East Suffolk and North Essex NHS Foundation Trust

Colchester General Hospital

Inspection report

Turner Road
Colchester
CO4 5JL
Tel: 01206747474
www.colchesterhospital.nhs.uk

Date of inspection visit: 07 March 2023
Date of publication: 05/05/2023

Ratings

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

Our findings

Overall summary of services at Colchester General Hospital

Requires Improvement 

East Suffolk and North Essex NHS Foundation Trust was formed 1 July 2018 following the merger of Colchester Hospital University Foundation Trust and Ipswich Hospital NHS Trust. There are maternity services located at both sites and Clacton Maternity Unit.

Colchester Hospital maternity unit comprises of an eight bedded consultant led unit with two obstetric theatres and a four bedded midwife led birthing unit. There is also a 4 bedded merged triage and day assessment unit. The maternity ward has 26 beds for both antenatal and postnatal patients. The unit also offers antenatal and fetal medicine clinics alongside scanning services. There is also a dedicated bereavement suite.

There were 3482 deliveries at Colchester between January and December 2022.

We last inspected maternity services at Colchester Hospital on 7 April to 15 April 2021 and the report was published on 16 June 2021. We previously only rated the safe and well- led domains which we rated requires improvement.

We carried out this unannounced focused inspection of maternity following emerging concerns regarding safety, culture and governance. Between 6 December 2022 to 18 January 2023, we received four concerns raised by whistleblowing. The key themes were poor staffing levels impacting safety and poor safety culture overall. As this was a focussed inspection, we only covered the safe and well- led domains which means the overall rating remains requires improvement.

During this inspection we visited all areas of the maternity unit, spoke with 50 members of staff, both during and post inspection. This included consultants, registrars, junior doctors, anaesthetists, midwives, student midwives, specialist midwives, matrons, and members of the senior leadership team. We reviewed 11 maternity care records and gained feedback from four current inpatients and their partners. We observed procedures, handovers, safety huddles and reviewed various policies.

Maternity

Requires Improvement ● →←

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

- The service did not have enough staff to care for women and keep them safe. The service provided mandatory and maternity specific training to all staff but did not always ensure everyone had completed it.
- The design, maintenance and use of facilities, premises and equipment did not always follow safety standards.
- The service did not control infection risk well. Staff did not always follow best practice to protect women, themselves, and others from infection.
- Staff did not always feel respected, supported, and valued.

However:

- Multidisciplinary working demonstrated staff worked well together across clinical groups and with external stakeholders such as LMNS and NHSE.
- The service had a clear strategy with aligned governance processes.
- All staff were committed to improving services continually.

Is the service safe?

Requires Improvement ● →←

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

Mandatory training

The service provided a comprehensive programme of mandatory and required training to all staff, however medical staff did not meet the trust target.

The service had an effective system to monitor staff were appropriately trained and competent to provide safe and evidence-based care for women and babies however, staff did not always receive and keep up to date with their mandatory training. At the time of inspection, the overall mandatory training for staff was 95.8% on a rolling 12-month cycle. This exceeded the trust target of 90%. However, the mandatory training completion rate for consultants was 84.6% which did not meet the trusts target completion rate.

The mandatory training was comprehensive and met the needs of women and staff. The training was delivered online and face to face and included but was not limited to adult basic life support, conflict resolution, infection prevention and control, prevent and safeguarding level 3.

Staff completed maternity specific training such as Practical Obstetric Multi Professional Training (PROMPT), which was a standardised course covering practical training scenarios of the management of obstetric emergencies such as Post-Partum Haemorrhage (PPH). The training uptake was positive for nursing and midwifery staff however there was low

compliance amongst medical staff, consultants had the poorest compliance rates. The trust had an overall completion rate of 91.09%. Midwives achieved 93.20% compliance, 100% for nurses, 96.49% for support workers, 69.23% for obstetric consultants, 94.12% for obstetric doctors, 93.94% for neonatal nurses, 81.25% for anaesthetic consultants and 68.75% for anaesthetic doctors.

Clinical staff also received face to face and online training on how to interpret and categorise cardiotocographs (CTG). Training was delivered annually and included an assessment. Evidence provided by the trust showed the overall completion rate for the online training was 83.62%. 82.31% completion rate for midwives, 92.31% for obstetric consultants and 88.24% for obstetric doctors. The data showed that only consultants were compliant with the trust target of 90%.

Clinical staff were also required to complete Growth Assessment Protocol (GAP) training, maternal sepsis training, saving babies lives amongst many other training subjects. The overall staff compliance was not met for maternal sepsis training.

Clinical staff received training on recognising and responding to women with mental health needs, learning disabilities, autism, and dementia but this had not been completed by all staff.

Practice development midwives had oversight of training required and would alert managers when they were due. Managers then prompted staff to complete the training. Managers informed us that training amnesty was available for staff who struggle with technology so they can receive in person support accessing e-learning as this was affecting completion rates. Staff returning from maternity leave also receive an allocated day to complete outstanding training.

Practice development midwives collaborated closely with the governance team to identify any themes or patient safety alerts that needed to be embedded into the training provided.

Safeguarding

Staff had training on how to recognise and report abuse however, less than half of medical staff had completed safeguarding training required for their role.

The trust provided safeguarding adults and children training at level 3. This formed part of the mandatory training for all clinical staff working within maternity services. The completion rates for nursing and midwifery staff met the trust completion target. However less than half of the medical staff had completed training to recognise and act upon safeguarding concerns. Overall completion for nursing and midwifery staff was 92% while medical staff completion was 43.58% which did not meet the trust compliance rate for training, this is not an improvement since the last inspection. Staff we spoke to could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

The safeguarding training included several topics such as how to safeguard patients and the unborn against female genital mutilation (FGM) and abuse. This training was provided to ensure staff were well informed and equipped with the knowledge and understanding of any potential safeguarding concerns. The training also provided information on making safeguarding referrals and who to inform if they had concerns. This training was not maternity specific however, midwives also attend an additional two-hour maternity only safeguarding session a year, this session includes, learning disability and referral pathway for maternity, substance misuse and domestic abuse including referral pathway for maternity, young parents and learning from reviews.

Maternity

Staff we spoke to knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make safeguarding referrals and who to inform if they had concerns. However, we observed staff having trouble identifying whether safeguarding questions on domestic abuse had been asked on a patient's electronic records. This meant that staff could potentially miss an opportunity to ask these questions and pick up on safeguarding cases. These questions should be asked at every antenatal appointment if the patient is alone.

Staff reported that the safeguarding lead for the service was visible, and staff reported this person as being very approachable.

The safeguarding team for the service consisted of only the named safeguarding lead midwife. The safeguarding lead informed us that there were a lot of safeguarding cases due to deprivation in the surrounding area. Due to the high demand and a limited team, there were tasks that were unmet such as the safeguarding lead being unable to attend case conferences with staff due to her increased workload.

The safeguarding lead told us that they had a good relationship with other agencies such as social services, the police, and local communities. The safeguarding lead also worked closely with the specialist perinatal health, drug and alcohol and teenage pregnancy midwives. They all attended daily ward rounds and supported staff as best as they could.

The service had an in date baby abduction policy which staff could access easily via the intranet. The latest baby abduction skills drill was carried out on 27 January 2023.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect women, themselves, and others from infection. They did not always keep equipment and the premises visibly clean.

Ward areas were not always clean or had suitable furnishings which were clean and well-maintained. The consultant led unit, maternity wards and clinic area were visibly clean and uncluttered however specialist equipment on the midwife led birthing unit was dusty.

Staff were aware of their responsibility toward keeping the unit clean. However, cleaning records were not always up-to-date or readily available to demonstrate that all areas were cleaned regularly. On the maternity ward we observed that staff did not have a checklist system to identify what areas had been cleaned. Staff did not always use green 'I am clean' stickers on equipment across the unit, which meant we could not assure all equipment had been cleaned after patient contact or identify when it was last cleaned.

We observed staff using correct PPE when treating women and babies. The maternity service provided staff and visitors with facemasks in all clinical areas, to protect people from healthcare associated infections.

Sepsis is a potentially life-threatening illness when the body's response to infection injures its own tissues and organs. Data from the maternity sepsis audit report showed inconsistency month to month in the management of sepsis. The service had a maternal sepsis screening tool, but compliance was 89% in October, 86% in November and 100% in December 2022. IV antibiotics should be administered within 1 hour in line with the Sepsis Six pathway, trust compliance was 75% in October, 67% in November and 100% in December 2022. These figures show that infection risk is not always controlled well.

Maternity

The service carried out an infection prevention and control audit for the year 2022/23, this involved but was not limited to observing hand hygiene technique, completion of daily urinary catheter assessments and the management of peripheral vascular devices (cannulas). The overall score was 84% which the trust identified as partially compliant. The trust created an action plan to improve compliance going forward, this action plan included sending emails to staff to remind them of IPC requirements.

Hand hygiene audits were also carried out monthly, the trust provided data for the maternity ward. In November 2022 the audit showed 93.88% compliance, 97.87% compliance in December 2022 and 89.13% compliance in January 2023. This audit was set against standards such as cleaning hands before and after patient contact, after bodily fluid exposure and before aseptic procedures.

Hand sanitiser gel dispensers were readily available at the entrances, exits and periodically throughout all clinical areas for staff, patients and visitors use. We observed multidisciplinary staff using hand sanitisers before entering clinical areas and washing their hands in between patient contact.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment and managed clinical waste well.

The premises were not always secure, we observed that the link door between antenatal clinic and the midwife led unit was left open. This should be closed with only staff access to reduce the risk of entry to unauthorised persons, patients absconding and baby abduction. This was escalated to senior staff and promptly closed. We were also able to gain entry to the maternity ward by following another member of staff without being questioned or challenged which means unauthorised persons may also gain entry to the ward.

The service had suitable facilities to meet the needs of women and their loved ones. The unit had two operating theatres. One theatre was used for planned surgical cases which was staffed with its own surgical team and the other was used for emergencies which was staffed by the on-call team. The service also had a two bedded recovery area which was staffed with recovery nurses.

The unit also has a specific suite for women and families who had experienced baby loss called the Rosemary Suite. The suite was located away from labour rooms and the maternity ward to provide privacy. It was designed and equipped to ensure that families had a clinical area for delivery and a comfortable, less clinical area to grieve the loss of their baby postnatally.

Women could reach call bells, call bells were available at the bed side and emergency call bells were available in every patient bathroom and were ligature free which is in line with the national patient safety alert from 3 March 2020. However, we observed that staff did not always respond to call bells in a timely manner when on the maternity ward.

The service had enough suitable equipment to help them safely care for women and babies. However, staff did not always carry out daily safety checks of specialist equipment. We reviewed daily safety checks across the unit and found gaps in the daily checks of emergency trolleys. We reviewed the daily checks of the neonatal trolley on the midwife led birthing unit between 13 June 2022 to 6 March 2023 and found 11 incomplete checks. We also reviewed the daily checks of the PPH trolley on the midwife led birthing unit for the month of February 2023;11 of the 28 days were incomplete.

Across the maternity unit we found items of equipment such as mattresses, blood pressure machines, CTG machines, suction units and weighing scales had been serviced and/or portable appliance tested.

Breast milk was labelled and stored in a lockable fridge in line with British Dietetic Association (BDA) guidelines for Preparation and Handling of Expressed and Donor Breast Milk.

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

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. However, the maternity triage was overburdened, this meant a potential risk of delayed treatment.

We reviewed 11 maternity care records; risk factors were highlighted in all the notes. However, safeguarding risk assessments were not always completed at every contact as appropriate. Staff did not always know how to navigate the electronic system to find safeguarding information and we observed a patient's notes who had not had safeguarding questions asked at any appointment.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool and used a structured communication tool known as Situation, Background, Assessment, Recommendation (SBAR) for communication between the multidisciplinary team. This communication involved discussions around pregnancy, labour and the postnatal period but also included safeguarding, mental health and other information of concern.

Staff used a nationally recognised tool, Modified Early Obstetric Warning Score (MEOWs) for women and Newborn Early Warning Score (NEWs) for babies to identify women and babies at risk of deterioration. This was recorded on a paper chart stored in the notes. We reviewed three MEOWs and eight NEWs charts on delivery suite and the maternity wards, we found all observations were completed and scored correctly.

Staff knew about and dealt with specific risk issues such as sepsis and venous thromboembolism (VTE). The service completed VTE assessments for all women to determine whether they were at risk of developing blood clots and would prescribe and administer prophylactic medication as required. We observed VTE assessments being completed in notes and medication being prescribed appropriately.

We observed a theatre case and saw staff completing the World Health Organisation (WHO) safer surgery checklist. Theatre staff were briefed about each patient and ensured that the list was conducted appropriately to keep women and patients safe. The service monitored the completion of the WHO checklist, data provided showed 100% compliance in November 2022, 99.1% compliance in December 2022 and 99.1% compliance in January 2023.

Shift changes and handovers were organised and included all necessary key information to keep women and babies safe. We observed both the midwives and doctor's handover across the unit. The handover on the consultant led unit did not only discuss the patients admitted there but also the patients on the ward who were currently having induction of labour (the process of artificially starting labour) to ensure they had an overview of the unit and could prepare for patients who needed to be transferred. The service also had a daily safety huddle which was attended by band 7 staff, matrons, and the bleep holder to discuss staffing, acuity of the unit, high risk patients and manage any risks.

Doctors attended the ward and reviewed patients during a ward round however, as they reviewed patients according to clinical priority this was not always completed in a timely manner. We observed patients waiting to be discharged later in the day as they had not yet been reviewed.

Maternity

Staff were clear on the escalation measures and process in the hospital. Staff we spoke to knew who to contact to escalate concerns and who to inform if a patient required transfer. The trust also had an escalation policy that was in date on the intranet and accessible to all staff.

The maternity triage system was recognised by the trust as being overburdened and therefore a risk to women's safety due to the functions of triage and day assessment unit being merged. The triage system had too many functions which included emergency attendances, scheduled appointments, routine checks and supervising the telephone helpline. Due to the increased burden on the system and inadequate staffing there was a risk to patients' safety. At the time of inspection, there was a body of work being undertaken as part of a national and regional Local Maternity and Neonatal Systems (LMNS) work stream to review splitting day assessment unit and triage to help ease the burden.

The service was in the process of implementing Birmingham Symptom- specific Obstetric Triage System (BSOTs) which was being overseen by the new triage lead and matron. BSOTs is a system to assess patients presenting with pregnancy related concerns. This allows staff to determine the clinical urgency in which each patient needs to be seen by a doctor. Patients are RAG rated and each colour determines the timeframe in which the patient should be reviewed. Patients in the green category required a review within 4 hours, the yellow category required a review within 1 hour, the orange category required a review within 15 mins and the red category required an immediate response. Due to low staffing BSOTs had not been fully embedded. Staff reported that it was not possible to complete on the night shift as two midwives were needed for BSTOTs and currently triage was only staffed with one midwife and one support worker at night.

Data supplied by the trust showed that in December 2022 BSOTs was used to assess 77.6% of women who attended triage and 41.5% of women in January 2023, which confirmed that BSOTs was not yet fully embedded.

Patients were not always seen by doctors in line with the BSOTs timeframe. Staff reported that a doctor was allocated to cover both triage and gynaecology from 9am-5pm but there was no doctor allocated from 5pm. This often led to patient reviews being delayed and the potential risk of delayed treatment. Data from December 2022 to January 2023 showed of all the women RAG rated in the yellow category only 29% were seen within the one hour timeframe and only 1% of women in the orange category were seen within the 15 minute timeframe.

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 were aware how to refer patients if they had concerns with mental health and had a dedicated perinatal mental health midwife who was visible in the unit. Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

The service provided us with evidence of completed environmental ligature risk assessment following the national patient safety alert to ensure mental health patients are kept safe.

Staffing

The service did not have enough maternity staff 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 did not have enough nursing and midwifery staff to keep women and babies safe. On the day of inspection, we found that the number of midwives and healthcare assistants did not match the planned numbers. Data provided by the trust showed that actual staffing levels did not meet planned numbers. Data from December 2022 to February 2023 showed that the unit was consistently short staffed. February 2023 showed the qualified staff fill rates was 84.1% on day shifts and 79.1% on night shifts which meant they were short staffed.

Maternity

The service had enough medical staff to keep women and babies safe. The service always had a consultant on call during evenings and weekends. The current vacancy rate for the medical workforce was low and the service managers could access locums when they needed additional medical staff. Locum staff had a full induction to the service before they started working on the unit.

The service currently had a low vacancy rate for midwives, data from the trust showed that the vacancy rate for nurses and midwives was 2%. This vacancy rate included midwives from a recent recruitment drive however, they had not yet started at the time of inspection.

Staff turnover for nursing and midwifery staff in the last six months was 8.9% and 29.4% for medical staff. The service had employed a recruitment and retention midwife to help reduce staff turnover and support newly qualified preceptorship midwives.

The trust sickness target was 3.5%. Data supplied by the trust showed that in August 2022 the sickness rate was 3.78% and in September 2022; the sickness rate was 4.32% which exceeded the trust target.

Managers accurately calculated and reviewed the number and grade of qualified and unqualified needed for each shift in accordance with national guidance. The service used the acuity tool birth rate plus to monitor staffing levels in accordance with patients on the unit as recommended by the Royal College of Midwives (RCM). The acuity tool was calculated by the labour ward coordinator and was to be completed four hourly. Staffing was reviewed at the daily safety huddle and staff shortages were escalated to the bleep holder. The bleep holder could adjust staffing levels daily according to the needs of women. The birth rate plus workforce report was not available due to it being reviewed by the national team. The trust aims to use the results to identify the number of staff to be fully established.

Community and specialist midwives were used to cover any gaps in maternity areas, particularly labour ward as per Maternity Escalation Plan V2.0.

Senior staff informed us that they used bank and agency staff familiar with the service regularly to fill gaps in the rota. Managers made sure all bank and agency staff had a full induction and understood the service. Data shared by the trust showed the service had high rates of bank an agency staff.

According to national recommendations, all women should expect to receive one-to-one care in established labour (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007). The percentage of women who received one to one care during active labour was 88.7% in March 2022, 96% in April 2022, 97% in May 2022, 99% in June 2022, 98.6% in July 2022 and 93% in August 2022 which is not in line with national recommendations.

Managers supported staff to develop through yearly, constructive appraisal of their work. The average appraisal rate for the maternity workforce which includes maternity admin staff, midwives, senior midwives, and specialists' midwives was 91.24% as of March 2023. Data supplied by the trust showed appraisal rates for the medical workforce were 94.4% in March 2023.

Records

Records were clear and up-to-date. However, records were not always stored securely, and staff did not always navigate them easily.

Records were not always stored securely, we observed staff leaving patients paper records unattended in open areas that could easily be accessed by an unauthorised person.

Maternity

Women's notes were comprehensive; however, midwives did not always navigate them easily. The unit used paper and electronic records. An electronic system is used for antenatal and postnatal record keeping, this system was also used to access diagnostic results. Paper records were used in triage and during labour. The paper triage and labour notes were then scanned on to another electronic system that was accessible to all staff. The scanning of records could be fast tracked if required. Staff reported no issues in the use of a mixed record system, they could easily access and audit patient records.

We reviewed 11 records for women at different stages of pregnancy and found records were comprehensive, risk assessments such as VTE, fetal movement and MEOWs were complete. We also observed staff dated, timed, and signed entries in paper notes. However, staff could not always navigate the electronic system smoothly and we observed staff having difficultly locating whether safeguarding questions had been asked.

When women were transferred to a new team, there were no delays in staff accessing their records due to records being electronic and the ability to scan paper records quickly.

Medicines

Medicines were not always stored and managed safely.

Medications that were required to be refrigerated were not always stored correctly, fridge temperatures were not always checked daily.

Staff stored medication in locked cupboards in a locked room that only authorised staff had access to. However, staff did not always store and manage all medicines safely. We found expired medication on the midwife led birth unit, this included intravenous Sodium Chloride that expired March 2022 and ampoules of Water for Injection that expired in April 2020, March 2021 and May 2022. This was escalated and they were disposed of.

We found controlled drugs were stored correctly in locked cupboards and checked by two qualified staff twice daily.

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed patient's medicines records accurately and kept them up to date. We reviewed six prescription charts for women across the unit and found that these were accurate and up to date. All prescriptions were signed, dated legibly, and allergies were identified on the front of the chart.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The unit also provided patients with self-administration medication charts once they had been reviewed as competent to self-administer by the obstetric team. This allowed patients to become more independent and prepare to be discharged.

Incidents

The service managed patient safety incidents well however, staff did not recognise the need to report poor staffing.

Staff we spoke with understood and followed the process of how to report incidents however, when we discussed what was appropriate to be reported staff were not aware that staffing issues should also be reported as this could potentially impact on patient safety. The trust used an electronic reporting system which all grade staff had access to.

We reviewed incidents reported from 1 January 2022 to 31 December 2022. Data showed 2061 incidents reported and they were appropriately graded.

Maternity

Managers debriefed and supported staff after any serious incident. Staff told us that they felt supported and there was not a culture of blame regarding incidents.

The trust had a backlog of 35 open maternity incidents being reviewed or awaiting final approval and had referred four cases to the Healthcare Safety Investigation Branch (HSIB) in the last six months. Three of the four cases referred to HSIB were rejected.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBBRACE) launched the perinatal mortality review tool kit (PMRT), and the service used this tool to review perinatal mortality. MDT staff reviewed and discussed patient deaths in the unit at monthly perinatal mortality review meetings. Actions from these meetings were then disseminated to staff.

Staff reported that they did not always receive adequate feedback from investigation of incidents of no harm. We saw evidence of themes and learning from incidents were generally shared with staff. Staff received weekly memos and monthly newsletters which included clinical information to update staff. The newsletters included themes from incidents, learning identified, clinical reminders and how to contact the governance team for support. Staff also received updates via a closed social media for staff, handovers, emails and from their managers.

Staff understood the duty of candour (DoC). They were open and transparent and gave women and their families a full explanation when things went wrong.

Practice development and clinical effectiveness midwives shared learning about incidents and never events with their staff and across the trust to improve safety.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service, they understood the issues the service faced. However, did not manage them in a timely manner. Leaders were not always visible and approachable in the service for patients and staff.

The leadership and management structure were undergoing many changes which has resulted in instability within the senior leadership. This had not improved since the last inspection. The service did not have a director of midwifery in post, but the trust had very recently recruited into this post. The trust senior leadership included the deputy head of midwifery currently acting as the head of midwifery which covered both the Colchester and Ipswich site, a divisional director for women and children services, an associate director of operations for women and children services and a clinical director for obstetrics. They were supported by the chief nurse who was also the maternity board safety champion.

Maternity

The acting head of midwifery met with the chief nurse, clinical director, and divisional management team regularly. The senior leadership team had oversight of the issue's maternity faced and collaborated with external stakeholders such as the Local Maternity and Neonatal Systems (LMNS) and National Health Service England (NHSE) to discuss them and implement solutions.

The senior leadership had action plans in place for various concerns highlighted. Action plans were discussed and updated at a local level and at regular maternity specific stakeholder meetings. However, the action plans were extensive which could lead to potential delays. For example, the separation of triage and day assessment unit (DAU) had been an ongoing action since being identified at the last inspection in June 2021. There has been delays in finding a suitable area in the unit for DAU to be moved to.

Maternity safety champions were in post and met with the board safety champion regularly. The board safety champion had monthly drop-in sessions for staff and conducted regular walk arounds.

The maternity board safety champion attended board meetings, this raised the profile of maternity services and supported the board in understanding current issues such as staffing, compliance with initiatives and implications on finances. The trust provided evidence of this. The board safety champion informed us that once the new director of midwifery was in post, they will also be invited to board meetings.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. This was developed with staff, patients and relevant stakeholders.

There was a maternity and neonatal strategy for 2022-2027 created by the Suffolk and North East Essex LMNS. The strategy outlines five outcome statements that they hoped families would experience during their care.

The five outcome statements were:

1. We received excellent, high quality care throughout our pregnancy, childbirth and early days of parenthood, that helped us to feel safe, and to be safe and well.

2. We knew what was happening throughout our pregnancy, childbirth and early days of parenthood, we felt heard, trusted our care givers, and were involved in all decisions.

3. Our care was tailored to our individual needs, culture, and circumstances, with our family involved in decisions and care.

4. We felt prepared for becoming new parents, knew how to care for our child, and knew where to go for help when we needed it.

5. Care givers were kind, explained everything in clear and easily understood language, and were on our team, helping us to have a positive experience.

The women's services collaborated with staff, patients, and other stakeholders to co-create a vision for Women services at East Suffolk and North Essex NHS Foundation Trust. This was done by gaining evidence from staff surveys, patients, family, friends and staff interviews, stakeholder reports and patient experience reports.

Maternity

The collaborated vision was: 'To be the service of choice for patients and staff, offering consistently outstanding, compassionate, informed, and personalised care. Our patients, families and staff feel valued, invested, and involved in everything we do.

Staff were aware of the vision and strategy for the service and took pride in being able to help create the vision.

Culture

Staff did not always feel respected, supported and valued.

Staff were proud to work for the trust and were passionate about their roles and the difference they made to the experience of women and their families. We observed staff working together as a team to provide high quality care and positively impact patient care and experience. However, we also saw low morale due to the pressures of insufficient staffing and lack of visibility of senior leadership.

Staff sickness exceeded the trust target from the months of April 2022 to September 2022 and the largest contributing factor was anxiety, stress and depression which accounted for 30.22% of sickness.

Staff did not always feel well supported, listened to, respected, and valued by their colleagues and senior managers. Although senior leadership listened to their concerns there were not always updates or immediate action in response. Senior clinical staff also mentioned that they were not given the opportunity to attend lead meetings which meant they did not feel involved in the improvement of the service.

Staff reported that matrons were very supportive however the instability of senior leadership was affecting staff morale. Staff were not always aware of the management structure and reported that the divisional management team were not visible. However, staff we spoke to were aware of who the board safety champion was and reported they were visible.

The senior leadership team were keen to ensure there was an improvement in culture and culture is frequently discussed in stakeholder meetings. Freedom to speak up guardians were in post and posters were seen across the unit. Safety meetings were open to all staff and leadership informed us that these sessions were also attended by a psychologist from the trust to provide additional support to staff.

Results for the trust staff survey 2022 were released on 9 March 2023; the women's and children division scored lower than the hospital on all nine questions audited such as teamwork, staff engagement and morale. The service also carried out regular staff temperature checks with the aim to 'measure our cultural health, and to understand if we have been implementing the appropriate interventions to make change'. The trust has provided evidence of action plans that have been put in place as leadership have identified that they still have a long way to go in terms of improving culture.

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 a governance system in place which included governance managers and a consultant lead for risk and governance. Staff were clear about their roles and accountabilities however the governance team informed us that the system was severely burdened and required engagement from staff at all levels to ease the pressure. At the time of the inspection staff informed us that a governance deep dive was underway to review all governance processes, roles, and responsibilities. This was being led by the transformation team and supported by the maternity improvement advisors.

Maternity

The maternity service sought reassurance through various governance meetings in the service. This included weekly governance team meetings, maternity quality and risk group meetings and perinatal mortality review meetings. We reviewed a selection of governance meeting minutes and found them to be detailed and clear with multidisciplinary team (MDT) attendance. Patient safety, complaints, quality improvement and the risk register were discussed at these meetings and outcomes were share with staff via posters, newsletters, emails, and video messages from leadership.

The governance team also worked closely with practice development midwives to ensure appropriate medicine and safety alerts were disseminated to staff. This dissemination was done via newsletters, a weekly memo and via social media.

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.

There were systems in place to manage performance and risk. The maternity service had a risk register. There were 14 risks on the register, these included the triage service adversely affecting patient safety, risk to patient safety due to not being able to fill the midwifery staffing template and small for gestational age babies not being detected in the antenatal period. Risks were recorded and managed using the trust's electronic reporting system, the trust used a RAG rating (red, amber, green rating) to assess the risk. All risks on the register had a named person responsible for reviewing and monitoring them. All the risk identified on inspection were on the risk register assuring us that leadership had oversight.

Matrons also reported that they were able to add to the risk register and had oversight of the risk which they could then disseminate to staff as appropriate. Staff we spoke to were aware of their top risks across the service.

Maternity performance measures were reported using the maternity dashboard which was displayed in maternity areas. The maternity dashboard helps to identify where the trust is performing better or worse than expected using a RAG rating. The unit provided us with evidence of integrated performance reports that include the maternity dashboard outliers, Clinical Negligence Scheme for trust (CNST) compliance, Saving Babies' Lives Care Bundle compliance, Ockenden assurance and updates from the last assurance visit, the risk register and recent completed Healthcare Safety Investigation Branch (HSIB) reports.

The service had a quality improvement lead in post spearheading quality improvement projects to mitigate risk and improve the overall performance of the service. The quality improvement lead worked very closely with the PDM midwives and the governance team.

Information Management

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

The maternity service had clear performance measures and key performance indicators (KPIs). The maternity dashboard captured information on workforce and staffing, risk management and patient safety, clinical outcomes, and clinical outcome indicators. The parameters on the maternity dashboard had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts. The maternity dashboard was clearly displayed on the unit for staff, women, and visitors to access.

The service submitted data to external bodies as required, such as MBRRACE-UK and NHS Resolution.

Maternity

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

Engagement

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

The service engaged well with various stakeholders and were actively involved with their local maternity and neonatal system (LMNS). On the day of the inspection, we observed an NHS England advisor at the unit supporting the trust with interpreting results from the acuity tool birth rate plus.

The maternity service also had a Maternity Voices Partnership (MVP) team that met regularly. The service engaged with women via social media such as Facebook and Instagram and held stakeholder and listening events that staff were encouraged to join.

There were systems in place for managers to engage with staff such as monthly meetings, weekly round ups and newsletters.

The safeguarding, perinatal health, drug and alcohol and bereavement midwives engaged with external organisations and charities to provide care and support for women with complex or additional needs.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff and management were committed to improving services by learning from incidents and making changes in practice through shared learning, external reviews, promoting training, research, and innovation.

The trust had quality improvement midwives who informed us of the projects they were currently undertaking. One of the quality improvement projects was around reducing Post-Partum Haemorrhage (PPH) within the service. We saw evidence of the project in the development of the post-partum haemorrhage document which will be used clinically to help manage PPH's more efficiently.

The service also had evidence of innovation. The antenatal clinic was launching new infant feeding pods called 'My Pods' to promote infant feeding in a comfortable and secure environment. The service decided to call the pods 'My Pods' rather than 'Mum Pods' to promote equality and inclusion for the LGBTQ+ community.

Areas for improvement

Action the trust MUST take to improve:

- The trust must ensure they fully implement a system to assess risks to women attending the triage unit and prioritise their care appropriately. Regulation 12(1)(2)

Maternity

- The service must ensure that medical staff complete mandatory and safeguarding training and ensure compliance with the trust target. Regulation 12 (1) (2)(a)(c)
- The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit. Regulation 18 (1)

Action the trust SHOULD take to improve:

- The trust should ensure all areas are secure and only authorised personnel have access.
- The trust should ensure patient and staff records are stored securely to maintain confidentiality and compliance with the trust policy and national legislation.
- The trust should ensure medicines are managed and stored appropriately, and medicine storage temperatures are monitored and recorded in line with trust requirements.
- The trust should ensure staff adhere to control measures to protect women, themselves, and others from infection.
- The trust should ensure senior leadership is visible and actively work to improve staff morale.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one inspection manager, a team inspector and two other specialist advisors. The inspection team was overseen by Antoinette Smith, Deputy Director of Operations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing