Dorset County Hospital NHS Foundation Trust

Dorset County Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Dorset County Hospital

Requires Improvement 

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

Dorset County Hospital provides maternity services to the population of west and north Dorset, including Dorchester, Weymouth and Portland, and Purbeck.

Maternity services include an assessment area, antenatal and postnatal ward, a co-located midwife-led birth centre, delivery suite, and 1 maternity theatre. Between June 2022 and May 2023, 1519 babies were born at the trust. The home birth rate was 5%.

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

We carried out a 48-hour announced, focused inspection of the maternity service, looking only at the safe and well-led key questions.

The overall location rating for Dorset County Hospital went down as a result of the maternity services ratings. We rated Dorset County Hospital as requires improvement.

How we carried out the inspection

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

We visited maternity assessment unit which includes a triage service, delivery suite, the antenatal and postnatal ward, maternity theatre, and general theatres to see where maternity patients would be taken in an emergency if the maternity theatre was in use.

We spoke with 13 midwives, 2 support workers, 6 women and birthing people. We received 27 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 10 patient care records, 10 Observation and escalation charts and 4 medicines charts.

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

Requires Improvement ↓

Our rating of this service went down. We rated it as requires improvement because:

- Staff were not always up to date on mandatory training, including basic life support and safeguarding.
- Infection rates were not monitored.
- Medicines were not always managed safely.
- There was no standardised framework to support safe and effective prioritisation of patients according to clinical need.
- There were not always enough staff to keep women, birthing people, and babies safe.
- Governance processes were under-developed and there was no comprehensive, rolling programme of audit to monitor and improve services over time.
- Data collected by the service was not always up-to-date, detailed, or accurate and did not support effective governance and oversight of the service.
- Service leadership sustainability and succession planning was not present or effective.
- The service did not always recognise and take sufficient action to mitigate risks.

However:

- Staff risk assessed women and birthing people appropriately and records were complete.
- Staff reported safety incidents and the service learned lessons from them.
- Staff understood how to protect women from abuse.
- The service had developed a service and used specialist physiotherapists to improve women's and birthing people's pelvic health after birth.
- 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, birthing people, and the community to plan and manage services.
- The service performed well in the CQC maternity survey and women felt well cared for.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so.

Is the service safe?

Requires Improvement →←

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

Maternity

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, not all staff had completed fetal monitoring training.

The mandatory training was comprehensive and met the needs of women and staff. Staff completed professional obstetric multidisciplinary training (PrOMPT) training once a year. Data showed as of June 2023, 91.5% of midwives, 87.5% of consultant obstetricians, 92% of consultant anaesthetists, and 87% maternity care assistants, had completed yearly PrOMPT training. The trust target compliance rate was 90%. Where staff had not completed yearly PrOMPT training, they were booked to complete this in July 2023.

Data showed as of June 2023, 95% of midwives of midwives had completed yearly neonatal life support training which was above the trust target rate.

The service provided staff with basic life support training but did not make sure everyone completed it. An average of all staff groups showed 84% of staff had completed the training which was below the trust target of 90%. A total of 94% of midwives had completed basic life support training which was above the trust target.

Figures submitted to the trust board in June 2023 showed an average of 72% of all staff groups (medical and midwifery) had completed fetal monitoring training in May 2023, which was below the trust target of 90%. However, mandatory training figures showed 100% and 93% compliance on electronic fetal monitoring (CTG) training for doctors and midwives respectively in June 2023. The service provided additional fetal monitoring training sessions which should be attended twice per year. From January 2023 to May 2023, 66% of midwives and 34% of doctors had attended.

Staff completed regular skills and drills training. For example, staff had completed pool evacuation training as part of PrOMPT in 2022. The service ran skills and drills drop-ins every other Wednesday on topics such as hypertension, shoulder dystocia and airway management. Data showed there were 61 attendees at the 17 sessions delivered in the past year. The practice development team used learning from events to improve skills and drills training.

The service employed practice development midwives to design, monitor, and manage training for staff, including the development of in-house training videos. The service had a programme for newly qualified midwives which was regularly updated and combined practical and theoretical learning, alongside peer support and supervision.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff we spoke to had completed online safeguarding training in the past year. As of June 2023, 95% of midwifery staff and 85% of obstetric medical staff had completed safeguarding level 3. The trust target compliance was 90%. The average compliance rate for all staff groups for safeguarding level 3 training was 87% for 2022. Safeguarding training was built-on and developed each year depending on local concerns, learning from events, and staff requirement.

Maternity

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could access the safeguarding team which was made up of safeguarding specialist midwives and perinatal mental health midwives who oversaw the care of vulnerable women and birthing people having babies at Dorset County Hospital.

There was a baby abduction policy in place and the most recent baby abduction simulation training took place in April 2022. Several areas of learning and improvement were identified and had been implemented at the time of inspection. The maternity unit had locking entrance doors and staff, patients and visitors were able to move freely around the unit once inside. Staff knew to challenge visitors and check ID of unknown staff.

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. However, infection rates were not monitored effectively and there was not always clear documentation that issues were resolved.

Ward areas were clean and mostly had suitable furnishings which were clean. The service acknowledged some furnishings required updating and replacing with appropriate materials that could be cleaned and sterilised appropriately.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Trust housekeeping staff completed cleaning audits twice a week and compliance between April and June 2023 and the average compliance for this period met the 98% target for cleanliness.

Staff followed infection control principles including the use of personal protective equipment (PPE), and consistently scored 100% compliance in hand hygiene audits between January 2023 and June 2023.

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

However, the trust did not effectively monitor the rates of infection for women using services. The service maternity dashboard did not include data on rates of infection or maternal sepsis.

Environmental audits from October 2022 identified areas on the maternity unit where dust, limescale, and disrepair were evident however, it was not clear how and when these had been addressed in the documentation.

Environment and equipment

Daily checks were not always completed and systems for managers to monitor maintenance and checking were not effective. However, the design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

Staff mostly carried out daily safety checks of specialist equipment. However, we found some resuscitaires had daily checks missing, and some checklists only contained checks from the previous week.

We asked the service to provide environmental audits for the most recent 3 months in June 2023. The service provided audits from September and October 2022, with some actions marked as updated in June 2023. These audits showed several items of equipment not properly cleaned or maintained, including kitchen equipment and refrigerators, however it was not clear if the refrigerators were used for medicines or food. The audits documented areas for improvement but

did not always document if action was taken and when. The impact of this was leaders could not be assured that maintenance had taken place appropriately or in a timely way. However, the service provided basic cleaning audit compliance rates which showed results consistently above 97%, except on 2 out of 27 (7%) occasions between April 2023 and June 2023, both of which were in maternity theatres.

Data supplied by the service showed some equipment including fetal heart monitors and blood pressure devices had not been safety tested within the previous 12 months or had planned maintenance completed. The trust told us this was because they were in the process of consolidating documentation, however, the data submitted did not evidence safety checks were completed therefore it was not clear how the service was assured.

The service monitored levels of inhalational nitrous oxide (Entonox) used for pain relief in labour, as per national safety recommendations. Two rooms on the delivery suite were found to have high levels of residual gas; the service said it was monitoring this, using a gas scavenging system, and had installed sensors and vents in the rooms to ensure the safety of staff and patients. The service shared records of the readings and documented risk mitigations with us, and planned continued monitoring until resolution.

There was 1 emergency trolley for the maternity unit. Staff knew how to access it and said the small footprint of the unit meant they could access it easily. Staff were unclear if the service had risk-assessed having 1 emergency trolley.

There were 2 low-risk midwifery-led birthing rooms on the unit, called ‘The Cove’. At the time of inspection, 1 room was out of use due to leaking from the roof; external and internal repairs to the building were being carried out. However, staff said the room had been closed for several months and repairs were slow. This was raised as risk in January 2023 but was not yet resolved by the estates department in June 2023. We also saw a storage room with a collapsed ceiling awaiting repair.

There was 1 bereavement suite for families who had experienced the death of their baby. The location of the room was close to the delivery suite which was in-line with national recommendations however, it was directly on a busy corridor which was potentially noisy or disruptive for families. We were not able to see the bereavement suite as it was sadly in use on the day of inspection.

Resuscitaires were not available in every birth room, and this was not in line with national guidance however, there were mobile resuscitaires in corridors available for use. It was not clear if this had been risk assessed to ensure the unit had enough resuscitaires available.

The service had suitable facilities to meet the needs of women and birthing people's families and enough suitable equipment to help them to safely care for women, birthing people, and babies.

Women could reach call bells and staff responded quickly when called.

Staff disposed of clinical waste safely.

There was a ligature risk management policy dated June 2023.

Maternity

Assessing and responding to patient risk

The service did not use a standard prioritisation framework to ensure women and birthing people were seen according to clinical need. Waiting times were not appropriately monitored, and use of tools to identify deteriorating patients was not monitored. Processes for opening a second emergency theatre had not been appropriately risk assessed. However, 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.

We found staff used electronic maternal early obstetric warning score (MEOWS) charts to monitor women and birthing people at risk of deterioration. However, leaders did not routinely monitor the use of the tool and therefore could not be assured that staff escalated patients appropriately. After the inspection, the service told us that data was routinely extracted from the IT system for audit purposes. However, no evidence was supplied on how the service was assured of the correct, complete use of MEOWS, or that appropriate escalation had taken place. This was because the data extracted did not result in staff scrutiny of the statistics, or leaders entering the electronic patient records to perform detailed reviews of the quality of record keeping in a formalised way. After the inspection, the service sent us evidence that digital midwives would double check the quality of data that was submitted to the national maternity services data set however, could not demonstrate a formalised framework for this, and it did not show a process for audit of records and correct escalation and use of MEOWS charts.

The maternity unit had 1 obstetric theatre which was used for elective and emergency operations including instrumental births, perineal repairs, retained placentas, PPH, and caesarean sections. During the inspection we asked staff and leaders what processes were in place if a second theatre was required in an emergency. The service had a policy to use 1 of the main theatres, located on the floor above. These theatres were not the hospital's designated emergency theatres, but elective theatres for less urgent cases. This meant theatre lists could be safely postponed as cases were not urgent however, this presented a risk theatres may not be appropriately equipped if an obstetric emergency case escalated in severity. After the inspection the service provided assurance on theatre equipment checks, and there were no recorded incidents where equipment was not available when needed.

The theatre was largely staffed by the main theatres team however, main theatres may have to cancel or postpone elective surgeries to accommodate an obstetric emergency. Staff were not always clear on the processes in place, and there was no formal risk assessment in place for opening and use of a second theatre in the event of an obstetric emergency. There was confusion between staff groups around what was required in opening a second theatre, what equipment was required, who checked it and ensured its safety, and how enough staff to mobilise a second theatre were made available. We escalated this to leaders on the day of inspection, and we asked the service to provide us with further information on how they maintained safety. Leaders told us that due to the small number of births per year, the risk of requiring a second theatre was small. It was not clear how the risk was mitigated effectively. The service provided feedback that was given to staff as evidence of good practice when a second theatre had been required, and we found evidence of other incidents when the second theatre had been required. After the inspection, the service told us that it performed a retrospective review of incidents requiring a second theatre between January 2021 and June 2023, and found this had happened 9 times. Leaders told us there was no written risk assessment for use of, and transferring emergency patients to a second theatre however, that an incident report would be completed at the time.

There was a day assessment unit open from 8am to 8pm for women and birthing people to attend both planned appointments and for unplanned or emergency care (maternity triage). Outside of these hours women requiring unplanned or emergency care would be seen and triaged on the delivery suite. There was no standardised prioritisation framework for staff to use to ensure women were seen according to clinical need. This presented a risk that women and

birthing people may receive different care from day to night, or that staff competent to work in a triage setting may not available overnight. However, staff completed risk assessments for every woman or birthing person on arrival considering previous history and any current or new risk factors. There was a list of symptoms that required medical assessment within 15 minutes of arrival as mitigation for lack of standard prioritisation framework.

Staff told us they were able to perform observations on women fairly quickly once they arrived but waiting for a medical review depended on the workload as there was only one rostered duty doctor to oversee the whole unit. Managers had started an audit of triage arrival and observation times which looked at a 2-week period in January and February 2023. The results of the audit were not known at the time of inspection in June 2023 which is a slow response for a small amount of data and was potentially out of date. The audit did not look at how long women and birthing people waited for a doctor's review, whether the risk assessment and the wait time was appropriate, or whether appropriate escalation took place. Therefore, the audit was not able to provide useful data for the service on performance and areas for improvement or aid successful implementation of a new triage service, which the service told us it had planned for 2023. The provision of triage services had been added to the service risk register in January 2023. Triage services should have been identified by leaders as a risk and on the risk register before January 2023.

The service had completed an audit of electronic fetal monitoring in labour in 2022 and found records to be non-compliant in 3 out of 5 standards, including hourly 'fresh eyes' reviews, hourly senior reviews, and appropriate care planning in relation to fetal monitoring. Compliance scores for these standards were 87%, 81% and 91% respectively. The service planned a rolling audit to monitor compliance and to disseminate learning at each fetal monitoring 'drop in' session. However, the service did not share any evidence of repeat audits and it was unclear if improvements had been made in a timely way.

There was a virtual transitional care service on the postnatal ward for babies who required complex care but not admission to the neonatal unit. Leaders had appointed an advanced neonatal nurse practitioner to work with the postnatal lead to improve service provision. However, not all staff we spoke to were aware of the pathway and provision of transitional care services. Staff told us a business case was in progress to improve the offer of transitional care.

Managers audited the use of the World Health Organisation (WHO) theatre checklist and compliance rates were 100%. However, during the inspection we saw that the WHO checklist was not completed in a formalised way by staff and therefore was not working as intended to reduce the incidence of mistakes. We escalated this to the service on the day of inspection.

There was a supernumerary senior shift leader allocated to delivery suite who supervised staff and co-ordinated care for women and birthing people. This was in line with national recommendations.

Multi-disciplinary handovers took place twice per day and followed a situation, background, assessment, recommendation (SBAR) format for each patient. This was in line with national recommendations. Learning points for junior staff were clearly explained, and doctors reviewed electronic blood results for inpatients as a part of handover. Safety huddles took place daily and learning from events and incidents was shared.

The service had an escalation policy for times of high acuity and used the Operational Pressures Escalation Levels (OPEL) framework which is in line with best practice recommendations. The service used a senior midwife on-call rota to manage escalation appropriately.

The service used a sepsis management bundle, staff were aware of it and could describe the process.

Maternity

Staff could access guidelines and pathways via QR codes on noticeboards.

Staff had access to transcutaneous bilirubinometers to monitor babies' jaundice levels in a timely and non-invasive way.

The service had appointed a 'baby friendly' lead midwife to support the service in obtaining Unicef Baby Friendly accreditation which supports parents to feed and care for their babies effectively. A breastfeeding support clinic was offered weekly.

The service was an early adopter for the perinatal pelvic health workstream through the Local Maternity and Neonatal System (LMNS). The service employed specialist physiotherapists to support women and birthing people through pregnancy and after the birth of their baby to maintain all aspects of pelvic health. There was positive feedback from staff and patients about the service.

The service worked closely with local independent midwives to ensure the safety of women choosing independent midwifery services, and staff reported this worked well. There was a policy in place to support joint working with independent midwives.

Midwifery Staffing

The service mostly 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. However, actual staff numbers did not always match the planned numbers. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction. The service made sure staff were competent for their roles. Managers mostly appraised staff's work performance and held supervision meetings with them to provide support and development.

The service mostly had enough nursing and midwifery staff to keep women and babies safe however, staffing levels was on the risk register and monitored by managers constantly.

The number of midwives and healthcare assistants did not always match the planned numbers. Managers and specialist midwives worked clinically when required, and managers reviewed rosters a week in advance to ensure safe staffing was achieved. However, we saw evidence of an incident in March 2023 where there were no rostered midwifery staff. Night staff had to work overtime, and training had to be cancelled to ensure women and birthing people were cared for. As a result of this, the service said it was working to implement an improvement to the manager on call system.

The service monitored red flag events to best mitigate staffing levels. A red flag event is a sign that something might be wrong with maternity staffing levels. In May 2023, there were 20 red flag events reported which resulted in delays in induction of labour, lack of clinic provision for women at risk of premature birth, and diverting of maternity services to neighbouring providers. The service provided a monthly quality and safety report to trust board which tracked red flag events however sometimes this area was blank or partially completed, it was not clear if this was because some months there were no red flag events.

The service used a flexible framework to monitor staffing acuity and told us it had decided on this model because the small size of the service required a dynamic approach to managing and assessing safe staffing. Staff had received training on how to implement the acuity model.

Managers mostly supported staff to develop through yearly, constructive appraisals of their work. Data supplied by the trust showed that an average of 83% of maternity staff had appraisals, which was below the trust target of 90%.

The service did not use agency midwives but had heavy reliance on employed staff working bank shifts or overtime. This had been acknowledged at board level and was being discussed as part of the service's workforce planning. The service used an electronic rostering system to monitor the amount of bank shifts staff were doing to ensure the safety and wellbeing of staff and patients. Managers made sure all bank staff had a full induction and understood the service.

The service turnover rate was 8% whole time equivalent (WTE). The service had commenced a workforce review in November 2022 which estimated a recruitment rate of 6.5 WTE per year to maintain current staff numbers and ensure safe staffing levels when people were on leave, completing training, or unwell.

Whilst the trust saw sickness rates trending below 5% between May and October 2022, since November 2022 nursing and midwifery sickness rates have trended upwards above 8%, despite fluctuation in February 2023. At the time of inspection, the sickness rate was 6%. The trust target sickness rate was not included in the data submitted.

Managers accurately calculated and reviewed the number and grade of midwives and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of women.

Medical staffing

The service did not have 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 reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

There were 7 consultants able to provide out of hours cover for the service and they were rostered to work one night in every 7 alongside their normal in-hours work. There was 1 vacant consultant post at the time of inspection. We raised concerns about the sustainability of this rota and asked the service how they were assured of staff wellbeing and safety. Leaders told us that consultants were able to approach them with concerns and would speak out if they felt unable to work for any reason, for example due to tiredness. There was no formalised process for securing replacement consultant cover. It was not clear whether the medical staffing establishment had been reviewed recently and if current staffing was fit for purpose. Consultants provided ward rounds, delivery suite cover and handovers as per current national safety recommendations.

We asked staff what the process was if there were 2 emergencies happening at the same time. Staff told us that due to the size of the unit, it would be a rare occurrence and there was no formalised plan to cope with the scenario. Staff told us they would call another consultant from the team at random, but this was not recorded. There meant there was no way to track who was being called or how often to enable appropriate diary management and ensure the safety of consultants to work when not pre-planned. This may present a risk. We found evidence that emergencies had happened concurrently, and 1 incident was only managed safely because an obstetric consultant was in the unit by chance when not officially on the rota.

There was no junior doctor (SHO) planned to work at night on the maternity unit and this was standard practice at the service. We asked staff what the process was for having enough theatre staff to safely perform emergency caesarean sections overnight. The process was for midwives to perform the role of the SHO in theatre, otherwise called the 'surgical first assistant' (SFA). Staff told us midwives gained competency to perform this role by spending time with consultants assisting with elective surgeries. We asked to see midwifery competencies and the service was unable to provide them as they had not been devised or formally recorded. The impact of this was the service could not be assured that midwives were competent to perform the role of the SFA in theatre, midwives were working outside of their scope

of practice, and did not have the skills, knowledge, or qualifications to manage complications potentially arising in emergency surgery. The Perioperative Care Collaborative states the SFA must meet key recommendations including: successful completion of a validated university programme of study that meets the nationally recognised standards underpinning the knowledge and skills required for the role, and, their scope of practice may be extended in line with service need but only following the successful completion of an appropriate certificated or credit-bearing award. This was not in place at the time of inspection. We escalated our concerns to the service on the day of inspection and asked them to provide us with immediate assurance that theatres would be safely staffed with appropriately trained practitioners overnight. The service provided an action plan which included the immediate implementation of a night-time SHO rota for 3 months, to allow the service to assess long-term options to safely fulfil this role.

During the inspection the night-time on-call consultant had been in the unit since 5.30am and planned to work on the unit until midday. Staff told us that the small team of consultants and the unit size meant that working more flexibly in this way was manageable. Staff told us they felt able to call managers to cancel their on-call shifts if necessary.

The duty registrar for the service overnight covered both maternity and gynaecology, and was expected to cover emergencies in both services, escalating to the service-specific consultant if required. As the service did not employ a night-time SHO, this role included clerking gynaecology patients attending the emergency department in another part of the hospital, which may impact on the doctors' ability to attend delivery suite in an emergency.

Not all members of the theatre team were dedicated to maternity and some theatre staff carried emergency bleeps, for example to respond to a cardiac arrest in the hospital. This may impact staff's ability to respond to obstetric operative procedures.

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 always had a consultant on call during evenings and weekends.

We asked the service to supply data about medical staff appraisal however this was not shared.

Records

Staff kept records of women's care and treatment. Records were clear, up to date, stored securely, and easily available to all staff providing care. However, the service did not perform regular audits to ensure the quality of maternity record-keeping.

Women's notes were comprehensive, and all staff could access them easily. The service used an electronic patient records system for all areas of care. We reviewed 10 sets of records in relation to the whole maternity pathway and found records were mostly complete. However, 3 out of 10 records did not always record risk factors at each appointment, 1 out of 10 records did not have completed mental health or safeguarding assessments made. When women transferred to a new team, there were no delays in staff accessing their records. Records were stored securely.

However, managers did not regularly audit the quality of records. Service leaders told us that when incidents occurred the safety team would review the records retrospectively and flag up any concerns. This was a reactive approach and did not provide assurance on the quality of record keeping to identify and monitor areas of concern and drive improvement. After the inspection, the trust told us that completeness of records was mandated on the electronic system. The service

provided some basic statistical data from the electronic records system to show where issues with record keeping had been identified and how this had been managed and is commented on elsewhere in the report. This did not fulfil the assurance gained by undertaking a rolling, comprehensive audit of records to ensure quality of documentation over time.

Medicines

The service did not have effective systems and processes to safely prescribe, administer, record and store medicines.

During the inspection we found that some emergency medicines were not available in standard dosages, or in easy-to-make or pre-made solutions. We found some documents that contained incorrect instructions on making medicine. One emergency box contained an unrelated medicine, and it was unclear why. The impact of this was the service had not made all practicable efforts to minimise the risk of mistakes in an emergency.

We found hard copies of several out-of-date guidelines attached to emergency medicines and equipment in the unit. We escalated this to managers on the day of inspection and they provided new emergency instructions for staff to follow however, these were still complex and involved several processes and calculations that may have been difficult for staff in an emergency. It was not clear if the service had risk assessed this appropriately. Several emergency medicine boxes were not clearly labelled for use, and this may cause a delay or mistake in an emergency.

We found some medicines were out of date, this was escalated immediately to staff and resolved.

We saw a refrigerator used to store medicines in theatre was not locked when theatres were not in use which presented a risk. After the inspection, the service provided evidence that the medicines refrigerator in theatres was routinely locked, and this was audited to provide assurance of safe storage.

The pharmacy team centrally monitored medicines rooms temperatures however, some fluid storage room temperatures were not monitored, and this may impact the shelf life of fluids if stored for long periods of time. Staff told us stock was high turnover and recurrent high temperatures in the unit were not considered an issue. The service managed the risk presented by potential high ambient room temperatures through the pharmacy stock control team and mitigated the impact of this on medicines by storing small amounts in each area. This ensured prompt use and less risk of exposure to high temperatures. The risk of medicines storage rooms sitting at temperatures between 25 and 30 degrees Celsius was managed on the trust risk register and was monitored by leaders. Staff told us action would be taken if room temperatures exceeded 30 degrees Celsius.

Patient medicines charts and prescriptions were paper records. We looked at 4 medicines charts and none contained a documented patient weight, writing was not always legible, 3 out of 4 did not have appropriate venous-thromboembolism prophylaxis prescriptions, and in 1 chart we found prescriptions were not always signed and dated. The impact of this are potential mistakes leading to poor outcomes for women and birthing people.

When doctors prescribed take-home medicines, they wrote prescriptions over the take-home medicine form. Documentation, name and designation of the prescriber, and amount of medicine issued was not clear which could lead to mistakes.

The service provided staff electronic training in medicines management competency although it was not always clear from records when staff training was overdue.

Maternity

Incidents

The service managed safety incidents. 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. However, formalised patient safety incident review meetings were not held, and governance processes in relation to incident management were not always clear.

Staff reported serious incidents clearly and in line with trust policy. Serious incidents were monitored by the trust quality committee via the monthly maternity quality and safety report produced by the Director of Midwifery. There were 8 serious incidents dated between August 2022 and May 2023, reviewed by the trust as ongoing. However, it was not always clear what action had been taken and when, and whether the service had produced ongoing action plans or monitoring processes to ensure safety recommendations are embedded.

There was a lack of understanding of incident review processes at the service from staff we spoke to, and staff told us that members of the multi-disciplinary team met on an informal basis to review incidents. This was not in line with national recommendations. Staff told us meetings were not minuted at present but there were plans for incident reviews to be developed as part of the safety and governance review. However, after the inspection, the service provided evidence of the trust-wide incident review process and governance framework which provided them with assurance.

We looked at incidents of all severity ratings reported by the service to the national reporting and learning service (NRLS) between January 2023 and June 2023. The service regularly graded incidents as a lower severity than appropriate, for example obstetric anal sphincter injury (OASI, or 3rd and 4th degree tears sustained during birth), postpartum haemorrhage (PPH), and hospital readmissions were all consistently graded as low or no harm. The impact of this is potential missed opportunity for learning and appropriate investigations to take place.

Staff knew what incidents to report and how to report them.

The service had no never events. We saw evidence that trust leaders monitored never events through the quality committee.

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 received feedback from investigation of incidents and told us about recent shared learning from incidents. Staff met to discuss the feedback and look at improvements to the care of women, birthing people, and babies.

There was evidence that changes had been made as a result of feedback, for example the service had plans to implement a barcode system to track, obtain, and administer blood products for an additional layer of safety within this process.

Managers investigated incidents. Women and their families were involved in these investigations. Incidents were monitored by the quality committee and a recent reduction in reporting had been recognised. Staff said work was underway to understand the reason for the reduction.

Maternity

Approximately 20% of incidents reported in the 3 months preceding the inspection were about reduced maternity staffing levels.

Managers debriefed and supported staff after any serious incident.

Mangers did not collect data on health inequalities in relation to incidents.

Is the service well-led?

Inadequate 

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

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced, however did not always manage these effectively. 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.

Leaders were visible and approachable to staff and people using the service. Staff told us leaders were supportive and available to discuss concerns.

Maternity services at Dorset County Hospital were led by a Director of Midwifery, a Clinical Director, and a General Manager. The Director of Midwifery was supported by 2 matrons, a governance lead, and the obstetric medical team. This demonstrated a flat leadership structure. Service leaders chose to give up booked annual leave to facilitate the inspection and provide an accurate overview of the service. Without this, it would not have been possible to gather the required information about the service. We found there was no consideration of succession planning to enable seamless provision of services and oversight of work in the event of absence of key leadership figures.

Maternity services were managed as part of the Family Services division.

There was an executive maternity safety champion, and a non-executive maternity safety champion supported by service-level safety champions to act as conduits from ward up to board level. Service-level safety champions had direct access to board level safety champions and the group met monthly to discuss any concerns. Staff told us learning and improvements from these meetings was relevant to the trust as a whole and was disseminated accordingly. For example, maternity services had done some work around understanding each other's roles and responsibilities, and every member of staff feeling able to speak up and feel part of the team, and this was shared trust wide.

Executive safety champions completed safety walkarounds in the maternity unit every other month. Minutes from the safety champions' meeting were shared with us and showed discussion around various identified safety issues such as the efficacy of the call bell system, work on informed consent, and notes from the previous walkaround which included action the service had taken on meal portions in response to feedback. However, there was a lack of oversight by leaders in terms of succession planning and the continued pause in audit activity since the COVID pandemic.

Maternity

Vision and Strategy

The service did not have a maternity strategy. The service had developed a vision for what it wanted to achieve specific to risk, and a strategy to turn it into action, but this was not developed with all relevant stakeholders. The strategy was not aligned to local plans within the wider health economy and the strategy had not been shared with staff.

There was no maternity service specific vision and strategy. We asked the service to provide us with this and a Maternal Neonatal Safety Quality strategy focused on risk and governance was provided. The strategy contained a paragraph on overarching service vision however, this was underdeveloped and there was no strategy by which to realise the vision within the service. At the time of inspection, the strategy had not been shared with staff. The strategy was published in September 2022 to run until 2027, prior to this there was no maternity-specific strategies in place.

The strategy was written in line with the trust values and was focused on improving the safety culture and empowering staff to make improvements. The strategy focused on theory of change but did not demonstrate how it would drive the service forward practically.

The strategy was not aligned to local plans and did not reference how the service would work with local trusts in the local maternity and neonatal system.

The strategy did not reference how the service would meet the needs of the communities it served or how the service would work to reduce health inequalities.

There was a trust-wide strategy published in 2021 focusing on people, place, and partnership.

Culture

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

Women, birthing people, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Women could access a birth afterthoughts service to speak with a midwife about their experiences.

Managers investigated complaints and identified themes. Themes from recent complaints included communication between staff and people using the service. The service responded to complaints compassionately and apologised when things went wrong. For example, the service provided reflective discussion to staff members involved in a complaint around communication. The service had improved its catering following patient feedback and complaints.

The service was categorised ‘better than expected’ overall in the 2022 CQC Maternity Survey in comparison to other trusts. It scored ‘about the same’ for 25 questions, ‘somewhat better than expected’ for 4 questions, and ‘Better/ Much Better than expected’ for 22 questions. Women and birthing people generally displayed high levels of satisfaction with the service and said midwives were caring and supportive. However, they said there was sometimes inadequate communication and information provided by the service, long waiting times, and some negative psychosocial experiences were reported.

Maternity

Staff told us they were proud to work for Dorset County Hospital and to provide kind care to women and birthing people using the service. Staff reported good working relationships between the multi-disciplinary team. We found an incident where staff had raised concerns about personal behaviour, and this was managed sensitively and proactively by service leaders.

The 2022 General Medical Council national trainee survey showed that the trust scored significantly below (worse than) the national average, and worse than their 2021 scores for two indicators: overall satisfaction and handover. The scores that saw the most negative change between 2021 and 2022 were in feedback and gaining adequate experience. It was unclear what measures the service had taken to improve this. However, the service scored significantly higher than average, and better than their 2021 scores for facilities and workload.

The service submitted data to the NHS Workforce Race Equality Standard. There were statistically significant differences between the experiences of White staff and staff from ethnic minority groups for several WRES indicators, indicating poorer experiences for staff from other ethnic groups across the trust. The trust had a WRES action plan in place and was rated as 'developing'. There were no staff from ethnic minority groups available for us to speak with about their experiences during the inspection.

Governance

Leaders did not operate effective governance processes throughout the service. There was no effective audit programme and there was no effective maternity dashboard in place. Leaders did not have accurate data or monitor, review, and act on it effectively to improve or maintain the safety of the service. Sustainability of the service was not monitored or reviewed effectively. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service did not have an effective audit programme to gain assurance and oversight that safety was maintained. The audit programme was ad-hoc and audits were not repeated to check for improvement over time. This meant that audit results were ineffective at driving improvement within the service, and leaders did not have assurance that quality improvement measures were identified or working as required.

Quality committee meeting minutes showed that the trust's clinical audit plan had been a deferred topic at the meeting since February 2021 and had not been reinstated at the time of inspection. This was because during the COVID-19 pandemic, NHS England told trusts that some activities could be postponed or paused to help with clinical workload. The service told us this was the reason that many audits had not yet recommenced. However, nationally, services had transitioned to normal activity following the pandemic for over 1 year, and leaders could not articulate a reason why a full programme of clinical audit and the agenda item at the quality committee meeting had not been reinstated.

Processes for ensuring guidelines were up to date were ineffective. There were 8 guidelines flagged as out of date at the time of inspection which meant staff may not have been providing the most appropriate care.

The service was asked by NHS England (NHSE) to review the rates of PPH as they had been outliers for high incidence of PPH since February 2022. The service had not recognised this before being contacted by NHSE, and had not recognised that an anomaly in the way they collected and documented data on PPH had created large inaccuracies in the figures they reported to the national maternity dashboard. We wrote to the trust after the inspection, and they provided new data analysis which showed the accurate rates of PPH. However, this demonstrated that governance and assurance processes around key performance indicators and safety metrics were ineffective.

Maternity

The service did not have effective processes to monitor important safety metrics such as potential hypoxic brain injury to babies at birth, and smoking in pregnancy as the maternity dashboard was under-developed and showed basic statistics only. The maternity dashboard was not fit for purpose as a tool to monitor and improve the safety and efficacy of the service. After the inspection the trust said the service used exception reporting to monitor cases of hypoxic brain injury and tracked cases referred to the Healthcare Safety Investigation Branch via monthly maternity safety reports. Since the inspection, the service has implemented a new maternity dashboard to better track and monitor performance.

The service was undergoing a review of governance processes including the creation and implementation of various maternity forums, terms of reference, lines of reporting between service-level staff and the trust board, action trackers, gap analysis, and staff training monitoring tools. The service was also looking at incident reporting, safety huddle meetings, and a rapid response learning group. Not all these systems and processes were implemented at the time of inspection.

The quadrumvirate held monthly meetings which were minuted, and discussed arising and ongoing service concerns, for example vacancies on the obstetric registrar rota, implementation of reviews and prioritisation framework in maternity triage, and wider service issues. These meetings were implemented in January 2023 following the Ockenden insight visit, and leaders told us that the most recent meetings booked for April and May 2023 were cancelled. Meeting minutes were brief and did not provide a way for the service to monitor and drive progress against discussions or contain actions to take forward.

There was a reproductive health clinical governance meeting, and after the inspection, we saw minutes and an action tracker from the meeting which showed service leaders had oversight of issues dating from May 2023.

The service produced a monthly quality and safety report for the trust board. We reviewed the last 3 reports and found a standard format was used to report on risk register entries, incidents, and complaints. Presentation of data was simplistic and under-developed and did not provide an accurate or detailed view of risks and challenges within the service.

To facilitate the inspection, service leaders were called away from annual leave to provide an accurate overview of the service. Without this, it would not have been possible to gather the required information about the service. The service had not completed effective succession planning to enable seamless provision of services and oversight of work.

The service held a reproductive health clinical governance committee monthly, which fed into a monthly divisional business and quality governance group. This fed into a monthly quality committee which reported to the trust board.

There was a joint obstetric & anaesthetic mortality and morbidity meeting to review serious incidents that adversely impacted on maternal health, and a joint perinatal mortality review tool (PMRT) meeting with a neighbouring NHS trust. Service leaders told us that obtaining external panel members for timely case reviews could be challenging.

The Director of Midwifery personally responded to each complaint, and progress of complaints cases were monitored by the trust board. We were not assured this was sustainable. After the inspection, the service provided the trust complaints process and said any complaint not able to be managed by the Director of Midwifery would be managed as per process and this was sustainable for the small number of complaints received at the service.

Maternity

Management of risk, issues, and performance

Leaders and teams did not have effective systems to manage performance. They did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. Action planning and progress tracking was under-developed, however, there were plans in place to cope with unexpected events.

The top-rated risks on the maternity risk register included: maintenance of the call bell system, maternity triage, maternity staffing, and nitrous oxide exposure. The service did not have a formalised risk review process to manage and monitor identified risks. Entries did not always contain dates for review or completion, mitigating actions, or named people responsible. We asked leaders about the process, and they said staff updates would prompt them to look at the risk register, or risks were reviewed by the patient safety team however, it was not clear how often or whether this happened in a formalised way. Staff description of the process was informal and ad-hoc, which may lead to missed opportunities and lack of oversight. Some risks were discussed within the maternity safety and quality report that was taken to board, and this contained updates on risks but no action planning. During the inspection we found risks that were not previously identified by the service, or risks that were known but had not been actioned to resolve. This is indicative of poor oversight of risk. After the inspection, the service said risks were managed in a formalised way via the monthly maternity quality and safety committee which has been commented on elsewhere in the report, as a standing agenda item on the reproductive health governance meeting, and up through trust board. The service said they were working on ways to ensure a robust history was recorded.

The maternity dashboard was reported up to board through the monthly maternity quality and safety report. It comprised of statistics using minimal, simplistic metrics: bookings, registerable births, babies born at home, babies born at The Cove (co-located midwifery-led unit), caesarean births: elective and emergency, successful inductions, 3rd/4th degree tears, PPH more than 1000ml, and first feed. This level of data was limited and did not provide adequate levels of oversight.

The trust board did not regularly monitor data in relation to the incidence of Hypoxic-Ischemic Encephalopathy (HIE) a type of new-born brain damage caused by oxygen deprivation and limited blood flow, and this has been commented on elsewhere in the report.

The trust board did not regularly monitor data in relation admissions to the level 1 special care baby unit or transfers out to level 2 or level 3 neonatal intensive care units. This was despite the service recognising and recording a risk on the maternity risk register in relation to the “increasing difficulty to identify a neonatal unit with a cot available and then the corresponding bed on labour ward”, a risk that was opened in July 2022. After the inspection, the trust told us that some data was reported at board and was locally monitored at service-level ‘Avoiding Term Admissions Into Neonatal units’ (ATAIN) meetings. However, since the inspection, the trust has implemented metrics to monitor this on the new maternity dashboard effective from July 2023.

The service maternity dashboard and the trust board did not adequately monitor the incidence of pre-term births. The service had recognised issues with premature babies being born at the trust inappropriately, as there was not the right level of neonatal care provision available. This presented a risk.

The service did not have an effective or comprehensive audit programme. Most audits submitted to CQC as part of the inspection data requests were not completed in the past 6 months and were in relation to data collected and analysed between January 2019 and December 2022. We saw documents showing the service had rolling audits (to check compliance and improvement over time) in 3 areas: women and birthing people seeing their named consultant, personalised care plans, and risk assessments. There were 12 ongoing audits at the time of inspection however, the service did not audit the use of maternal early obstetric warning sign (MEOWS) charts, complete regular and consistent

record keeping audits, or monitor the safe interpretation of electronic fetal monitoring in labour. We asked for evidence of audits performed and the service told us they raised and completed audits based on risk, and that risk was identified through incident reports. This showed a reactive response to risk rather than actively seeking out areas that may contain risk to prevent and reduce incidents from occurring. This did not provide an effective level of oversight to maintain or promote safety.

The service provided evidence that audit and maternity incentive scheme compliance was discussed at quality committee meetings. The service was working to produce an action plan to achieve compliance against transitional care provision for babies requiring more complex care but did not meet the threshold for admission to the neonatal unit.

After the inspection, the service told us that the dashboard metrics were updated monthly through the electronic patient record and that this acted as continuous monitoring in place of rolling audits. We saw evidence that the trust was able to extract data about cannula and catheter documentation from the electronic patient record. Data from January 2023 to April 2023 showed that catheter use was not documented correctly between 41% and 87% of the time, and there was no documentation that the dressing was dated, and the cannula site inspected in any month. Catheters were not documented as being removed between 26% and 83% of the time. The impact of this was women and birthing people may not receive appropriate and timely bladder care during labour and postnatally, or a chance to recognise and treat infection is missed. We saw evidence that the service had implemented a training poster for correct documentation on the electronic patient record, and there were staff registers to show who had completed further training with support from the digital midwives. As of March 2023, 52% staff had received specific training on recording catheter care on the electronic notes. After the inspection, we saw that the service had identified bladder care as a top risk during the postnatal period due to the number of incidents raised. The practice development team had developed a study day directly related to bladder care. However, there was not an action plan in place to improve this and the service did not provide recent data to show if improvements had been made. This not indicative of proactive oversight or swift mitigating actions taking place.

After the inspection, we saw data from the reproductive health clinical governance meeting which identified the service as being the second-worst performing trust in the region for Avoiding Term Admissions Into Neonatal Units (ATAIN), ranking 13th out of 14 providers. The service had recognised that statistics had not changed since the previous year and stated that a ‘deep dive’ of cases should be done however, the service did not provide evidence of an action plan or quality improvement planning that had been implemented following recognition of the previous year’s performance. This indicated that governance processes potentially identified issues, however, were slow to act on information to improve performance. It was unclear why action had not been taken following the previous year’s findings. In the January 2023 maternity incentive scheme declaration provided by the trust it stated an action plan had been developed. However, the service said progress against the action plan was not shared at quarterly quality surveillance meetings as required. Staff said monthly meetings were held to discuss avoidable issues leading to a term admission to the neonatal unit.

The service was not able to gain assurance on every part of the maternity incentive scheme safety action 6, which benchmarks service compliance on the Saving Babies’ Lives care bundle version 2 (SBLv2). The service could demonstrate compliance in 30 out of 33 (90%) elements of safety action 6 however, areas of non-compliance were around reducing preterm births and reducing smoking in pregnancy. At the time of inspection, the service had employed a public health midwife to work on improving these areas, and there was evidence that smoking cessation efforts had resulted in a reduction in numbers of women and birthing people smoking in pregnancy when comparing statistics between October 2022 and April 2023. Since January 2023, trust figures for smoking in pregnancy were in line with, or below the national rate, and there was evidence in quarterly reports by the public health midwife of ongoing work to improve smoking cessation services and related action plans.

Maternity

After the inspection, we reviewed Local Maternity and Neonatal System (LMNS) meeting minutes which showed smoking cessation was discussed and progress was tracked. The LMNS also acknowledged problems with the way data is extracted from the electronic patient record regarding stillbirths and neonatal deaths. The service had done work to gain assurance that data was accurate and was in discussion with the IT provider to resolve the issue. The LMNS had acknowledged this was a 'significant risk' for any service using the same IT system, this had not been recognised on the service risk register. After the inspection, the service added this to the local risk register for monitoring.

In January 2023 the service reported to the LMNS on preterm births that occurred at the hospital, where babies needed to be transferred to hospitals with the correct offer of neonatal care for their gestation and complications. The service recorded 16 preterm births in 2021 and 2022 combined, and identified good practice, areas for learning and improvement, and overall themes when assessing these cases. Cases were discussed at the service's perinatal governance meeting and 10 out of 12 case histories provided were discussed within 4 months of the incident occurring. We found 1 case was not discussed at the governance meeting until 10 months later. The service acknowledged difficulty in finding available cots in neonatal units which caused delays or an obstruction in transfer of women and birthing people at risk of pre-term birth. From the risk register it was not clear what mitigations the service had put in place to reduce the impact of this. However, we saw minutes for safety champion meetings which documented daily updates to the local network used for cot availability.

The service had a process to report and monitor incidents requiring early notification to external organisations. The service reported 3 early notification incidents that occurred between June 2022 and July 2023.

During the inspection, the service provided data around rates of postpartum haemorrhage (PPH) which showed errors in the recording of data, and this had not been identified by the service. The regional NHS team had alerted the service to its apparent outlier status in the number of women and birthing people experiencing PPH, and the service had not taken action to investigate this when we inspected. After the inspection, the service examined the data and provided us with new, accurate evidence about PPH rates however, this showed internal governance and assurance processes may not always work as intended to highlight areas of concern to leaders.

The IT system which included the electronic patient record was able to extract data to the maternity dashboard and complete simple statistical audits, for example the number of babies transferred to the neonatal unit and the date they were transferred. This enabled leaders to view statistics related to performance within the service. However, we did not see that leaders followed up on the collection of this data in a formalised way. We did not see evidence that leaders used the basic data from the IT system to identify areas for quality improvement, or look more closely at data, for example the reasons why babies are transferred to the neonatal unit, how long they stay, and what interventions were required in their care. This may mean that the service lost opportunities to provide safer care.

Audits had identified lower compliance rates of staff completing situation, background, assessment, recommendation (SBAR) handovers in January 2023 and managers created an action tracker to improve this. The action tracker detailed extra communications with staff and embedding use of SBAR into mandatory training days however, it was not clear if these actions had improved the use of SBAR.

The service had completed a workforce review in November 2022 which considered retirement planning and ensuring the sustainability of the workforce in the next 5-10 years.

We escalated concerns about emergency blood pressure medicine to the trust on the day of inspection, and this has been commented on in the medicines section of the report. Staff said the same safety issue had been raised approximately 2 months prior to the inspection, which demonstrates slow or no response.

Maternity

Information Management

The service did not always collect reliable data and analyse it effectively. However, staff could find the data they needed, in easily accessible formats to make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service used an electronic records system. Data was encrypted and secure.

The local maternity dashboard did not effectively analyse trends in clinical outcome data. The service did not use statistical process control (SPC) charts to review how performance changes over time and track the impact of improvement projects or changes in service delivery. This has been commented on elsewhere in the report.

The service used an interactive electronic app to manage use of locum doctors.

Engagement

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

The service worked with the local Maternity Voices Partnership (MVP) to improve patient experience. The MVP chair described positive working relationships with the service and colleagues in the region, and an appetite from the service to take service-user voices seriously. Meetings were well attended by staff and stakeholders, and the culture was described as inclusive and welcoming.

The MVP had shared its work on health inequalities with the service; the local population demographic included higher percentages of lower income families, young parents, and travelling communities. The service also looked after smaller numbers of women and birthing people who did not speak English as a first language or came from an ethnic minority group. The MVP had provided the service with feedback on patient leaflets and completed '15 steps' exercises on the unit (a framework to assess and improve patient experience when accessing care in hospital settings) however, told us that more work could be done with the service to achieve joint co-production from the start of projects.

The MVP were involved in sharing knowledge from incidents and creating two-way communication between the service and women and birthing people who used it, especially for informal feedback, plaudits, and complaints.

The LMNS had a plan to tackle health inequalities and there was a tracker to monitor progress against the plan. The service worked collaboratively with the LMNS on various areas of improvement including maternal mental health, perinatal pelvic health, and smoking cessation services.

The service conducted patient led assessment of the care environment (PLACE) and had identified meal provision as an area for improvement as a result. Progress on the improvement was being monitored at a trust level by the quality committee.

The service had supported 2 maternity support workers in training to teach baby massage and they provided classes to parents on-site.

Maternity

Following results of the 2022/2023 staff survey, the service created an action plan to mitigate staff feeling burnout and exhaustion, the service used staff survey results to feed into business planning and recruitment efforts. However, the action plan was not completed in entirety therefore it was not able to show progress or current position at the time of inspection.

The service encouraged staff to engage through various means including newsletters, safety champions on the wards, professional midwifery advocates, and suggestion boxes.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The specialist perinatal mental health midwife worked closely with the bereavement midwife and identified a gap in the service for women and birthing people after the death of their baby. The service had implemented specialist bereavement and grief counselling which had been met with positive feedback by families and there were plans to continue expanding and improving this new service.

Staff had access to trust wide quality improvement training however it was not clear how many staff had accessed the training and how much staff involvement there was on quality improvement projects.

Areas for improvement

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

Dorset County Hospital maternity services

Action the trust MUST take to improve:

- The service must ensure governance processes are effective including but not limited to complete governance documentation, action plans and progress tracking, accurate data collection and analysis, and regular monitoring of safety measures, outcome data and key performance indicators. (Reg 17)
- The service must ensure an effective and comprehensive, rolling programme of audit is in place, and results are monitored for use to improve services. This includes but is not limited to effective monitoring of wait times and appropriate care in maternity triage, and the quality of record keeping. (Reg 17)
- The service must ensure guidelines are in-date. (Reg 17)
- The service must ensure the safe management of medicines. (Reg 12)
- The service must ensure the process for opening and staffing a second theatre is risk assessed, safe, and familiar to staff. (Reg 12)
- The service must ensure women and birthing people are seen according to clinical need and a standardised framework is in place to support patient safety. (Reg 12)

Action the trust SHOULD take to improve:

Maternity

- The service should ensure all staff complete mandatory training including but not limited to safeguarding and basic life support.
- The service should monitor infection rates.
- The service should ensure maintenance issues are resolved in a timely way, daily safety checks are completed and documentation regarding maintenance is clear and complete.
- The service should ensure MEOWS and NEWS charts are completed correctly and used to effectively identify and escalate deteriorating patients.
- The service should review the process for contacting medical staff in an emergency to ensure safe and timely management.
- The service should ensure incidents are harm-graded and rated appropriately.
- The service should consider the vision and strategy for achievable, well-defined objectives and the ability to measure and monitor progress delivery.
- The service should consider ways to improve effective tackling of health inequalities affecting the local population.
- The service should implement an effective process for in-utero transfers with neighbouring units offering a higher level of neonatal intensive care.

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 midwifery specialist advisors, an obstetric consultant specialist advisor and 1 other CQC inspector. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist care.