Mersey and West Lancashire Teaching Hospitals NHS Trust

Whiston Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Whiston Hospital

Good 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Whiston Hospital.

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

The Whiston Hospital provides maternity services to the population of Mersey and West Lancashire.

Maternity services include antenatal clinics, triage, a mixed antenatal and postnatal ward, a midwife-led birthing unit and a consultant led delivery suite. Between April 2021 and March 2022, 3,885 babies were born trust-wide within Mersey and West Lancashire Teaching Hospitals Trust, across 2 locations, Whiston Hospital, and Ormskirk District General Hospital.

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

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

Our rating of this hospital stayed the same. We rated it as good because:

- Our rating of good for maternity services did not change ratings for the hospital overall. We rated safe and well-led as good.

We also inspected 1 other maternity service run by Mersey and West Lancashire Teaching Hospitals NHS Trust. Our report is here:

Ormskirk District General Hospital - https://www.cqc.org.uk/location/RBN04.

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited maternity assessment (triage), labour ward/delivery suite, the midwife-led unit, the antenatal and postnatal ward.

We spoke with 7 midwives and 3 obstetricians. We received 91 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 6 patient care records, 6 observation and escalation charts and 8 medicines records.

Our findings

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

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

Maternity

Good ➔➔

We rated it as good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect women and birthing people from abuse, and managed safety well.
- The service controlled infection risk well. The environment was suitable, and the service had enough equipment to keep women and birthing people safe.
- Staff completed and documented fresh eyes observations in line with national and trust guidance.
- The service had enough midwifery and medical staff; planned and actual staffing numbers were equal to each other.
- Staff assessed most risks to women and birthing people, acted on them and kept good care records. They managed most medicines well.
- The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- The service staff engaged well with women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- Staff did not always complete baby observations.
- Not all epidural medicines were recorded in line with trust guidance.
- The service did not have a service specific vision.

Is the service safe?

Good ➔➔

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

Mandatory training

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

Maternity

Midwifery and maternity support staff received and kept up-to-date with their mandatory training. Records showed that 88% of midwifery staff had completed the required maternity specific mandatory training courses against a trust target of 85%. Ninety per cent of maternity support workers (MSW) had completed mandatory training. More than 95% of midwives had completed adult and neonatal resuscitation training. MSWs had completed adult resuscitation training at a rate of 95% and 90% for neonatal resuscitation training.

Medical staff received and kept up to date with their mandatory training. Ninety-three percent had completed all mandatory training courses. Medical staff had an overall maternity specific mandatory training compliance of 93%. Ninety per cent of medical staff had completed adult resuscitation training, and 93% had completed neonatal resuscitation training.

Fetal surveillance study days were held each month to ensure all staff had the opportunity to complete. Ninety percent of midwifery staff, 89% of middle grade doctors and 94% of consultants had completed fetal wellbeing training.

The service made sure that staff received multi-professional simulated obstetric emergency training. Data provided by the trust showed all clinical staff received obstetric emergencies skills training and completion rates were above 95% for both midwives and medical staff, and 90% for MSWs. Completion of Practical Obstetric Multi-Professional Training (PROMPT) was monitored by the trust's practice development midwives and local leads were notified about required training.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. This included non-maternity consultant anaesthetic staff who would be required to support in the event of a third theatre use for caesarean section.

Managers monitored mandatory training and alerted staff when they needed to update their training. Attendance was monitored by the professional development midwives, who were able to book staff on new training quickly if initial sessions were missed. The service had systems in place to ensure staff that rotated frequently, such as band 5 midwives and junior doctors, also received the relevant maternity training as soon as possible.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Leaders identified that senior midwives' (band 7 and above) would be trained to safeguarding adults' level 3 and all other clinical staff would be trained to safeguarding adults' level 2. The training needs analysis had been reviewed and signed off by the integrated care board.

We found that 89% of Midwives and 97% of medical staff were compliant with safeguarding adults' level 2 training and 88% of those eligible were trained to safeguarding level 3. For safeguarding children level 3 data provided showed 89% of Midwives and 100% of medical staff were trained.

Maternity

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

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

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

Cleanliness, infection control and hygiene

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

Maternity service areas were visibly clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service generally performed well for cleanliness.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed infection prevention and control audits were completed in all maternity areas. From August to December 2023, compliance was consistently above 95%. An infection prevention and control action plan showed all actions were completed or ongoing to achieve and improve infection control compliance.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Environment and equipment

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

The design of the environment followed national guidance. The maternity unit was fully secure with an alarmed baby tagging system that locked down all maternity services when activated. There was a monitored buzzer entry system to the maternity unit and reception areas.

The service had a dedicated maternity theatre suite next to delivery suite for easy access. There were 2 theatres for elective and emergency caesarean sections with access to a third theatre for additional emergencies if required.

Maternity triage consisted of a dedicated waiting area, one 3 bedded bay and a single room that enabled staff to relay information in a private setting. However, not all of the waiting area was visible from the corridor, the reception area was

behind frosted glass and these windows were closed when we visited. We saw a poster advising women and birthing people to contact staff if their condition changed. Following this inspection, the service advised staff carried out hourly checks of all patients, including those in the waiting area. The triage unit was situated next to delivery suite and close to the fetal surveillance team, which ensured further assessment or transfer quickly.

The service's bereavement suite was developed to provide parents with a private entrance, the room was sound proofed, and beds and seating areas were large enough for both parents to be comfortable.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment and resuscitaires were checked daily.

Staff regularly checked birthing pool cleanliness.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. Women and birthing people could reach call bells and staff responded quickly when called. We saw that call bells were within easy reach and staff responded in a timely manner when these were rung.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. The service had a system to monitor equipment safety checks, such as portable appliance testing (PAT), which were last completed in May 2023. All equipment seen during our inspection visit had been checked within the last 12 months.

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

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff acted when women, birthing people and babies were at risk of deterioration. However, not all baby observations were completed.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration, such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. Staff completed audit of MEOWS records to check they were fully completed. The audit for December 2022 to November 2023 showed neither the March 2023 target of 80% nor a higher target in September 2023 had been met. There had been an overall reduction of MEOWS not completed correctly by 7% in September 2023, however the completion rate remained at 73% in November 2023. Senior managers identified reasons why staff had not met targets for recording these and put actions into place to improve. They identified there were issues with the use of the electronic system when transferring between areas, when frequency of observation recordings changed and not all staff having access to the electronic system. Some observations were also recorded on paper when these were more frequent. During the inspection we reviewed 6 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff.

Maternity

Following our inspection, the service provided additional information to explain why these targets had not been met. This was due to the transfer of women and birthing people following induction of labour back to delivery suite, where MEOWS was completed on paper records. These records did not form part of the electronic audit but when audited accounted for the reduced compliance. It also showed compliance rates for completion of MEOWS was 99% to 100% for September 2023 to November 2023.

Staff did not always record baby observations when they were due. Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. At birth, staff completed APGAR scores at 1 and 5 minutes and again at 10 minutes if needed. APGAR is a quick test performed on a baby to determine how well they are doing after being born. Staff also completed Newborn Early Warning Score (NEWS) scores for newborn babies who were at risk. An audit of completion records and escalation between July 2023 and September 2023 showed 50% compliance with accurate completion. A rationale for not completing NEWS was given for a third of the scores not recorded. Just over half of the NEWS scores that required escalation, had been appropriately escalated. Of those that had not been escalated, just under half had no documentation to show whether any action had been taken at all. Senior managers identified reasons why staff had not met targets for recording these and put actions into place to improve. The service provided transitional care for babies who required additional care.

Following our inspection the service completed a deep dive, which showed their audit of NEWS scores had not taken into account all mitigating factors for staff not completing observations or escalating when needed. The deep dive confirmed that completion of NEWS scores between July 2023 and September 2023 was 82%. It also identified all babies had a plan of care that included ongoing investigations, treatment and paediatric reviews, and this explained why some adverse NEWS scores were not escalated.

In maternity triage staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage. The maternity triage waiting times for review audit for August 2023 to November 2023 showed midwives reviewed over 95% of women and birthing people within 15 minutes of arrival. Staffing in triage had been increased so there were always 2 midwives. Women and birthing people were reviewed by an obstetrician if this was indicated.

The service had a telephone triage line, available 24 hours a day, with midwives from the triage unit allocated to take the calls. Staff told us the phone line could be very busy and if they were unavailable, the call was answered by the ward clerk and put through to delivery suite if deemed urgent. Leaders assured us ward clerks received induction training and were part of a duty rota of familiar staff. The service recognised there was an issue with the current phone system as they were not able to easily gather data about calls to maternity triage. A dedicated phone line with recording facilities and data collection was being installed the week after our inspection visit. The electronic records system automatically flagged to staff if the woman or birthing person had called before, and this helped staff recognise when there may be an ongoing issue.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks, such as the risk of developing blood clots, the risk of carbon monoxide poisoning or a reduction in fetal growth. Assessments had been completed at each antenatal visit and staff recorded the outcome of assessments in patient records we looked at. An audit of clinical record keeping between July 2023 and September 2023 showed venous thromboembolism (VTE) assessments had been completed 93% of the time and other risk assessments were completed

96% of the time. Staff took additional action, such as referring women and birthing people to smoking cessation services, to further reduce risks to unborn babies. Overall, only just over half of the women who smoked at the time of booking their pregnancy were referred to this service, although this had increased in the 2 months before this inspection to 72% in November 2023.

In theatres from September 2023 to November 2023, staff achieved 98% compliance in the World Health Organisation (WHO) surgical checklist audit.

Staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. It is best practice to have a 'fresh eyes' or buddy approach for regular review of cardiotocographs (CTG) during labour. Fresh eyes checks had been completed in the 6 records we looked at. Leaders audited how effectively staff monitored women and birthing people during labour having CTG monthly. Audits for January 2023 to September 2023 showed clear interpretation and management plans following CTG in 91% of cases and staff did 'fresh eyes' at each hourly assessment in 81% of cases overall. Despite an improvement to 100% for the most recent 4 months the service identified where improvements were needed and developed an action plan.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. Staff completed, or arranged, risk assessments and psychosocial assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff completed skills and drills regularly and had practised how to evacuate women, birthing people and babies from the birthing pool in an emergency.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the woman or birthing person's care. Each episode of care was recorded by health professionals and was used to share information between care givers. Staff used the SBAR (Situation, Background, Assessment and Recommendation) tool to handover patients to others. The communication tool prompts staff to record key information and recommendations about patients. An audit of SBAR records over the last 3 months showed a 97% compliance rate.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge. Staff completed Newborn and Infant Physical Examination (NIPE) assessments of newborn babies before they were discharged.

Midwifery Staffing

Staffing levels usually matched the planned numbers. Managers regularly reviewed and adjusted staffing levels and skill mix. The service made sure staff were competent for their roles. Staff received support through supervision and appraisals.

Maternity

Staffing levels usually matched the planned numbers to keep women, birthing people and babies safe. The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between July 2023 and September 2023 there were 4 red flag incidents, 3 of which related to delays in women and birthing people not being assessed within 15 minutes of arrival in triage. Only one delay was in relation to induction of labour (IOL) and when artificial rupture of membranes (ARM) was required.

Managers accurately calculated and reviewed the number and grade of midwives, maternity support workers and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in April 2022. This review recommended 160.8 whole-time equivalent (WTE) midwives Band 3 to 8. A review of maternity staffing between July 2023 and September 2023 showed no additional staff requirements were needed since the April 2022 review. There was no shortfall in midwifery staff employed as there were 161 WTE at the end of September 2023.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Compliance for the provision of 1 to 1 care in labour was at 100%. Monthly audits confirmed 100% compliance with the delivery suite coordinator being supernumerary.

The service had experienced a consistent reduction in sickness from 13.62% in Jan 23 to 8.76% in September 2023. Staff shortages were mitigated by offering extra shifts and bank hours, together with redeployment of all staff including senior management midwives and specialist midwives, to areas of greatest clinical need.

The service had an ongoing rolling recruitment programme to address any potential vacancies as early as possible and be proactive to cover prospective maternity leave, retirement and staff leaving. Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Compliance with annual appraisals was at 96% across all maternity inpatient staff groups. A clinical practice educator lead supported midwives.

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

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff exceeded the planned number. The service had 16 whole time equivalent (WTE) consultant doctors, 5.6 specialist and associate specialist doctors, 19.6 doctors in training and 3 junior doctors.

Maternity

The service maintained 7 days a week obstetric consultant presence on site and facilitated twice daily consultant led ward rounds in line with national guidance. Consultant attendance was required for certain clinical situations, and this was known and understood by medical and midwifery staff. A business case was approved in May 2023 to increase obstetric and gynaecology staffing to include full consultant residency once recruited. Two new consultants had been appointed and were in post, a further consultant had been appointed and was due to commence in March 2024.

The service always had a consultant on call during evenings and weekends. However, If simultaneous obstetric emergencies occurred 'out of hours', which required the attendance of an obstetrician, there was a risk of delay that may potentially result in a patient harm. The service had developed a standard operating procedure for simultaneous obstetric emergencies.

The service had low vacancy, turnover and sickness rates for medical staff. The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Part of the rota coordinator's role was to make sure trainee medical staff had enough training opportunities.

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used an electronic patient records system. We reviewed 6 records and found records were clear and complete. The electronic records were on a secure patient record system used by all staff involved in the woman or birthing person's care.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. This was because the electronic records system linked to other hospitals using the same system.

Records were stored securely. Staff locked computers when not in use. There were enough mobile computers, which were used to document patient records by the bedside.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, the controlled drug register was not always signed for the disposal of epidural infusions.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their stay. We reviewed 8 prescription charts and found staff had correctly completed them.

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

Staff completed most medicines records accurately and kept them up to date. Medicines administration records were clear and up to date. However, the controlled drugs register was not always signed as required and the actual administered dose was not always recorded accurately for epidurals. This posed a risk that checks to witness medicines disposal were not completed correctly. We told senior staff about this during our inspection, and they took immediate action to improve recording. Midwives could access the full list of midwife exemption medicines, so they were clear about administering within their remit.

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

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

Incidents

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

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

The service used an 'incident management framework' to support effective identification, reporting, investigation, and learning. Managers reviewed incidents on a regular basis so that they could identify potential immediate actions.

Serious incident review meetings took place so that investigations were carried out and learning could be shared. Reviews took place for incidents graded as a moderate or a higher level of harm.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Moderate and serious incidents were reported to the board level maternity safety champions and the Local Maternity and Neonatal System (LMNS) monthly. Data from the maternity service showed all but 7 incidents had been reviewed in a timely way but these 7 were still open after 60 days. The service reported 2 serious incidents between July 2023 and September 2023, both of which met the criteria for reporting to the maternity and newborn safety investigations programme (MNSI, formerly HSIB). MNSI undertake independent investigations into incidents within maternity services which fall under a defined criteria that includes maternal deaths, stillbirths and babies that require treatment for a lack of oxygen to the brain caused during birth. All investigations accepted by MNSI were reported as a serious incident. Cases returned to the trust were investigated with a full multidisciplinary team review including an external representative from the Cheshire and Merseyside LMNS.

Maternity

Managers investigated incidents thoroughly. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 3 investigations, managers performed duty of candour and shared draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. 'Lessons learned' newsletters reminded staff about current risks and safety actions and encouraged an open reporting culture.

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

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed serious incidents and shared learning at an obstetric clinical governance meeting in November 2023. Leaders were then able to feed back to staff recommendations and action plans in relation to a MNSI report and an investigation into a baby's need for further treatment following birth.

Managers debriefed and supported staff after any serious incident. We saw this when we visited, shortly after a major incident. Senior managers provided staff with multiple opportunities to reflect and discuss any concerns they had or simply to talk about the incident. All staff were able to access support from managers, professional midwifery advocates or pastoral care leads.

Is the service well-led?

Good ➔➔

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

Leadership

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

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. There was a clearly defined management and leadership structure. The hospital had an executive director of nursing, midwifery and governance. The maternity leadership team consisted of an assistant director of operations, obstetric clinical director and head of midwifery. A neonatal clinical lead formed the maternity and neonatal quadrumvirate. The service was recruiting to a deputy head of midwifery post to strengthen the maternity midwifery leadership. All members of the quadrumvirate were undertaking the NHS England programme in perinatal culture and leadership. The quadrumvirate met formally each month. They were supported daily by the head of midwifery, lead clinicians, matrons, governance leads and specialist midwives.

Maternity

The quality and safety matron line-managed a quality and safety midwife, specialist midwives for governance, specialist midwives for audit and guidelines, a pre-term birth midwife, bereavement specialist midwives, a preceptor/workforce midwife and a clinical practice educator.

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

The service was supported by maternity safety champions and non-executive directors. The maternity safety champions met bimonthly. We reviewed minutes of the last 3 maternity safety champions meetings and saw they followed a set agenda that included maternity performance and feedback from champion walk rounds and regional meetings.

They supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

The service did not have a separate vision or strategy for maternity, although there was an overall trust strategy. The strategy was focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them, although change in some areas was slow.

The service did not have a separate vision for what it wanted to achieve or a separate strategy to turn it into action. Leaders could explain the vision and what it meant for women and birthing people and babies.

Prior to the recent merger of the 2 trusts, the trust had developed nursing and midwifery strategies for 2022 – 2025. However, the strategy was not specific to maternity services but an overarching strategy for the delivery of nursing and midwifery care across the trust. Leaders developed a ‘maternity strategy priorities at a glance’ document that identified underlying aims and high-level actions to achieve them. It did not include all the recommendations following the Ockenden 2020 and 2022 reports on the review of maternity services. One of the key priorities following the Ockenden report in 2022 was escalation and accountability, however this did not appear on the service document. Although the document included implementing a new maternity electronic system, ensuring learning from incidents and robust audits to provide assurance, we found during this inspection that only half of adverse baby observations were recorded and escalated appropriately.

Underpinning the nursing and midwifery strategy were 6 priorities; a workforce that was valued, embedding safety, clear communication, achieving person centered care through improved systems, raising standards of care, evidence-based pathways to improve outcomes. The maternity strategy also followed these priorities.

Following the inspection, the trust advised us that there were plans for a creation of a maternity specific strategy for the trust follow the implementation of the new management arrangements for the Women’s and Children’s Division on 1st April 2024.

Culture

Maternity

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

Staff felt respected, supported, and valued. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff told us there was great teamwork and support from the current head of midwifery, and they worked well together. The service had a monthly staff recognition award, called 'The Maternity Star', which was introduced to recognise and value staff.

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

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

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

The service had an action plan to address known inequalities of women and birthing people from ethnic minority groups. This included early identification of women and birthing people at risk and the opportunity to receive care from a specific team of midwives.

The service provided an overview of the main themes from the most recent staff survey in 2022. They identified maternity services as 1 of 3 areas across the trust with the lowest scores across a range of questions including work pressures, opportunity to contribute to improvements, changes, and challenges. The response rate to the staff survey was 25%. The service held focus groups with staff following the survey results to develop an action plan. We reviewed the action plan and saw it addressed the areas of lowest score in the survey and had clear actions with action owners and deadlines which were monitored. The service was taking part in the national NHSE culture survey, and this was underway at the time of our inspection.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in clinical and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints, identified themes, and shared feedback with staff. Learning from these was used to improve the service. This was a fixed agenda item on each regular team meeting.

Maternity

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

The service received 5 complaints in the 3 months before the inspection. We reviewed the complaints and found they covered issues such as waiting times and concerns about care in the maternity assessment unit, poor communication and attitude of staff of delivery suite. Of the 5 complaints, only 1 had received a response, 2 were open and 2 had responses in draft at the time of inspection.

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.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. There were clear lines of reporting from the delivery suite forum and senior midwifery managers meeting to directorate meetings and directorate clinical governance and quality meetings. These fed into monthly trust-wide councils including clinical effectiveness and governance, patient safety, and risk management. These councils reported directly to trust quality committee, which also met monthly.

The directorate clinical governance and quality meeting was held monthly. We looked at minutes of the last 3 meetings and saw there was a set agenda which covered all key aspects of performance and safety including risks, incidents, and the maternity safety dashboard.

Oversight of safety in maternity services was reported to the board quarterly. We reviewed the maternity services update to the quality committee for July 2023 to September 2023. It provided an update on progress towards the Maternity Incentive Scheme for trusts year 5 safety actions, reportable deaths, serious incidents, Saving Babies Lives Care Bundle v3, complaints and claims, and maternity staffing.

The maternity dashboard was reviewed at the monthly directorate clinical governance and quality group and reported from this to the trust quality committee.

Maternity services participated in both national and local audits, including the National Maternity and Perinatal Audit. This looked at statistical information about birth, such as the number of caesarean sections performed, whether an episiotomy (deliberate cut to avoid a perineal tear during birth) was performed or the number of women and birthing people who had given up smoking while pregnant. This showed the service's statistics between November 2022 and November 2023 for 3rd and 4th degree tears, at 3%, which was lower than the trust target of 3.5% and lower than the national average. Statistics for postpartum haemorrhage were also lower than the national average.

The service had an audit and guideline midwife to oversee audits in progress and due for completion and review guidelines and policies. They reported to the monthly clinical governance and quality group, where all guidelines for approval were presented.

Maternity

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

The introduction of Governance Boards in each area including maternity theatres which highlights Ockenden infographics, top 3 risks, incidents and complaint themes, lessons learnt and safety messages of the week.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed 8 policies and guidelines during inspection and saw all were up to date and had a review date. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date.

Management of risk, issues, and performance

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

The service reported outcomes to the NHS Digital Maternity dashboard, the National Neonatal Audit Programme, the National Maternity and Perinatal Audit and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiry). Outcomes for women and birthing people were positive, consistent, and met expectations, such as these national standards. Managers and staff used the results to improve women and birthing people's outcomes.

The service had undertaken a gap analysis and collation of evidence of compliance to Saving Babies Lives version 3 (SBLv3) and met with the local maternity and neonatal system (LMNS) to assess compliance with the care bundle. In November 2023, the service self-assessed against 6 elements and a month later was found to have improved against previous scores validated by the LMNS. The service planned to provide further evidence to the LMNS including audits which would improve compliance.

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

The service had an audit plan for all maternity guidelines, policies, and standard operating procedures, which was last updated in November 2023. This included audit leads and a rating system to show if audits were completed, on track or overdue.

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

The service had a risk register in place. We reviewed the risk register and saw there were 4 risk initially rated as high, 32 as moderate and 2 as low. The high risks related to midwifery staffing for triage, consultant attendance at simultaneous obstetric emergencies, scan review clinics and the electronic patient system used by community midwives. These aligned with information we saw and were told during our inspection. Mitigating actions and controls had been put in place for each of these high risks which mitigated 3 risks to moderate and 1 to low.

The risk register was reviewed and updated at the monthly directorate clinical governance and quality group and actions noted to mitigate risks.

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

Information Management

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

The service collected reliable data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. Key information from the dashboard, score cards, audits and performance data were displayed across the service for staff, women, birthing people and public to access.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff used electronic patient records to access all the information they needed, including screening results and safeguarding information.

The information systems were integrated and secure. Electronic patient records systems were password protected to prevent unauthorised access.

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

Engagement

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

There had been no formal leadership of the Maternity and Neonatal Voices Partnership (MNVP) since December 2022, which meant leaders had less engagement with women and birthing people from the local population. Since our inspection, the service had recruited a chair to the Whiston MNVP role and is working to establish terms of reference and a working relationship.

Leaders had continued to work at obtaining women and birthing people's views while they were in hospital following the results of the inpatient survey 2022. These showed a significant decrease in 10 scores from the 2021 survey and somewhat worse than expected in 5 scores, worse than expected in 3 scores and much worse than expected in 1 score

compared with other trusts. They had developed an action plan to support this, which contained updates on the 2023 inpatient survey and other ways they ensured views were heard, such as the safety champions walkaround. The bleep holder for maternity services also carried out a walkaround each day, which provided the opportunity to gather the views of women, birthing people and their families.

The service always made available interpreting services for women and birthing people and collected data on ethnicity. Staff used a 24-hour telephone language line when they could not book an interpreter in person.

Leaders understood the needs of the local population. One of the service's identified priorities was in relation to the larger geographical area the new trust covered, and its impact on women and birthing people from diverse backgrounds. The service had also developed personalised plans and risk assessments where women and birthing people had specific needs, such as deafness.

The service had systems to engage with staff, women and birthing people. The ward and units had 'positivity' boards, which highlighted 'You said, we did' information, improvements made, quality initiatives and feedback. There were staff and student information boards in clinical areas that provided contact details for Freedom to Speak Up Guardians and others where staff could get support.

We received 93 responses to our give feedback on care posters which were in place during the inspection. Of these responses the majority were mixed, and some were negative. There were no solely positive comments. Themes included positive experiences of staff, particularly in delivery suite and theatres, although there were also negative experiences around support following caesarean section and in receiving pain relief. Some women also felt they were not listened to or were ignored.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had an understanding of quality improvement methods, but systems were not embedded to look at quality improvement.

Staff were committed to continually learning and improving services. They had an understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and change. Staff contributed to programmes, such as the patient safety incident response framework (PSIRF) and multidisciplinary review meetings, that provided reflection and learning. Meeting minutes for June 2023 to September 2023 showed overall continuing improvement in outcomes for women, birthing people and babies.

The service provided various methods to widen the availability of learning to staff. These included a private social media learning hub page and maternity newsletters. The service also introduced a quality bus, which was used to distribute information to staff in clinical areas. This was adopted by the rest of the trust in 2023.

Quality improvement was embedded within existing meetings, about national programmes in general, however there was not a specific maternity improvement plan or group to focus on the service development needs.

Maternity

Leaders encouraged participation in research. The service collaborated with regional organisations, such as the Integrated Care Board and Local Maternity & Neonatal System, where these organisations supported research ideas. The service collaborated with regional universities and charities to support research studies. For example, women and birthing people had been enrolled to participate in research studies for high blood pressure in pregnancy and group B streptococcus screening.

Areas for improvement

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 service SHOULD take to improve:

- The service should ensure a vision and strategy is developed for the service that incorporates recommendations from the Ockenden report.
- The service should continue to monitor and take action to ensure baby observations are completed in line with national and trust guidance.
- The service should ensure staff discarding or witnessing epidural infusions sign the controlled drug register and record the actual amount administered.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 other CQC inspectors, 2 midwife specialist advisors and an obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare