in charge disposed of the out-of-date equipment and replaced them. The adult resuscitation trolley located on the delivery suite also had out-of-date equipment and did not have a full weekly check, as per guidance. A full check is to ensure all the equipment and medication within the resuscitation trolley are in date and easily accessible to use in an emergency such as a woman going into cardiac arrest. A full check was only completed once in the month of August and twice in both September and October 2023 instead of weekly. We found 2 out-of-date blood gas syringes and 1 out-of-date Hartman's solution. We informed the midwife in charge who took immediate action by removing and replacing the out-of-date items.

Women could reach call bells and we observed staff responding quickly when called. All toilets on the post-natal ward had call bells that worked and were ligature free.

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

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman at each outpatient antenatal contact however, staff identified and quickly acted upon women at risk of deterioration.

We reviewed 9 sets of maternity care records, and the lead clinician was identified in all of them. Risk factors such as a raised body mass index (BMI) and comorbidities were highlighted. However, risk assessments did not always take place at every contact, 3 of the records we reviewed did not have a risk assessment done at every contact. A risk assessment involves, reviewing and assessing the plan of care for pregnancy, identifying women who need additional care and assessing each woman's general health and wellbeing. This meant we could not be assured that risk assessments were completed, and action was being taken appropriately in response to any risks found.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used a Maternity Early Obstetric Warning System (MEOWS) to detect the deterioration of women during pregnancy, delivery and postnatally. We reviewed 8 MEOWS charts and found staff had completed, scored, and escalated correctly. The service carried out an audit of MEOWS charts on a rolling basis between October 2022 and November 2023. The compliance rate for the appropriate use of MEOWS charts were 97% on delivery suite, 95% on the day assessment unit and 92.5% on Orchard ward.

The service also used new-born early warning trigger and track (NEWTT) to detect deterioration of babies postnatally. We reviewed 3 NEWTT charts and found staff had completed, scored and escalated correctly. The service carried out an audit of NEWTT charts and provided data for July to September 2023. The findings showed 84% compliance in July, 98% compliance in August and 98% compliance in September 2023. The trust did not have a target for MEOWS or NEWTT audits.

During labour some women may be attached to a Cardiotocograph (CTG), which is equipment used to monitor the fetal heart rate and uterine contractions. According to NICE guidelines NG229, women on a CTG during labour should have an hourly fresh eyes review of the reading. Hourly fresh eyes are when another clinician reviews the CTG trace during the intrapartum period to ensure the baby is safe to continue with labour. All fresh eyes stickers were completed appropriately in all the labour notes we reviewed. The service carried out a monthly audit of CTG documentation. In September 2023, 85% of women had an hourly fresh eyes on all intrapartum CTG's or a 4 hourly fresh eyes review when intermittent auscultation was used. This exceeded the trust target of 80%.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool. Most women attending the delivery suite were admitted through triage. The triage service used the Birmingham Symptom-Specific Obstetric Triage System (BSOTS) to assess women on arrival. BSOTS is a system to assess women presenting with pregnancy related concerns to be seen or prioritised based on their clinical need. Prioritisation was undertaken using a red, amber, green (RAG) rating, recorded on a paper documentation sheet. We observed staff using this tool and saw evidence of it being completed in the women's notes we reviewed. Due to the number of deliveries the service had per year BSOTS recommended that only 1 midwife and maternity care assistant (MCA) was required to work in triage. However, we observed that triage was overburdened with too many functions for 1 midwife and 1 MCA to safely manage. The functions included assessing and prioritising women, escalating to the appropriate member of staff, and answering the telephone triage line.

Staff we spoke with acknowledged that triage can get very busy and additional support is often needed for all the functions. They also mentioned that they often breach the timeframe for obstetric review as there were no planned hours for doctors on triage.

In response to this the service had a BSOTS site visit in October 2023 which was carried out by an official BSOTS implementation midwife. Several recommendations were made which included having a core team which included a lead midwife for triage. It was also recommended that the telephone triage line be removed from the triage clinical area and monitored by a non-clinical midwife to allow the midwife in triage to focus on the triage workload. The last recommendation was to expand the number of notes audited as the current number of 20 notes is not representative of the service.

The service carried out an audit of BSOTS in which they reviewed 20 cases per month to identify whether women were seen by a midwife within 15 minutes of arrival, seen in the correct timeframe with the appropriate clinician and that the appropriate referrals and follow-up plans were made. Data supplied by the service demonstrated compliance for women being seen by midwives within 15 minutes was 85% in August and September, and 100% in October 2023. Compliance for women being seen by the appropriate clinician within the set timeframe was 80% in August, 100% in September and 65% in October 2023. Compliance for appropriate referrals and follow-up plans being made was 95% in August, 100% in September and 90% in October 2023. The service identified themes from the audit and had an action plan to improve figures which included emailing staff reminders.

The information from the site visit and the audit supports what we observed on both days of the inspection and what staff had expressed. The service reported they were currently in the process of assigning a dedicated non-clinical midwife to the telephone triage line.

Staff we spoke with and observed throughout our inspection were familiar with signs and symptoms of sepsis. Staff used the sepsis bundle when required. The service had 0 clostridium difficile or bloodstream infections cases between October 2022 and October 2023. In all records we checked; staff had completed risk assessments for venous thromboembolism (VTE).

Theatre staff completed the World Health Organisation (WHO) 5 steps to safer surgery checklist prior to starting surgical procedures. The WHO checklist is a set of priority checks to ensure patient safety before, during and after a surgical procedure.

Staff we spoke with were aware of how to complete, or arrange, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Shift changes and handovers were organised and included all necessary key information to keep women and babies safe. We observed the consultant led unit handover and ward round. The unit had 2 handovers in the morning, 1 for midwives and another for medical staff. Midwives were allocated to a woman by the oncoming labour ward coordinator midwife and then the outgoing labour ward coordinator would give a more detailed handover one on one which shared key information.

The second handover was attended by the obstetric team, the anaesthetic team, the ward manager, the labour ward coordinator and the neonatal unit coordinator. A structured introduction was performed and a ward round book was signed morning and evening to confirm attendance of handover and the completion of the consultant led unit ward round. The handover was detailed, and all key information was shared.

The service performed a safety huddle at lunchtime to assess the whole unit. We observed a safety huddle which was led by the labour ward coordinator. The huddle took place at the main desk in delivery suite and introductions were not made at the beginning of the huddle, so it was unclear who was in attendance. The safety huddle was brief and discussed staffing within the unit however a structured agenda of topics was not followed. According to the 'Implementing handover and huddle: a framework for practice in maternity units' by NHS Improvements, safety huddles need a standard template to ensure all staff attending are clear about what information they must share. The framework also highlights that the safety huddle should take place in a private space or room to ensure that the information shared is confidential.

Midwifery Staffing

The service did not always have enough nursing and midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. However, they had enough medical staff to keep women and babies safe. The service used Birthrate Plus to monitor acuity on the unit as recommended by the Royal College of Midwives (RCM). The acuity tool was calculated by the labour ward coordinator and was completed four hourly. Staffing was reviewed at the daily safety huddle and staff shortages were escalated to the bleep holder. The bleep holder could adjust staffing levels daily according to the needs of women.

Maternity

On both days of our inspection, the delivery suite was short staffed which required them to pull staff from the maternity ward. On day 1 of our inspection, the delivery suite was originally short of 3 midwives and 2 maternity care assistants, which resulted in them having to pull 2 midwives and maternity care assistants from other areas. On day 2 of our inspection, the delivery suite was short of 1 midwife and 2 maternity care assistants. Staff we spoke with reported that this was a common occurrence and had a negative effect on staff morale as junior midwives were often pulled to work on delivery suite causing them to miss out on their time allotted placement on other areas within the unit. The labour ward coordinator informed us that the shortage of midwives was due to sickness.

Data showed that in September 2023 the fill rate for midwives on a day shift was 95.15% and 99.07% during night shifts. However, the maternity care assistants fill rate was 36.76% on a day shift and 71.8% on a night shift. The service reported ongoing recruitment of maternity care assistants as the fill rate was very low, this was also observed on both days of inspection.

As of October 2023, the service had a low vacancy rate of -4.4 WTE for midwives, which meant that they were over-established. However, staff reported there was not a good skill mix as they currently have a lot of junior midwives joining the workforce. The service had a high sickness rate for midwives which was 8.28% in September 2023. This was an increase from 7.16% in July and 7.81% in August 2023, and this far exceeded the trust target of less than 3.25%. Managers had monthly staffing sickness meetings with human resources (HR) and managers to ensure they had oversight and to ensure they update relevant staff affected.

Managers used bank staff to cover midwifery staff shortages and made sure all bank and locum staff had a full induction and understood the service before they started work. However, these shifts were not always filled which meant staff often had to be pulled from lower risk areas of maternity such as the maternity wards to work on delivery suite.

The trust provided us with red flag event data for September 2023. A midwifery red flag event is a warning that there may be an issue with staffing. Red flag events are situations such as missed or delayed care, delay between admission for induction and beginning of process, and the coordinator being unable to remain supernumerary. Once a red flag event is highlighted, the midwife in charge should be alerted and if staffing is identified as the cause, action should be taken. In the month of September 2023 there were 19 red flag events. The 3 categories that flagged were; delay in providing pain relief due to midwifery staff which accounted for 1 of the red flags, delay between admission for induction and the beginning of the process which accounted for 11 of the red flags and lastly, occasions when the coordinator was not able to maintain supernumerary status (not providing 1:1 care) accounted for 7 red flags. In response to the red flags, the service reported ongoing recruitment. This was to ensure that there were enough midwives to avoid delays in care and allow labour ward coordinators to remain supernumerary during shifts.

Medical Staffing

The service generally 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 reviewed and adjusted staffing levels and skill mix and offered locum staff an induction.

The service had enough medical staff to keep women and babies safe. Medical staff matched the planned numbers on both days of inspection. This was reflected in the data provided by the service that showed that the service had the right number of consultants, speciality trainees and junior doctors in post. Many of the medical workforce had portfolios that included both obstetrics and gynaecology activities. However, staff on triage, the day assessment unit and orchard ward reported that they often had to wait for reviews from medical staff which often caused delays in discharging women.

The service had low sickness rates for medical staff, data from August to October 2023 were consistently below the trust target of 3.25%.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Consultants completed ward rounds 7 days a week and were supported by a team of specialty registrars and junior doctors. Anaesthetist cover of the consultant led unit and obstetric emergency theatre were staffed by a consultant and a duty anaesthetist. The duty anaesthetist was available 24 hours a day and mainly covered labour ward but was also responsible for all maternity inpatients. The duty anaesthetist also attended the obstetric ward rounds. The trust was compliant with the Anaesthesia Clinical Services Accreditation (ACSA) and staff reported good anaesthetist cover for the unit.

Records

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

The unit used both paper and electronic patient records. Staff reported that they were able to easily access patient records. We reviewed 9 maternity records for women at different stages of the maternity pathway. Risk assessments and clinical assessments such as venous thromboembolism (VTE), fetal movement, high or low risk pregnancy, safeguarding questions, fluid balance charts and modified early obstetric warning score (MEOWS) were all recorded and documented correctly. However, we noted that women weren't always risk assessed at every antenatal appointment which meant we could not be certain that appropriate referrals were being made.

The service carried out an audit of maternity records, this was carried out yearly and the last audit covered the period of December 2022 to February 2023. This audit covered, but was not limited to, all entries being signed, dated, timed, risk assessments being completed at each contact and completion of VTE both in the antenatal notes and the intrapartum notes. Compliance for December 2022 was 94% in the antenatal notes and 75% in the intrapartum notes, compliance January 2023 was 90% in the antenatal notes and 73% in the intrapartum notes, compliance in February 2023 was 96% in the antenatal notes and 83% in the intrapartum notes. This meant that we were not assured that records were always detailed and up to date. The findings from the audit also supported what we found in relation to risk assessments not being completed at each contact as this was also consistently identified as being missed on the audit. Areas for improvement were highlighted and shared with staff.

Women had handheld records which they took to all clinical appointments, when accessing care from other services and on admission to the hospital. Staff reported that when women transferred to a new team, there were no delays in accessing their records.

Records were stored securely. Women's records were stored securely in staff areas of the clinical areas within lockable trolleys. This meant that information about women accessing care was available to all staff.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, they were not always stored securely.

Staff mostly stored and managed medicines safely. Most medicines including controlled drugs (medicines requiring additional control due to the potential of misuse) were stored securely. Controlled drugs were checked daily and recorded in the controlled drugs book. However, the clinical room on delivery suite was left unsecured along with a cupboard where intravenous solutions was stored. This was raised with the labour ward coordinator and both the cupboard and clinical room door were locked.

Maternity

Staff followed systems and processes to prescribe and administer medicines safely. Medication was prescribed on an electronic system. Medicine records we reviewed showed that allergies and weights were always documented to ensure medicines were prescribed safely. We also saw that medication was administered correctly, this included medication to prevent blood clots which was an improvement since the last inspection.

Prescribers and midwifery staff had access to resources to ensure medicines were prescribed correctly. Midwives were also able to administer medication under midwife exemptions.

Staff completed medicines records accurately and kept them up to date. Each midwife had personal access to the electronic system and was able to sign off medication easily. Midwives we spoke with informed us that medication such as those given intravenously had to be checked by 2 midwives and signed by both on the system to reduce the risk of medication errors.

Fridges where medicines were stored were locked and temperatures were monitored by staff. Staff we spoke with understood when and how to escalate a deviation from the safe temperature range.

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

The governance team reported that they monitored all safety alerts and incidents related to medication, to be used as an opportunity to improve practice.

Incidents

Most staff recognised and reported the majority of incidents and near misses. However, we found there was not an open culture of incident reporting in relation to all types of incident, particularly in regards to those relating to racism and discrimination. When things went wrong, staff apologised and gave patients honest information and suitable support, however, the service did not always correctly grade incidents or manage them in a timely manner.

Most staff raised concerns and reported incidents and near misses in line with trust/provider policy. However, there were some concerns that staff did not report as they did not feel they would be acted on. Most staff felt they were encouraged to be open and honest with service users and staff when things went wrong, although some staff did not feel safe to report concerns without fear of reprisal.

On inspection we were told that lack of staffing and increased acuity on the wards had meant that staff were working in challenging situations when women and birthing people were at the point of delivering a baby and that a learning culture was not encouraged when things went wrong. Staff did not feel able to report instances of racism when this had been experienced on the ward and between midwife staff, including managers. We spoke to leaders who acknowledged that some parts of maternity had a challenging culture and were working on increasing visibility on the ward. Staff were concerned that incidents of racism would not be investigated in line with the trust's values. Following the inspection, we raised concerns about racism within maternity and how incidents could be managed in a culturally competent way.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. The trust had 198 incidents reported by maternity at the trust between January 2023 and October 2023. The governance team reported that they reviewed this regularly. Incidents had been reported appropriately by staff. However, they were not always graded appropriately. The incident grade would determine the level and timeliness of the service's response to the incident. Of the 198 incidents reported 47 were not graded which meant we could not be assured that they were being reviewed and investigated as required.

Maternity

The service had no 'never' events on any wards. Never events are serious, largely preventable safety incidents.

The service had 214 open incidents, these incidents were either awaiting investigation, currently being investigated, or awaiting final approval. The service reported that incidents rated 'no or low harm' would be closed within 10 working days and incidents rated 'moderate harm' would be closed in 30 working days. However, this was not reflected in the data provided and incidents rated 'low harm' in October 2022 were still open and awaiting final approval, which meant that incidents were not always managed in a timely manner.

When reviewing incidents the service did not have a named investigator responsible for investigating each incident. However, the service reported that they had a plan in place to identify and send out a report weekly to ensure a senior member of staff is accountable for their own incidents and ensure they are managed in a timely manner.

Staff received feedback from investigations of incidents, both internal and external to the service. Staff were updated about learning from incidents through various channels, including but not limited to, newsletters, emails and the risk and governance board displayed in staff areas around the unit. The maternity governance team reported working closely with the practice development midwives to ensure local learning was used in training.

Staff we spoke with reported that managers debriefed and supported staff after any serious incident. Women and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent and gave women and their families a full explanation when things went wrong.

All stillbirths, maternal deaths and neonatal deaths were investigated and reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK). They were discussed at monthly perinatal mortality review meetings using the perinatal mortality review tool kit which was produced by MBRRACE-UK.

Staff met to discuss the feedback and look at improvements to patient care. We saw evidence of senior staff attending governance meetings to discuss incidents, serious incidents, and any themes that were arising.

There was evidence that changes had been made as a result of feedback. The service had introduced partners staying on the maternity ward in response to feedback from women accessing care.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

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

Staff followed policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a selection of guidelines relating to the maternity services and although many of them were out of date for

review, they reflected national guidance. Guidelines were easily available on the intranet and included, but was not limited to, obstetric sepsis management, induction of labour and reduced fetal movements. The senior leadership team informed us that they were currently in the process of updating and merging their policies and guidelines across both maternity sites.

The service had a structured audit programme to ensure practice was reviewed and audits were completed to ensure staff followed local and national guidance.

Staff we spoke with knew how to protect the rights of women subject to the Mental Health Act and followed the Code of Practice. Where appropriate, staff would refer or signpost women for further support. The service also had specialist midwives to cover a variety of holistic needs and would also be involved with a woman's care if required.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives, and carers. This ensured that appropriate referrals to specialist staff such as the perinatal mental health midwife and safeguarding midwife.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. The service could meet the needs of all dietary requirements and cultural or religious requirements. In addition to this, additional provisions were offered to women, such as tea and toast in between set mealtimes when women required this.

Staff fully and accurately completed women's fluid and nutrition charts where needed. We saw completed fluid balance charts to monitor fluid input and output for women receiving intravenous fluids.

Specialist support from staff such as dietitians and speech and language therapists were available for women who needed it. However, this was not a common requirement within the service.

The service had an infant feeding lead responsible for the oversight of infant feeding. All maternity staff attended regular infant feeding training to ensure they could support women to feed their babies. The service provided women with breast pumps and a dedicated locked fridge for the storage of milk. This dedicated fridge was checked daily to ensure the temperature was suitable for the storage of expressed breastmilk. Records showed that this was up to date.

Pain relief

Staff assessed and monitored women to see if they were in pain however, they did not always give pain relief in a timely way.

Staff assessed women's pain using a recognised pain assessment tool and gave pain relief in line with individual needs. Pain relief such as nitrous oxide, oral pain relief and an epidural were available to women. Epidurals (an injection of anaesthetic into the spinal area) were available 24 hours a day. The service had an anaesthetist available on the unit 24 hours a day and were able to call a second anaesthetist if an epidural was required and the core anaesthetist was busy in theatre.

The service also provided birthing balls, birthing pools, and stools to promote choice and comfort of women in labour.

Women did not always receive pain relief soon after requesting it. The service carried out an audit on pain relief post caesarean section to assess patient satisfaction. The findings showed that 23% of women experienced more than a 30-minute delay receiving their regularly prescribed pain relief and 57% of women received their regularly prescribed pain relief. Data from the audit did not specify why there were delays or omission of pain relief medication during the postnatal period. 90% of women however were satisfied with the pain relief they received.

Staff prescribed, administered, and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits including the national report for perinatal mortality for births: Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) 2021 audit. The result showed the still birth rate was 3.7 and the neonatal death rate was 1.7 (per 1000 live births) which were both slightly higher than the England averages of 3.5 and 1.7 respectively. The hospital had an action plan in place to improve outcomes. This included independent external reviews from LMNS (local maternity and neonatal system), reviewing trust level data frequently to identify modifiable factors and work with the MNVP (Maternity Neonatal Voices Partnership) team to communicate with women from Black and Asian populations to identify specific needs.

Managers and staff carried out a programme of repeated audits to check improvement over time. These audits included but were not limited to SVBL element 4 (saving babies' lives), pre-eclampsia, LoCSIPPS (local safety standards for invasive procedures) etc. Data provided by the service post-inspection showed that the service had action plans in place to improve audits that were not achieving trust compliance.

The service held regular quality governance and audit meetings to discuss women's outcomes, ongoing audits, and follow-up on audit outliers. Managers shared and made sure staff understood information from the audits.

The service used a LMNS maternity dashboard to monitor and compare various clinical outcomes figures with their peers within the LMNS. This included but was not limited to emergency caesarean sections, vaginal deliveries, third and fourth degree tears, stillbirths, post-partum haemorrhage, maternal deaths and pre-term deliveries. The data for November 2023 showed that the service met the targets for midwives that have undertaken multidisciplinary CTG training, relevant staff undertaken multidisciplinary PROMPT (practical, obstetric, multiprofessional training), breastfeeding initiation at birth, smoking rates at booking, number of babies cooled and massive obstetric haemorrhage.

The service did not meet the targets for booking before 10 weeks gestation, unassisted vaginal births, third and fourth degree tears, succussful VBAC (vaginal birth after caesarean), NICU (neonatal intensive care unit) admissions at birth and obstetricians that have undertaken multidisciplinary CTG training. However the figures were similar to their peers within the LMNS. The service also monitored clinical outcomes independently which they then measured against various national ambition rates. The clinical outcomes included massive obstetric haemorrhage, third and fourth degree perineal tears, smoking at time of delivery, pre-term birth rate, term admission to the neonatal unit, pre-term

administration of magnesium sulphate, pre-term administration of antenatal steroids and women being in the right place of birth. We reviewed data between June 2023 and August 2023 and found that the service consistently met the national ambition of less than 6% for pre-term birth rate but consistently did not meet the maternity incentive scheme figure of 80% for pre-term administration of antenatal steroids.

Competent staff

The service made sure staff were competent for their roles however, managers did not always conduct yearly appraisals.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

Managers gave all new staff a full induction tailored to their role before they started work. However, they did not always support staff to develop through yearly, constructive appraisals of their work. Data from the service showed that 100% of medical staff had completed their yearly appraisal. This exceeded the trust target of 90%. However, only 81% of maternity staff had completed their appraisal, which did not meet the trust target.

The practice development team supported the learning and development needs of midwifery staff.

The practice development team made sure that all newly qualified staff, including internationally recruited midwives, had an organised preceptorship programme in place that could be adjusted to the needs of each member of staff if required. They had regular reviews with staff to ensure that newly qualified staff were well supported and areas for development were identified, along with any other concerns from the preceptor. Staff we spoke with reported that they felt well supported and felt comfortable asking for further support if required. Internationally recruited midwives had a clinical educator specifically for internationally trained midwives at the time of inspection. Midwives from the practice development team informed us that the role was due to end in December 2023, which meant we could not be assured that internationally trained midwives would get the required levels of support going forward. However, since raising this concern the trust has extended the role for the foreseeable future.

Managers identified poor staff performance promptly and supported staff to improve. There were clear processes for line managers to follow when staff were identified as underperforming. Senior leaders discussed examples of where they were managing challenging behaviour. Medical leaders also had oversight of the locum medical staff who worked within the service to ensure they met the expected standards.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw minutes from meetings were comprehensive and detailed, noting the actions and recommendations.

The service shared important clinical and non-clinical updates with staff through various communication methods, including private social media groups, emails, and newsletters.

Managers made sure staff received any specialist training required for their role.

Staff had the opportunity to discuss training needs with their line managers. However, not all staff were supported to develop their skills and knowledge. Staff reported that whilst there were opportunities for professional development, these were not always advertised to all staff.

Maternity

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. The service had weekly cardiotocography (CTG)meetings which were attended by midwives and obstetricians to aid multidisciplinary learning.

There was effective multidisciplinary working between the midwives, obstetricians, and neonatal staff. There were attendees from all areas at the handovers and staff worked closely to involve all teams in care planning depending on the needs of each woman and baby.

We observed all staff working well as a team to ensure women had safe care and treatment. Staff were complimentary about other members of the multidisciplinary team (MDT).

Staff worked across health care disciplines and with other agencies when required to care for women. Staff were aware of how to contact other agencies such as social services.

Seven-day services

Key services were available seven days a week to support timely care.

All women could access maternity care 24 hours a day, 7 days a week. Women over a specific gestation could attend maternity directly by triage, but women could also report to the hospital in an emergency through the accident and emergency (A&E) department. There was also access to an advice line 24 hours a day, 7 days a week.

Consultant obstetricians and anaesthetists were available on-call 24 hours a day, 7 days a week. The service always had a consultant anaesthetist and obstetrician on call along with a full obstetric team who were physically on the unit. Consultants led daily ward rounds on the delivery suite and maternity ward. Women were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests such as MRI and x-rays, 24 hours a day, 7 days a week.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. At the initial booking appointment midwives screened for risk factors such as raised body mass index, low blood haemoglobin levels and smoking. These were discussed with the woman and used to inform care planning and advise the woman accordingly.

The service had relevant information promoting healthy lifestyles and support on wards/units. Staff gave health promotion advice to women on various topics which was evident on all women's record reviewed. This included gestational diabetes, alcohol, smoking cessation, immunisation, flu vaccines, Covid vaccines, breastfeeding, safer sleep, healthy eating, vitamin D, sudden infant death syndrome (SIDS) and emotional wellbeing.

Maternity

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff supported women to make informed decisions about their care by providing women with all the information required either verbally or in the form of print. Specialist midwives were also involved with some women to enable them to make informed decisions about their care and treatment. Staff clearly recorded consent in the woman's records. All 9 records we reviewed demonstrated staff clearly recorded consent.

It was unclear whether staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as the service did not provide any data on this. However, there is not usually a regular need for MCA and DoLs in maternity.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. We observed staff engaging with women in a positive and personalised way. Staff attitude was positive, and the atmosphere was warm and welcoming. Women told us that staff treated them well and with kindness. Women we spoke with on inspection all had positive comments about the hospital and staff.

Staff followed policy to keep patient care and treatment confidential. Staff closed curtains around patient bed spaces when delivering care to protect privacy and dignity. We observed staff knocking on doors, politely asking before opening curtains and waiting to be invited into rooms and cubicles.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. This included ensuring that the Friends and Family Tests were available in different language formats to ensure all women from different backgrounds could complete it and this information could be used to improve the service. The service had seen an increase in responses since adding different language formats.

The service carried out Friends and Family Tests which is a single question survey which ask whether women who have used the service would recommend it to friends and family who need similar care or treatment. Data from the trust showed that between August 2023 and October 2023 the service received 685 responses and an average of 96% of women reported very good and good care. The comments also consistently praised midwives for compassionate and respectful care.

Emotional support

Staff provided emotional support to women, families, and carers to minimise their distress. They understood women's personal, cultural, and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them.

All maternity staff received bereavement training, this included training taking photographs, making casts of hands and feet, the use of cold cots and creating memory boxes. The service also provided training on breaking bad news and demonstrating empathy when having difficult conversations. This support was provided in a designated bereavement suite and staff could get additional support from the lead bereavement midwife if required. Staff told us they generally felt well supported and had been given training on this subject. The service also provided emotional support for staff involved in the care if required.

The service has also launched a rainbow clinic for women who have previously lost a baby to provide additional support through their current pregnancy. Women are identified by a sticker in their notes to alert all team members that there has been a previous loss.

Women who had known mental ill health had further support from the specialist midwife for mental health. In addition to this, ongoing care and support could be requested if this was required.

Multifaith chaplaincy and spiritual support was available for all women.

Understanding and involvement of women and those close to them

Staff supported and involved women, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and their family understood their care and treatment. We observed staff talking with women and their families in a way they could understand. Staff reported that translation services where easily available to them and they were comfortable using it.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. We observed posters on the unit encouraging women and their families to give feedback.

The service also worked closely with Maternity Neonatal Voices Partnership (MNVP). The MNVP helps the NHS to hear the diverse voices of service users, they have done this by hosting listening events at baby groups, children's centres, and libraries. This information is then fed back to the trust to improve women's experiences using the service.

The trust scored similarly to other trusts in England in majority of the questions in the CQC maternity survey for women who gave birth between 1 and 28 February 2022.

Maternity

Data provided by the service showed that they generally received positive feedback about the service. The service also identified the themes of the negative responses received from feedback from women and their families. These themes were added to the newsletter disseminated to all staff to ensure staff were aware and are encouraged to seek out support or training.

Is the service responsive?

Requires Improvement 

We did not previously rate this key question. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Women could access maternity services 24 hours a day and 7 days a week, either in person or through the telephone triage line, where women could speak to trained midwives about any concerns they may have.

The service had multiple clinics throughout the week that took place in the antenatal clinic on the unit. Between August 2023 and October 2023 there had been 117 missed appointments. Staff we spoke with told us that there was a process in place to identify who did not attend appointments. However, the follow up process of contacting women who did not attend was not always followed due to staffing issues. The service reported that they had implemented a text reminder for women in October 2023 as part of an ongoing improvement plan to help bring the number of missed appointments down.

The trust had a maternity unit on both the Bedford site and the Luton and Dunstable site. Staff reported that they were able to transfer women to Luton and Dunstable Hospital maternity when they required more complex care. This was arranged and monitored by senior staff.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Managers made sure staff, women and their families could get help from interpreters or signers when needed. Staff had access to 24-hour language interpretation services, this service could be by telephone, video, or face to face. BSL sign language interpreters were available for face-to-face appointments or by video link.

The service had information leaflets available in languages spoken by the women and local communities. The trust website also had an accessibility tool called 'Recite Me', which will translate the entire web page to over 130 languages.

Women were given a choice of food and drink to meet their cultural and religious preferences. This included Halal, vegetarian, and vegan options for women.

Maternity

The service had suitable facilities to meet the needs of women's families. The service had a dedicated bereavement room on delivery suite with all the facilities needed for families to be comfortable including a double bed. Each delivery room also had a reclining chair so families could stay overnight.

The service also had systems to help care for women in need of additional support or specialist intervention. The service had many midwives in specialist roles to provide support or specialist intervention for women. This included a perinatal mental health midwife, bereavement midwife and an OCEAN midwife. OCEAN mental health services provide compassionate, emotional support for those living through birth and trauma. Staff reported having support from these specialist teams.

The service offered HOPE (Hold on Pain Eases) boxes for women who experienced separation from their babies at birth. The service had applied to join the project and were successful, the pilot ran from December 2022 to December 2023. The HOPE box initiative was created by Lancaster University after research showed an increasing number of newborns taken into care and the traumatic effects this could have on the mothers.

The safeguarding team were very passionate about this initiative as they reported women who had suffered this kind of loss were not always supported. The HOPE boxes aimed to promote an ongoing connection between mother and baby and help parents grieve their immediate loss and acknowledge their maternal identity. 8 boxes had been given out at the service between December 2022 and September 2023. The service showed evidence of women’s stories and how positive the HOPE boxes had been not only at the birth but also in future cases.

Staff received information sessions on the HOPE box initiative to ensure all women who were eligible were able to access it and staff were confident in supporting women.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems. Staff we spoke with knew how to identify and escalate any concerns about women’s mental health.

Access and flow

People could access the service when they needed, however they did not always receive the right care promptly.

Women were referred to the service either through their GP or through the community midwives. Women could also self-refer using the trust’s website. Women were able to access the maternity triage unit 24 hours a day through self-referral or after calling the maternity telephone triage line which was also available 24 hours a day.

Staff reported that there were often delays with Induction of labours (IOL) and discharges. However, managers monitored waiting times and worked to keep the number of delayed IOL to a minimum. Women undergoing IOL and awaiting transfer to the delivery suite on the maternity wards were discussed at the handover on labour ward to ensure the labour ward coordinator had oversight and could transfer them safely. The service monitored the delay between admission for IOL and the beginning of the process. In July 2023 there were 2 delays, in August 2023 there were 22 and in September 2023 there were 11 delays. Data from another audit showed that 10 women out of the 50 reviewed experienced delays between the start of IOL (administering cervix ripening gel) and ARM (artificial rupture of membranes) which is the next step of the IOL process if women do not go into labour spontaneously after the gel.

The main reason for delay in induction of labour (IOL) was staffing and acuity levels. To mitigate the risk of delay the individualised care plans were developed with the obstetric team to start the IOL process when safe to do so.

Maternity

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. The service had a fully operational obstetric theatre and a second obstetric theatre used in emergencies. The labour ward coordinator reported that the dedicated obstetric theatre team responded quickly in emergencies.

Managers and staff worked to make sure women did not stay longer than they needed to. Managers and staff started planning each woman's discharge as early as possible however, they reported that there were often delays getting doctors to review women which then delayed discharges. Women were also discharged home directly from the delivery suite if this was appropriate for them. This meant that beds became available on a regular basis and women were able to go home as soon as possible.

The service did not monitor the delay in discharges from the unit. However, they monitored the bed occupancy on the maternity wards. The average bed occupancy in July 2023 was 79%, 93% in August and 86% in September 2023. This data showed that on average the service had enough antenatal and postnatal beds for the number of women accessing the service.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Staff reported that specialist midwives were very visible, and they felt comfortable requesting support for complex individual cases when required. Staff supported women and babies when they were referred or transferred between services.

Learning from complaints and concerns

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

Women, relatives, and carers knew how to complain or raise concerns. Women told us they knew who to contact if they were not happy or wished to raise a concern. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff tried to resolve any complaints or concerns locally; however, they were aware of the escalation policy if this was required.

Managers investigated complaints and identified themes. Information about the number of complaints and concerns made was discussed at Clinical Quality Governance meetings. The service received 4 formal complaints between July and November 2023. The main themes raised were communication and quality of care. The service provided evidence of complaints being investigated and suitable letters being drafted to women in response.

Managers shared feedback from complaints with staff through staff newsletters and ward meetings and learning was used to improve the service.

Is the service well-led?

Inadequate 

Maternity

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

Leadership

Leaders demonstrated that they understood some of the issues the service faced, however, they were not always managed and prioritised effectively.

Leaders had not understood all the issues the service faced in terms of safety and quality, such as the issues around racism detailed in other sections of this report.

The service was within the Women's Health and Sexual Health Directorate of the trust. The service had a defined leadership structure cross-site and a hospital specific leadership structure. The cross-site triumvirate consisted of the director of midwifery, general manager and clinical director of gynaecology and obstetrics. The Bedford site triumvirate consisted of the head of midwifery, deputy general manager and 2 separate clinical leads for obstetrics and gynaecology. The service was also supported by the board level maternity and perinatal safety champion, who was also the chief nurse.

Leaders had the skills and abilities to run the service. They understood most of the challenges and issues within the service such as the risks within the service, but not those relating to workforce equality as detailed in other sections of the report. The service held monthly clinical service triumvirate meetings and Cross Site Performance and Business Meetings. We reviewed the meeting minutes between July and October 2023 and found that the meetings were well attended and covered key topics such as training figures, compliance updates, safeguarding, patient experience, workforce, and finance updates.

There were clear lines of reporting from the maternity leadership team to the triumvirate. Staff commented on the visibility of the head of midwifery and felt they were sighted on the challenges faced on a day-to-day basis. We saw evidence of listening events being hosted by the head of midwifery. Staff also reported that they were comfortable approaching matrons and ward managers at every level. However, some staff were not assured that if they raised concerns, they would be dealt with effectively by ward managers and matrons.

The maternity board safety champion attended board meetings. This raised the profile of maternity services and supported the board in understanding the challenges the maternity service faced. We saw evidence that maternity services had been discussed at board meetings regularly.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, however not all staff were aware.

Some staff were not aware of the vision and strategy for the service. The trust was still in the process of developing a new maternity specific strategy across both sites. The development of the new strategy started in 2022 and the trust had engaged with various stakeholders to produce it. These stakeholders included service users, maternity and neonatal voice partnership (MNVP) colleagues and partners from the local maternity and neonatal system (LMNS). The final strategy was planned to be presented in early 2024.

The service adopted the trust values which were described by the acronym THRIVE. Teamwork, Honesty, Respect, Inclusivity (and) Valuing people (which leads to) Excellence. Staff we spoke with were aware of the trust values and were aware that the service was in the process of developing a new strategy.

Maternity

The service had a vision for workforce training and education which was, “We will look after the people who work with our families, recognising they are our greatest resource. This is underpinned through having positive learning environment where staff development is encouraged and fostered, and we are known as a maternity service where people will want to stay and develop their careers.” The service had objectives and a plan to measure the success of this vision.

Culture

Not all staff felt respected, supported and valued at a local level. The service provided opportunities for career development. However, the service faced challenges with promoting equality and diversity in its daily work. The service was working towards an open culture where patients, their families and staff could raise concerns without fear.

Staff we met were welcoming, friendly and helpful. We observed staff working together as a team to provide high quality care and to positively impact patient experience. The majority of staff we spoke with were positive about the service. However, most of the clinical staff reported that they did not always feel well supported, respected, and valued by the service. They reported this was largely due to the pressures of insufficient staffing and poor skill mix on shifts which resulted in low morale.

We spoke with members of staff who reported that there had been episodes of division and racism towards the internationally recruited midwives that was not always adequately addressed by the trust. Leadership was aware of the cultural issues within the service, but we were not assured that this was being treated as a priority as we did not see any evidence of it being discussed at relevant meetings. We raised this with the practice development team and the triumvirate who informed us that they were aware of the cultural issues and as a result had introduced cultural safety and competency workshops. The workshop was open to all obstetric and maternity staff and had multiple dates to choose from throughout the year. However, the workshop was not compulsory for staff to attend.

Internationally recruited staff we spoke with reported that the service had adequate pastoral support in place for internationally recruited staff once in the United Kingdom such as arranging accommodation, hosting welcome days, providing information on local religious communities, useful contact numbers, information on British banks and so on. Internationally trained staff were complimentary of the support they received from the trust.

Most staff reported that they felt able to raise concerns without fear of retribution however, there was a cohort of staff who felt that appropriate action would not be taken when they reported incidents of racism and division within the workforce. The trust had a Freedom to Speak Up Guardian and staff we spoke with were aware of this role. Information provided by the trust showed that maternity staff at Bedford hospital had not contacted the freedom to speak up guardian in the last 12 months despite the concerns raised throughout our inspection.

The trust participated in the nationally mandated Workforce Race Equality Standard (WRES) data collection. Workforce Race Equality Standard (WRES) data collection. The data at trust level (rather than for the maternity service) as of March 2022 showed disparity for staff from ethnic minority groups for the following indicators:

- Indicator 1: representation of staff from ethnic minority groups in the workforce by pay band: there was disparity of representation for every level of staff apart from non-clinical staff lower to upper bands.
- Indicator 2: likelihood of appointment from shortlisting: The likelihood ratio was 1.73. Specifically, 8.3% of White candidates were appointed from shortlisting compared to 4.8% of candidates from ethnic minority groups. The trust performed better than 34% of trusts and worse than 66% of trusts.

- Indicator 4: relative likelihood of White staff accessing non–mandatory training and continuing professional development (CPD) compared to staff from ethnic minority groups. The likelihood ratio was 0.85. The trust performed better than 43% of trusts and worse than 57% of trusts.
- Indicator 7: belief that the trust provides equal opportunities for career progression or promotion: This was significantly lower for staff from ethnic minority groups (46.2%), than for White staff (59.5%). The trust performed better than 58% of trusts and worse than 42% of trusts.
- Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months: This was significantly higher for staff from ethnic minority groups (17.2%), than for White staff (7.1%). The trust performed better than 41% of trusts and worse than 59% of trusts.
- Indicator 9: BME representation on the board minus BME representation in the workforce: the difference between representation of people from ethnic minority groups on the board and in the workforce was -40.1%. Staff from ethnic minority groups were underrepresented on the board by eight members in terms of a headcount, this was worse than 99% of other Trusts.

For other WRES indicators, trust level data did not show significant disparity, as follows:

- Indicator 3: The relative likelihood of staff from ethnic minority groups entering the formal disciplinary process compared to White staff. The likelihood ratio was 1.20. The trust performed better than 83% of trusts and worse than 17% of trusts
- Indicator 5: The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. This was similar for both White staff and staff from ethnic minority groups. the trust performed better than 56% of trusts and worse than 44% of trusts.
- Indicator 6: The percentage of staff who experienced harassment, bullying or abuse from other staff in the last 12 months. This was similar for both White staff and staff from ethnic minority groups. the trust performed better than 68% of trusts and worse than 32% of trusts.

Results from the trust NHS staff survey 2022 were released after the inspection on 9 March 2023, the survey asked staff multiple questions under 9 themes. The Women's Health and Sexual Health Directorate scored lower than the national average on 4 of the questions which were: we are compassionate and inclusive, we are recognised and rewarded, we are always learning, and we work flexibly. The Women's Health and Sexual Health Directorate scored the same as the national average on the remaining 5 questions which were: we each have a voice that counts, we are safe and healthy, we are a team, staff engagement and morale.

Staff were aware of the duty of candour and the culture towards it was positive. Staff also described a working environment in which any errors in a patient's care or treatment were investigated and discussed with the woman and her family.

Governance

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

Maternity

The service had a clear governance structure in place, with lines of reporting within the maternity service. The structure was intended to enable escalation upwards and information to be shared with sub-committees and all staff. The governance team included a cross site quality governance manager, a hospital-based quality governance manager and a quality governance facilitator.

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. Midwives we spoke with reported that the quality governance manager was visible on the unit and they new how to contact the team for support. The governance team reported that they had oversight of incidents, risks and were worked closely with the practice development team to improve staff knowledge on governance and to maintain a culture of transparency in relation to reporting incidents.

The maternity service sought assurance through various monthly cross-site- and site-specific governance meetings. We reviewed the minutes of maternity safety and governance meetings which was cross site, clinical service line quality governance meetings, perinatal mortality risk meetings, LMNS serious incident panel meetings between June and October 2023. The meeting minutes showed that the meetings were multidisciplinary, they were well attended and that actions were highlighted and reviewed at each meeting. Outcomes of governance meetings were shared with staff through newsletters, by email and displayed on display boards across the wards.

Maternity performance measures were reported using the maternity dashboard. However, the targets for performance were not identified, which meant that we could not identify whether the service was performing better or worse than expected in comparison to trusts within the local maternity and neonatal system.

Monthly incident and risk meetings were attended by members of the multidisciplinary team including obstetric, midwifery and the risk management leads. We saw that incidents and risks were discussed and action plans were developed.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified relevant risks and issues; however, they were not managed efficiently.

Service leads were aware of some risks across the service and there were systems and processes in place to identify risk. However, the service did not always manage risks in a timely manner.

Not all risks we identified were included such as the discontinuation of support for internationally trained midwives and the cultural issues between the UK trained and internationally trained midwives. The service had a maternity risk register which included a title, description of risk, risk rating score, the date it was opened, review date and the risk owner. The risk register had 40 risks that included some of the risks we had identified during our inspection which included out of date guidelines, the environment of the second theatre being unsuitable and staffing levels. We saw evidence of some risks being discussed at governance meetings. We observed risks on the risk register since 2017 without an update of ongoing mitigations and plans going forward which meant we could not be assured that these risks were being managed effectively.

The service had converted a delivery room on delivery suite into a second theatre during COVID19. However, in July 2022 the theatre was deemed unsuitable for use. This was due to, the air change not meeting theatre requirements, lack of temperature control and lack of space. This risk had been on the risk register since July 2022, however, there was no update, and the service continued to use the theatre in emergencies. Data shows that the theatre had been used 8 times between August and October 2023, even though it did not meet theatre requirements set out by the trust.

Maternity

The service was involved in the Maternity Incentive Scheme (MIS) and Evidence of saving babies lives care bundle version 3. The MIS is a national programme that rewards trust's that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service was currently working towards being compliant after being non-compliant in previous years.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service had clear performance measures such as key performance indicators (KPIs) and local/national audits which were reported and monitored. These included the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), maternity dashboard and friends and family test (FFT) results. Clinical updates were displayed across the unit for staff and discussed at service, triumvirate and board level to improve care and patient outcomes.

The service used a combination of electronic and paper records. Antenatal, intrapartum, and postnatal notes were written in paper records and prescription and medicine management were completed through an electronic system. The service had plans to move to electronic patient records in the future. Staff reported that they were able to access policies and guidelines easily through the intranet to help make clinical and non-clinical decisions.

Arrangements were in place to ensure confidentiality of maternity patient records. Wards had lockable notes trolleys where patient records were stored at the midwives' station, and we observed computer screens being closed when not attended. Staff had password access to electronic systems. The service also had a digital midwife to support staff accessing electronic information systems.

Women, relatives, and carers knew how to complain and raise concerns. The service clearly displayed information on how to raise concerns on the maternity ward and reported having a good relationship with the trust Patient Advice and Liaisons Service (PALS).

Engagement

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

Managers engaged with staff through newsletters, social media, display boards and during learning forums. The head of midwifery also held listening events to enable open conversation with staff at all levels. The service reported an improvement of sharing feedback to staff since the appointment of the patient experience midwife.

The service hosted regular staff engagement sessions to promote mental, physical, and nutritional well-being. These sessions were disseminated by email and social media to ensure all staff had the opportunity to attend.

The trust had 3 formal staff networks which were the black, Asian and minority ethnic (BAME), lesbian, gay, bisexual, transgender and queer (LGBTQ+) and Allies, Disabilities and Allies Staff Networks. The aim of these staff networks was to ensure the needs of all staff were met.

The service engaged well with stakeholders such as the Care Quality Commission (CQC), NHS England and Healthcare Safety Investigation Branch (HSIB). The service was also actively involved with the Local Maternity Neonatal System group (LMNS).

The maternity service had an active and functioning maternity and neonatal voice partnership (MNVP) team that met regularly and worked closely with the service. The MNVP worked with maternity services to bridge the gap with women that could be harder to reach. They did this by, planning events in areas with a more diverse population and reaching out to already established groups within the community. They used social media platforms and listening events to connect with women, raise awareness, and act as their advocates. This was then fed back to the trust to improve maternity services at the hospital at weekly meetings with the head of midwifery and patient experience midwife. The MNVP also held quarterly meetings which were well attended by the MNVP team and representatives from the service such as the head of midwifery, patient experience midwife, infant feeding midwife and the inpatient matron. We reviewed the minutes and found the agenda covered various topics such as themes identified from women's feedback at listening events, future events, finances, and updates from the trust.

The safeguarding and perinatal mental health midwives also engaged with external organisations and charities to provide care and support for women with complex or additional needs.

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.

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

There was a commitment to safety, learning and improvement. Quality improvement was routinely discussed at team meetings. The service had maternity services safety champions who engaged with staff. We saw evidence of improvements being made in response to staff's ideas and innovations.

Leaders encouraged innovation and participation in research. The service had recruited a research midwife and was currently involved in 3 research trials which were, Group B Strep trial, SNAP-2 which is a nicotine replacement therapy in pregnancy trial and, MCM5 which is a trial to detect bladder cancer through a new urine test. The service also showed evidence of work being done to embed research for the future workforce cross site. The service worked closely with the partnering university to amend the midwifery programme to include training required for researchers conducting clinical trials.