East Lancashire Hospitals NHS Trust

Burnley General 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 Burnley General Hospital

Good ➔➔

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

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

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

The inspection was carried out using a post-inspection data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records medicines charts and documentation. Following the site visit, we conducted interviews with senior leaders and reviewed feedback from women and families about the trust.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received 315 feedback forms from women. We analysed the results to identify themes and trends.

Burnley General Hospital is the main site for maternity services for the trust. It comprises of a central birth suite with maternity theatres and a close observation unit, post and antenatal wards, day assessment unit, maternity triage and fetal medicine unit. Ante and postnatal clinics are also provided at this location and there is an alongside midwife led birth unit adjacent to the central birth suite.

The local maternity population come from higher levels than deprivation than the national average with 34% in the most deprived decile compared to 12% nationally. More mothers were Asian or Asian British (24% compared to the national average of 14%) and fewer were White than the national average.

Maternity services delivered 5,857 babies between January and December 2021. Since February 2022, the trust has been in the upper 25% of all organisations for women who were current smokers at booking appointment.

We did not rate this hospital at this inspection. The previous rating of good remains.

We also inspected 2 other maternity services run by East Lancashire Hospitals NHS Trust. Our reports are here:

Blackburn Birth Centre – https://www.cqc.org.uk/location/RXR78

Rossendale Primary Care Centre – https://www.cqc.org.uk/location/RXRE9

How we carried out the inspection

Our findings

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

Maternity

Good

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

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. They managed 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. Staff understood the service's vision and values, and how to apply them in their work. 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 receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women 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:

- Not all medical staff had completed level 3 safeguarding training. Not all staff received an annual appraisal, with appraisal compliance rates low on the antenatal ward and central birth suite.
- Staff did not consistently complete checks of specialist equipment and we found some out of date and missing items on emergency trolleys.
- Staff did not always fully and accurately completed records of women's medicines.
- Managers could not always access reliable data to inform local audits from the electronic care record. However, managers did gather local audit data from case note audits.

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.

Nursing and midwifery staff received and kept up to date with their mandatory training. The service set a target of 90% compliance with core skills training. Compliance with core skills training on the antenatal clinic and ward and Burnley Birth Centre was 93% and was 95% on the central birth suite.

Staff told us they were given time to attend the annual training update day and to complete online mandatory training away from the unit.

Maternity

Medical staff received and kept up to date with their mandatory training. Compliance rates for core skills mandatory training module ranged between 97% and 74% for medical staff. For example, 97% of medical completed infection prevention and control training level 1 and 74% completed moving and handling level 2 training.

The mandatory training was comprehensive and met the needs of women and staff. The service conducted a training needs analysis to identify the required training for each role. This outlined mandatory and specialist training required and staff responsible for ensuring training was completed.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Staff completed training on perinatal mental health as part of the maternity specific mandatory training. 89% of relevant medical staff had completed dementia awareness training.

Managers monitored mandatory training and alerted staff when they needed to update their training. The team of practice education midwives were proactive in monitoring staff compliance with required training and alerting staff and managers to training which needed to be updated or completed. The service had clear guidance for managers to follow to escalate continued non-compliance with mandatory training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Midwifery 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. Evidence provided showed 81.3% of midwives had completed level 3 safeguarding adults and children training in the last 12 months. 93.6% of maternity support workers had completed safeguarding adults and children level 2 training.

Not all medical staff received training specific for their role on how to recognise and report abuse. 91% had completed training on safeguarding adults' level 2 but only 59% had completed safeguarding children level 3 training, 74% had completed level 2 children's training.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. All midwives had safeguarding supervision annually in addition to safeguarding training. This consisted of training and reflective practice based on local safeguarding issues and is above good practice standards which state midwives should complete level 3 safeguarding children training. The safeguarding lead facilitated a bi-monthly safeguarding collaborative meeting with all senior midwives where they reviewed all serious incidents, themes, trends and action plans related to safeguarding.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Midwives attended child protection conferences when required. Staff worked with local authorities to make safeguarding referrals and provide additional support for women whose baby would be separated from them after birth by the local authority.

Staff understood the trust policy on female genital mutilation and the service hosted an independent sexual violence advocate who was employed by a neighbouring council.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding issues were flagged on the electronic care record system. We saw staff were alerted to women where there were safeguarding issues through the daily safety huddle and at handover.

Staff followed safe procedures for children visiting the ward. Wards and units were secure and children accompanied by an adult.

Staff followed the baby abduction policy and undertook baby abduction drills. All areas were locked and visitors were buzzed in and out by a member of staff. On central birth suite administration staff monitored close circuit screens 24 hours a day. Staff in the birth centre told us they had recently completed a baby abduction drill.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean and dust free. Cubicle curtains in the central birth suite were disposable and had dates to show when they were first used. In areas which used material curtains, such as the antenatal ward, curtains had date labels to indicate when they needed changing.

The service performed well for cleanliness. The wards had dedicated domestic staff and we saw them carrying out cleaning duties throughout our inspection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Managers conducted 'walkaround' audits in each area which measured compliance with cleaning standards by area and by staff group. Facilities staff provided feedback to the matron or manager in each area by email and highlighted any actions to be taken to improve compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was available in all areas we visited, and staff and visitors wore surgical face masks to reduce the risk of spread of infections such as COVID-19. Hand hygiene sinks were available in all areas and in each individual birthing room and alcohol hand gel available at the entrance to each area. We saw staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene and followed 'bare below the elbows' guidance. Staff completed training on infection prevention and control as part of core skills training.

Housekeeping staff flushed taps 2 times a week to reduce the risk of water-borne infection such as legionella.

The service had low rates of hospital acquired infections. Between April and September 2022, there were 3 cases of ecoli and no cases of clostridium difficile, klebsiella, pseudomonas, methicillin-resistant Staphylococcus aureus or methicillin-susceptible Staphylococcus aureus.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. In antenatal clinics, we saw midwives or maternity support workers cleaning the clinic room and all equipment between each woman.

Environment and equipment

Maternity

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 alongside birth centre was adjacent to the central birth suite, which was the consultant led labour ward. The labour ward and maternity theatres could be accessed easily in case of an emergency through unlocked double doors. There was clear passage through the labour ward to the maternity theatres. The service had two maternity theatres and a third reserved and equipped as an emergency maternity theatre. Staff gave examples of quick response times of the emergency obstetric team to the alongside birth centre when bleeped.

The central birth suite had a 2 bed close observation unit, this was staffed by midwives with additional critical care training provided by a local university. There was not a high dependency unit on site, staff told us women who required high dependency care would be transferred by ambulance to the Royal Blackburn Hospital.

The service had a maternity triage area with capacity for 3 women with additional spaces in 2 side rooms and a bay if needed. This was on the same floor as the central birth suite so staff could easily transfer women in an emergency.

Women could reach call bells and staff responded quickly when called. We saw call bells available at each bed and women told us staff responded when they used them. However, following our inspection we received some feedback from women that said staff did not always respond to call bells on the postnatal ward.

Staff mostly carried out daily safety checks of specialist equipment. However, we found gaps in daily checks on the neonatal and adult emergency trolley in the central birth suite. We also found additional items in the emergency trolley on the antenatal ward which were not listed on the content checklist. We found some items missing from emergency trolleys which the checklist stated should be there. For example, the emergency trolley in the antenatal ward was missing an endotracheal tube introducer. The sepsis emergency trolley in triage did not have any blood culture bottles. Staff told us they could get some, if needed, from a nearby ward but there was a lack of stock across the service.

Staff on the antenatal ward checked the freezer used to store colostrum daily in line with trust policy.

The service had suitable facilities to meet the needs of women's families. The service had 2 bereavement suites situated on the central birth suite. These were at the end of corridor and sound proofed to minimise distress to women and families suffering baby loss. They had appropriate equipment including cooling cots.

However, feedback received following our onsite inspection showed some women were unhappy they had not been able to access facilities for partners to stay during the night following birth on the postnatal ward. The service told us they did provide such facilities including reclining chairs and some pull-out beds.

Following our inspection, some women told us the design of environment in the early pregnancy assessment unit and fetal medicine unit did not meet their needs. This was because the placement of these unit meant they were in contact with pregnant women and newborn babies when struggling with difficult news or baby loss.

The service had enough suitable equipment to help them to safely care for women and babies Each room on the central birth suite had access to cardiotocography (CTG) and computers, 2 rooms had a birthing pool. Each room had a

resuscitaire which was checked daily, however the resuscitaire was missing in one room and not working in another. Managers were aware of this and were in the process of gaining replacements. Following our inspection, the service told us the central birth suite capacity was for 19 rooms and there was a resuscitaire allocated to each room. They stated resuscitaires were always available for every labouring woman, with no incidents related to resuscitaires reported.

The birth centre had 3 rooms with birthing pools and 4 other birthing rooms. Staff could access equipment to help them evacuate a woman safely from the pool in event of an emergency and practiced this through skills and drills training. Each room had a neonatal resuscitaire which was checked daily.

The facilities department monitored when equipment was due for regular maintenance and had a schedule of work to ensure all regular maintenance was carried out.

Staff disposed of clinical waste safely. Staff disposed of sharps, such as needles, correctly in appropriate containers and in line with national guidance. Posters reminding staff which clinical waste bags to use to ensure clinical waste was properly segregated were displayed in utility rooms.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff recorded observations using modified early obstetric warning scores (MEOWS) and we saw all were completed fully and correctly in 10 relevant records we reviewed. Staff knew when to escalate women and babies for review by the medical team in line with trust policy. Managers audited compliance with use of MEOWS and audits showed 100% compliance on the postnatal and antenatal wards in October 2022. However, audits showed low compliance with MEOWS on central birth suite and the birth centre. Managers identified staff recording all parameters and frequency as issues and taken steps to address this with staff. Following our inspection, the service told us MEOWS was recorded in the women's intrapartum care record during labour which meant they were not able to pull accurate audit data from the MEOWS audit within the system.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Managers monitored the time of arrival in maternity triage to being seen by a midwife or doctor and this was discussed at the safety huddle.

The service had a standard operating procedure for women having induction of labour which limited delays in transfer to the delivery suite. This outlined how to escalate when any delay reached 2 hours, which included consultant risk assessment and incident reporting. Managers monitored and reviewed compliance with the standard operating procedure to identify any themes or trends in delays and impact on women's psychological wellbeing.

The service monitored the proportion of babies who received a new-born physical examination within 72 hours of birth, in line with national guidance. In September 2022, the service reported 95.7% of babies had this check within this timeframe. The service had a standard operating procedure which identified a failsafe to ensure all new-born examinations were carried out and documented within the national digital system.

Maternity

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 15 care records and saw risk assessments were completed at booking appointment and updated at every contact. We saw risk assessments identified key factors such as disability, age, and diabetes.

We saw women's carbon monoxide levels were monitored in all records we reviewed. This is in line with the 'Saving Babies' Lives' care bundle, which is an evidence-based bundle of care designed to reduce the numbers of stillbirth and early neonatal deaths bringing together five elements which are identified as best practice and includes reducing smoking in pregnancy.

Midwives in maternity triage followed a standard operating procedure which gave clear red, amber or green risk levels dependent on the woman's presenting concerns. Telephone calls to triage were all answered by a midwife and, if necessary, the woman given an appointment to attend maternity triage. There was a system in place to escalate if a woman called more than once. Any woman who called a third time that day was automatically offered a triage appointment. Managers had plans to further develop the triage service in line with current best practice risk assessment tools, this was to include new systems for managing telephone queues.

Staff knew about and dealt with any specific risk issues. All women were assessed for risk of developing a venous thromboembolism (VTE). VTE is a condition where a blood clot forms in a vein. The service policy stated all women should be given anti-embolism stockings. We found 2 women were not given these but had their risk of VTE assessed and were low risk.

Staff used cardiotocography (CTG) to monitor babies' heart rates. We saw this was completed in relevant records we reviewed and 'fresh eyes' checks recorded. National guidance on 'fresh eyes' checks requires a second checker to review CTGs every hour. The service audited compliance with 'fresh eyes' checks. On the central birth suite in October 2022 only 20% of required checks were completed, compared to 60% in September 2022 and 80% in August 2022. Managers had identified data in the electronic care record as an issue, as October was the first month this audit data was pulled from the electronic care record system and had taken action to address this.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). Staff could access support for women from a specialist perinatal mental health team.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. We saw mental health assessments using a recognised tool were completed in all records we reviewed.

Staff shared key information to keep women safe when handing over their care to others. Staff used a situation, background, assessment and recommendation (SBAR) format when handing care to another area. The SBAR was recorded in the electronic care record.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed medical and midwifery handovers on the central birth suite, antenatal and postnatal wards. The purpose and outcome of the handover was clear, it was attended by key staff and interruptions were minimised. Handovers included key learning points from incidents and key safety messages. In addition, key safety information on high-risk women was shared at the staffing safety huddle which was attended by all ward managers and matrons four times daily.

Midwifery Staffing

Maternity

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

The service 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.

The service had enough nursing and midwifery staff to keep women and babies safe. Staff reported any staff shortages through the online incident reporting system and managers reported this through a safer staffing report. In September 2022, there was a decrease in the number of local staffing incidents reported and none met the national maternity red flag events guidance. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing as outlined in National Institute for Health and Care Excellence (NICE) guideline NG4 safe midwifery staffing for maternity settings.

The maternity triage unit was staffed to national best practice guidance with 2 midwives to provide face to face contact and 1 to provide telephone advice 24 hours a day 7 days a week. The central birth suite had a supernumerary band 7 midwife as coordinator on each shift.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The Birthrate Plus report for the service was completed in September 2022 and the annual report and plan presented to the trust board. Birthrate Plus is a nationally recognised tool for workforce planning and decision making in maternity services. Birthrate Plus highlighted the need to increase midwife staffing by 7.5 whole time equivalent (WTE) at bands 3 to 7 and 13.42 WTE specialist midwives. Managers had conducted a gap analysis and were waiting for additional funding to be approved.

The ward manager could adjust staffing levels daily according to the needs of women. Staffing was reviewed 4 times in each 24-hour period at a staffing safety huddle attended by ward managers and matrons. Staffing was reviewed based on staff numbers and acuity of the women needing care and given a risk rating. Managers agreed actions such as staff moves and use of bank staff to maintain safe staffing levels. A manager was on call between 8am and 4pm to address any staffing concerns and attend the local maternity system calls to escalate any staffing issues across the system. At weekends and bank holidays an additional supernumerary senior midwife conducted walk rounds of all areas to ensure safe staffing was in place and coordinate any staffing gaps.

The number of midwives and healthcare assistants matched the planned numbers. In September 2022 the average fill rate (the number of actual staff on shift against the planned numbers) for midwives was 98% during the day and 94.2% at night. The rate for maternity support workers was 110% during the day and 97.4% at night.

The service had low vacancy rates of 2.3% for midwifery staffing. The vacancy rate for all staff groups for the obstetrics, midwifery and gynaecology directorate was 0.25%. The service had plans to recruit international midwives and all international recruitment midwives had to pass an English test before being accepted into employment.

The obstetric, midwifery and gynaecology directorate had low turnover rates of 5.16%. The service had a recruitment a retention midwife who completed exit interviews for staff and supported staff wellbeing initiatives to improve retention.

The service had low sickness rates. Overall sickness for midwifery staff was 2.39%. The overall sickness absence rate for the obstetric, midwifery and gynaecology directorate was 5.58%.

The service had reducing rates of bank staff. The service used the equivalent of 20.75 WTE midwives per week from the midwifery staff bank in September 2022. This was a decrease from 42.28 in January 2022. Staff were offered an uplifted hourly rate incentive to encourage them to take up additional bank shifts and managers reported this had increased uptake of available shifts.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us they did not use agency staff, only an internal bank. They allocated bank staff to areas they were familiar with. Managers made sure all bank and agency staff had a full induction.

Managers supported some staff to develop through yearly, constructive appraisals of their work. Managers told us the decision was made to halt appraisals during the COVID-19 pandemic and provided information to show appraisal had restarted and appraisal compliance rates were improving. By December 2022, the number of staff who had completed an annual appraisal on antenatal ward was 69%, on the postnatal ward was 88%, on the birth centre was 81% and on central birth suite was 58%. The overall appraisal compliance rate for the service was 72%.

Managers supported midwifery staff to develop through regular, constructive clinical supervision of their work. Staff could access support from professional midwife advocates and additional supervision such as safeguarding supervision was provided by lead midwives.

Managers made sure staff received any specialist training for their role. 91% of midwives and 83% of maternity support workers had completed Practical Obstetric Multi-Professional Training (PROMPT). PROMPT is an evidence-based multi-professional obstetric emergencies training package that has been developed for use in maternity services, with an emphasis on team working and communication. Staff attended an annual fetal monitoring study day and 99.4% of staff had either attended the study day or completed the K2 perinatal training programme. Midwives working in the close observation unit completed critical care training provided by a local university.

Medical staffing

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

The service had enough medical staff to keep women and babies safe. The service had consultant obstetrician on duty daily between 8am and 10pm. After 10pm there was a consultant non-resident on call. This was 7 days a week. Doctors we spoke with told us they always had access to support from a senior doctor or consultant.

The service had low vacancies across the obstetric and gynaecology directorate. Information provided by the service showed us they had 21.85 whole time equivalent consultants against a funded establishment of 21.79. However, managers told us the Ockenden assurance report had highlighted some gaps in consultant obstetric staffing which meant not all consultants rested following being on call.

Managers held an extraordinary meeting and put together an interim plan to manage the consultant staff workforce. Work was in progress to present a long-term consultant staffing plan to the trust board. The Ockenden report was written following a review at another NHS Trust in response to a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital. It outlines immediate and essential actions to improve maternity safety.

Maternity

The service had low turnover rates for medical staff at 5.46% across the directorate.

Sickness rates for medical staff were low at 0.34% across the directorate.

The service had low rates of bank and locum staff. Information provided showed no bank use and only 0.12 whole time equivalent agency use for consultant obstetricians between April and July 2022.

Managers could access locums when they needed additional medical staff. The service provided information showing locum doctors had filled 14 shifts between May and September 2022. Managers told us they could easily access locum doctors when needed and gaps in rota were filled.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The consultants ensured an on-call rota for junior doctors was completed for each shift.

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

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. 95% of medical staff had received an annual appraisal, those who had not was due to long term leave. Junior doctors told us they felt supported by the senior team, they could discuss their work and individual cases and had opportunities for development.

Records

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

Women's notes were comprehensive and all staff could access them easily. The service had introduced electronic care records 12 months ago. Women's records were available to them online and via a mobile phone application. Each birthing room had a computer tablet for midwives to use to record notes contemporaneously.

We reviewed 15 set of care records and saw they were fully completed with all relevant information and risk assessments recorded. Managers completed audits of care records focusing on different elements in each area. For example, in central birth suite manager monitored compliance with intrapartum risk assessments in records and in September 202 compliance was 90%. In the birth centre, compliance with recording place of birth on a care plan was audited and showed 100% in September 2022.

When women transferred to a new team, there were no delays in staff accessing their records as all notes were available on the electronic care record.

Records were stored securely. All computers and tablets were password protected and staff closed screens when computers were not in use.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. All midwifery staff received training in medicines management and 95.8% of midwifery staff had completed this. Midwives used midwife exemptions to administer some medicines and this was clearly recorded on medicines charts we reviewed. Pharmacy staff provided support to the wards and units daily.

Staff completed medicines records accurately and kept them up to date. We reviewed 4 medicines charts and saw they were mostly completed fully and accurately. However, we saw one medicine chart on the birth centre where the date and time of administration of dextrose was not recorded.

Staff mostly stored and managed all medicines and prescribing documents safely. However, we found gaps in daily checks to monitor the temperature of fridges where medicines were stored on the birth centre. In maternity triage we found methadone which was out of date. Manager took immediate action to return this to pharmacy for disposal.

The medicines team carried out audits of the safe and secure handling of medicines. Audit results for April to June 2022 showed compliance rates of over 90% for general medicines security, medicines fridges and storage of medicines trolleys and medicines in women's lockers. Audits of controlled drugs storage and security for April to June 2022 showed all areas were fully compliant with storage, balance checks and record keeping of controlled drugs.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services. Medicines charts were scanned to the woman's electronic care record so they could be accessed if they moved between wards or to other services.

Staff learned from safety alerts and incidents to improve practice. Staff described steps taken to improve the management of controlled drugs following a near miss in the last 12 months.

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 honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff were able to describe types of incidents they would report and gave examples of incidents they had reported.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff reported incidents on the trust electronic incident reporting system. We reviewed open incidents reported by staff and saw these were allocated to a manager for review and appropriately graded.

The service had no never events on any wards. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Maternity

Staff reported serious incidents clearly and in line with trust policy. The trust was an early adopter for the Patient Safety Incident Response Framework (PSIRF). This is a new incident reporting framework being developed by NHS England to replace reporting to the Strategic Executive Information System (StEIS). From January to October 2022 the service reported 4 serious incidents to StEIS. Managers carried out rapid reviews of the incidents to identify immediate learning and shared this with staff.

All maternity incidents reported to StEIS were reported to the trust board monthly. We reviewed minutes of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel held monthly and saw all key staff and the local clinical commissioning group attended. The meeting reviewed and agreed incident investigations and action plans and made suggestions for further investigation or improvement to the action plan.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Staff recorded duty of candour on incident and mortality review reports. The policy for temporary suspension of birth centre services guided staff to send duty of candour letters to apologise to women for the impact on their birth choices.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw learning from incidents discussed at daily handovers. Staff received a 'In Safe Hands' newsletter which shared learning from internal and external incidents.

Staff met to discuss the feedback and look at improvements to the care of women. Staff discussed incidents and updates on action plans at the weekly quality and safety group meeting. The meeting reviewed all serious incidents reported and incidents reported to the Health Safety Investigation Branch (HSIB). From January 2022 the service reported 14 incidents to HSIB, of these 9 were for babies who had been actively cooled. This is when a baby's body is cooled using a special mattress filled with cooled fluid to slow down processes which may cause brain damage. It is used when babies have experienced lack of oxygen or blood flow during delivery.

Managers also met at a weekly incident review meeting to review all incidents reported in their areas, share learning and agree next steps.

There was evidence that changes had been made as a result of feedback. We reviewed the service's HSIB action plan and saw recommendations were acted on with all either completed or in process.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Minutes of the PSIRI panel showed consideration and involvement of families and women in the investigation of serious incidents.

Managers debriefed and supported staff after any serious incident. Staff told us there was a 'no blame' culture when receiving feedback from incidents. They could access support from professional midwife advocates or practice education midwives. Specialist bereavement midwives supported staff as well as women and families following any incidents where a baby died and staff could access counselling.

Is the service well-led?

Good

Maternity

Our rating of well-led 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 staff. They supported staff to develop their skills and take on more senior roles.

Maternity services were part of the family care division which was led by a senior management team made up of a divisional medical director, head of midwifery and divisional director of operations. They were supported by a maternity leadership team which included a deputy head of midwifery, clinical director and 2 matrons. Local leadership was also supported by ward managers and lead midwives and specialist midwives.

Members of the senior management team met formally each week to discuss the service and were based together, which allowed for more informal, ad hoc communication. Local leaders also met regularly through a variety of forums including daily safety huddles and weekly quality and safety meetings. Managers told us they felt supported by leaders and leaders and managers worked well together.

Senior leaders were visible within the department, staff knew who they were and told us members of the senior management team were present on the department often. The non-executive and executive director maternity safety champions conducted regular walk arounds of the department and poster were displayed throughout the service telling staff who the maternity safety champions were and how to contact them.

During interviews, leaders demonstrated awareness of the key issues faced by maternity services and talked through actions taken to address some of the challenges. For example, they described action taken to address gaps in the fetal monitoring workforce to bring the service in line with recommendations in the Ockenden report.

We saw examples of staff being promoted internally and given opportunities to develop leadership skills. For example, the newly appointed safeguarding lead had completed NHS England safeguarding training and leadership modules and the fetal monitoring coordinator had been funded to undertake additional external training. The service also used experienced staff in part time roles to support newly promoted staff to develop into a managerial or leadership role.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision and aims which were visible on documents and posters throughout the service and on the trust website. Staff spoke about offering safe care which was person centred and based on best practice. The vision was underpinned by objectives, values, operating principles and improvement priorities.

The service had a number of strategies underpinning the vision. This included a clinical strategy and communication strategy. We reviewed minutes of the communication strategy working group and saw plans and actions took into account and sought out feedback from external partners such as the Maternity Voices Partnership and women and families.

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In July 2022 the service had facilitated a multidisciplinary away day to develop future projects and plans to deliver the national safety ambition. There was staff representation from all areas and levels of maternity services and staffed participated in working groups to examine strengths and weaknesses and identify future aspirations and project priorities.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women 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 , their families and staff could raise concerns without fear.

Throughout the service we saw a positive culture with staff happy in their roles and proud to work for the service. Staff told us they felt teams worked well together to support women and families and we saw positive examples of multidisciplinary team working during our inspection. Wards had an 'appreciation wall' area where staff and women could leave thank you messages and comments for staff. The service also used an online system where staff could record positive feedback received and thanks to staff who had gone the extra mile. This feedback was shared with individual staff by managers.

Midwives told us medical staff and managers were easily accessible and they felt confident to raise concerns or contribute ideas. Staff gave examples of where they had escalated concerns regarding staffing levels and they had been listened to and action taken to support them. Staff could access support from a trust Freedom to Speak Up Guardian and poster were displayed throughout the service informing staff how to contact them. A Freedom to Speak Up Guardian works alongside the trust's senior leadership team to ensure staff have the capability to speak up effectively and are supported appropriately if they have concerns regarding patient care.

The service had a number of staff wellbeing and support initiatives including a social media group with messages of gratefulness, therapy sessions for staff and a £1.50 meal to help with the cost-of-living crisis.

Staff at all levels told us they felt supported, and they could access opportunities for career development such as management and leadership development courses. The service scored above the national average in the 2022 General Medical Council national trainee survey for having a supportive environment.

Women, relatives and carers knew how to complain or raise concerns. Women we spoke with told us they felt confident to raise concerns with their midwife or other staff. The service clearly displayed information about how to raise a concern in women and visitor areas.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. When complaints were received, they were looked at in a timely manner and a manager allocated to investigate. We reviewed the complaint tracker and saw women and families were contacted and kept informed about the progress of the investigation.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints and learning from them was shared at the weekly quality and safety group and at handovers. Information about complaints was also displayed in staff areas across the unit.

Staff could give examples of how they used women's feedback to improve daily practice. We saw examples of women's feedback displayed across the service and the service displayed action taken in response to feedback on 'you said we did' boards.

We spoke to 6 women during our inspection, and all praised the staff and gave positive feedback about the service. Following our inspection, 315 women sent feedback about their maternity care at Burnley General Hospital. Most praised staff attitude with 149 being completely positive and a further 71 containing some positive feedback. However, several women were unhappy with the attitude of staff on the postnatal ward. We saw that issues women raised regarding staff attitude through the complaints process were addressed.

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.

The service had clear governance and reporting structures which outlined key meetings and committees and lines of reporting through directorate, divisional and trust wide structures. This ensured information flowed from floor to board and then back to floor. A monthly governance report was presented to the divisional quality and safety board which was then shared to the divisional management board and up to trust board.

The service had a number of governance committees such as health and safety, patient experience and safeguarding which met regularly and reported through the relevant divisional group to divisional or speciality boards.

The service measured performance against national schemes and reports and reported this to board through the governance structures. This included the Clinical Negligence Scheme for Trusts (CNST) and Ockenden reports (2019, 2022) were presented to the board. CNST is a scheme which applies all trust maternity services in which there is a financial incentive to meet 10 key safety standards.

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. Managers held a divisional briefing every two weeks with matrons and ward managers to ensure feedback was provided both from staff and to staff. Each area held a staff forum to share information about performance and learn from any incidents or feedback.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. The service displayed information on policy and guideline updates in staff areas to remind them to access and read them. The service followed trust policy on the implementation of National Institute for Health and Care Excellence (NICE) guidance and quality standards which set out a process for receiving, reviewing and updating staff of all new and updated NICE guidance and Quality Standards.

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.

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Managers carried out a local quality assurance audits and fed back results to staff. We saw areas of low compliance were investigated and an action plan put in place. Manager repeated audits each month to check improvement.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had a unit accreditation scheme called nursing assessment and performance framework (NAPF). Audit teams attended wards and units to assess performance against core standards. The level of accreditation dictated the frequency of audits, with less well performing areas audited more frequently. The postnatal ward had achieved green levels of compliance 3 times in a row so was being awarded NAPF silver standard. Green standard meant they had demonstrated compliance in all areas audited.

The service participated in relevant national clinical audits. 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).

The service had a consultant clinical effectiveness lead and a rolling programme of audit activity throughout the year. There was a comprehensive programme of clinical audit which aligned to key national standards such as royal college guidance, the Ockenden report and NICE guidance. Managers attended a monthly clinical effectiveness meeting and action plans and further audits were developed at this meeting.

Leaders monitored performance against key outcomes through a maternity dashboard. The maternity dashboard was comprehensive and captured 28 different metrics such as stillbirth rates, 3rd or 4th degree tears and eclampsia cases. The dashboard was RAG rated red, amber and green so leaders could see at a glance any metrics which were outside of expected ranges and showed a monthly trend graph so leaders could see if performance was changing over time.

Managers and staff used the results to improve women's outcomes. Managers and leaders met monthly to review the dashboard, validate data and review any outliers.

Outcomes for women were positive, consistent and met expectations, such as national standards. Data from the maternity dashboard was submitted to the local maternity system and compared with other trusts to see if they were an outlier for any outcome. Leaders gave an example of being a positive outlier for the number of babies born before arrival at hospital and sharing learning across the regions on how they achieved this.

The service stated it was fully compliant with the CNST scheme in year 3 and on track to achieve this in year 4. The service audited compliance with the Saving Babies Lives care bundle and reported compliance to NHS England. The most recent submission showed full compliance with the care bundle.

An Insight visit had taken place in April 2022 to assess the trust’s compliance with Ockenden immediate and essential actions. The visit had identified full compliance in most areas except workforce planning and ringfenced funding for training. Actions to address this were reflected in subsequent self-assessment and gap analysis. A maternity safety business case had been agreed to address some of the workforce issues arising out of the gap analysis. The updated gap analysis in October 2022 showed 95% compliance with Ockenden essential actions with action still ongoing to ensure funding for maternity staff training was ringfenced.

The service used the nationally recognised perinatal mortality tool to review all baby deaths and conducted a rapid review into all deaths. In line with Ockenden recommendations, the service provided a report to trust board with details

of all deaths reviewed and action plans. Perinatal mortality review meetings were held twice a week with an additional perinatal meeting monthly for full multidisciplinary team review of deaths. Each of the obstetric leads was assigned a case to investigate and report with the report going through the obstetric risk governance structure and presented to the perinatal board.

Leader and managers monitored risk through the local risk register. The risks on the register aligned with risks and concerns highlighted by staff and managers. Leaders could clearly articulate actions taken to address the highest risks. For example, they described action taken to procure additional equipment and resources and train staff to mitigate the risk of undetected fetal growth restriction. The risk register was comprehensive and risks rated with a risk handler assigned.

The service was accredited by Baby Friendly Initiative (BFI). It was reassessed in 2022 and regained the gold accreditation it had held since 2014.

Information Management

The service collected reliable data and analysed it. Staff could mostly find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, managers could not always access reliable data to inform local audit due to the way data was recorded in the electronic care record. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Policies and guidance were situated on a shared computer drive which all staff could access easily.

The service submitted data to external bodies including the National Neonatal Audit Programme, MBRRACE-UK and HSIB.

Staff were supported by a dedicated digital midwife who delivered training and ad hoc support as required. However, the introduction of a new electronic care record in November 2021 had increased the need for digital support for staff. We found that though the digital midwife was proactive in supporting staff more work was required to ensure all staff were fully compliant in the use of the new system. This meant that managers did not always have access to reliable data in local audits as some staff struggled with recording correctly in the electronic care record system. We saw examples of local audits where data quality issues had been identified when investigating the reason for low compliance.

Some staff told us they were not able to record or complete Local Safety Standards for Invasive Procedures (LocSSIP) forms on the electronic system and had to scan this or add a note separately to the system. This is important as LocSSIPS are standards and recommendations which bring together learning from national and local serious incidents, near misses and never events to ensure safe care for patients undergoing surgery and invasive procedures. However, following our inspection the service provided information to show LocSSIPs, apart from those used in fetal medicine procedures, could be inputted directly into the electronic care record system and this was audited monthly and showed 100% compliance. Managers monitored the effectiveness of surgical brief and debrief and reflected on sessions and recording issues and actions taken. The risk of gathering information from the electronic care record system was on the risk register.

Feedback from some women following our inspection showed they had experienced difficulty accessing important information about their pregnancy from the App which accompanied the electronic care record system.

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Engagement

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

Leaders engaged with partner organisations to help improve services for women. Managers attended daily calls with the local maternity system and worked with partners across the North West to enact the staffing escalation policy when needed. Leaders attended a monthly maternity acuity alliance board which included system partners to plan maternity services across the region. They were involved in the health equality alliance which brought together different partners such as health police and local authority to ensure services met the needs of the whole community.

Clinical leaders engaged with the local universities to ensure key safety information and updates were embedded in the curriculum for junior doctors.

The service had a maternity communication strategy which outlined objectives for communication with all key partners. This included ensuring key messages were available in different languages spoken across the local community and monitoring the way women used the website and social media to see if any improvements could be made.

Leaders met monthly with the chair of the local Maternity Voices Partnership (MVP) and had regular informal conversations. This meant the MVP was represented and took part in key improvement projects such as breast feeding and infant feeding projects. Staff reported positive relationships with the MVP, with a mature relationship where issues could be raised, and feedback given and heard leaders at the trust.

The service had a midwife champion for equality and diversity who linked with local groups representing people from black and minority ethnic communities to ensure services met their needs. Staff had worked with the local mosque and taken part in radio interviews to gain feedback from women from diverse backgrounds. The service had information on computer tablets in different languages in all clinics to enable them to share information with women. The service had secured funding to introduce specialist midwives to work with women from diverse communities including a lead midwife for consanguinity. Consanguinity is where partners are blood relatives, and this can increase the risk of some genetic disorders.

Leaders engaged with staff to gain feedback on improving services. Staff had attended an away day to input into future improvement programmes. Leaders and managers carried out ‘appreciative enquiry’ with staff involved in any incidents or concerns so they could identify strengths and what went well, as well as any learning, and fed that back to staff. Staff were encouraged to provide feedback from this at governance and team meetings. Staff from the service had attended a ‘Big Conversation’ in May 2022, which agreed actions for improvements to issues raised in the staff survey.

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.

Leaders described how they used the actions from governance meetings such as complaints to identify themes to highlight areas for improvement. These were communicated with staff through the 'In Safe Hands' newsletter. Staff were informed about research and improvement projects through notice boards in staff areas and team meetings.

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Managers and leaders were involved in experiential learning through staff presenting cases in clinical effectiveness meetings.

Staff were working with the national research project 'Born into Care'. They worked with external partners to provide memory boxes for women whose baby was being removed into care following birth. Midwives had received a safeguarding star award from NHS England for this work.

The service was participating in national research on Group B Streptococcus and collecting cord blood gas samples for submission to the research project. Information for women on the research was displayed across the unit.

The service was one of 40 hospitals in the UK participating in the COPE study to compare 2 medicines used to treat postpartum haemorrhage.

The service was the first in the UK to gain BFI gold accreditation and to retain this on all subsequent assessments.

Outstanding practice

We found the following outstanding practice:

- All midwives had safeguarding supervision annually in addition to safeguarding training. This consisted of training and reflective practice based on local safeguarding issues and is above good practice standards.
- The service was focused on the needs of local women and families. They had a midwife champion for equality and diversity who linked with local groups representing people from black and minority ethnic communities to ensure services met their needs and were recruiting a lead midwife for consanguinity.
- Leaders engaged proactively with staff to improve services. They carried out appreciative enquiry with staff involved in incident and concerns to identify strengths as well as learning.

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 trust SHOULD take to improve:

Maternity services

- The trust should ensure all staff complete level 3 safeguarding adults and children training, in order to protect women from abuse and improper treatment.
- The trust should ensure they operate effective systems to monitor specialist emergency equipment.
- The trust should ensure the proper and safe management of medicines, ensuring prescribing documents are properly and fully completed.
- The trust should improve compliance with annual appraisals to ensure all staff develop through an annual appraisal.

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- The trust should continue to improve the implementation and use of electronic care record systems, so managers have robust information to monitor and improve the quality and safety of services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 3 specialist advisors including midwives and an obstetrician and 5 other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.