Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Royal Albert Edward Infirmary

Inspection report

The Elms, Royal Albert Edward Infirmary
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Ratings

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

Our findings

Overall summary of services at Royal Albert Edward Infirmary

Good ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Royal Albert Edward Infirmary.

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

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

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

Royal Albert Edward Infirmary is a district general hospital located near Wigan town centre. It provides a full range of maternity services including both antenatal and postnatal ward with 28 beds including three single rooms. There are approximately 2000 deliveries each year, with caesarean sections and instrumental delivery rates in line with national average.

The trust has two offsite antenatal clinics; The Thomas Linacre Centre in Wigan and Leigh Infirmary; both clinics provide consultant and midwifery clinics. We did not inspect these clinics as part of this inspection.

Our ratings of the maternity service stayed the same and the ratings for the hospital remained the same. We rated safe as requires improvement and well-led as good and the hospital as good.

How we carried out the inspection

During our inspection of maternity services at Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust we spoke with 27 staff including leaders, obstetricians, midwives, and maternity support workers.

We visited all areas of the unit including the antenatal clinic, maternity triage, labour ward, birth centre, day assessment, antenatal and postnatal ward. We reviewed the environment, maternity policies and 12 maternity records. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recent reported incidents as well as audits and audit actions. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

We ran a poster campaign during our inspection to encourage pregnant women, birthing people who had used the service to give us feedback regarding care. We analysed the results of the eight responses we had back to identify themes and trends. These reflected a mixed response describing a kind and caring workforce but with some people experiencing delays to treatment and support during their stay in the maternity unit.

Our findings

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

Maternity

Good ➔➔

Our rating of this Royal Albert Edward Infirmary stayed the same. We rated it as good because:

- The service had enough staff to care for women and keep them safe. Staff worked well together and with other organisations for the benefit of women. Staff understood how to protect women from abuse, and managed safety well.
- The service controlled infection risk well and managed clinical waste well.
- Staff assessed risks to women, acted on them and kept good care records. Staff understood and followed medicine management processes and reported serious incidents when required.
- Leaders monitored and managed safety and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported, and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community offering services unique to their local population. People could access the service when they needed it and did not have to wait too long for treatment.

However:

- Staff were not always up to date with key skills training to ensure safe treatment of women and birthing people. However, staff we spoke with could describe when and how to escalate concerns and could gave examples of doing so.

Is the service safe?

Requires Improvement ➔

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

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff were up to date with all their mandatory training. However plans were in place and the service was on track with projected trajectory compliance targets to ensure target compliance by 2024.

Staff were not up-to-date with their mandatory training. However, other core modules were above target compliance such as fetal physical health at 97% compliance and neonatal lifesaving training at 93%. Although mandatory training was comprehensive, not all staff were compliant with the trust target of 90% compliance. Midwifery staff had achieved 78% compliance overall and 40% for perinatal mental health training compliance. Although compliance for perinatal mental health was at 40% the trust was on track with projected trajectory targets which need to be completed by February 2024. Additionally, the trust had identified additional pool evacuation training requirements in 2023 and had

begun a training programme, at the time of the inspection 35% of staff had completed pool evacuation training and the service were on track with projected trajectory compliance targets which need to be completed before January 2024. Following the inspection, the trust confirmed compliance had increased to 46% and there were always staff on shift who had completed the training in order to maintain the safety of both staff and women using the service.

Midwifery support workers had a higher overall compliance in line with target mandatory training at 80% compliance, with Neonatal life support training at 83% and Practical Obstetric Multi-professional Training (PROMPT) training at 75%.

Medical staff received mandatory training however not all staff were complaint with trust target of 90% compliance. Medical staff had achieved 86% compliance overall, with 96% of staff completing fetal physiology monitoring training and 74% completing PROMPT training.

Managers monitored mandatory training and alerted staff when they needed to update their training. At the time of the inspection, training dates had been scheduled, staff who had not received training had been contacted and invited to attend.

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

Safeguarding

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

Medical, and Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Overall safeguarding adults level 3 was at 88% with safeguarding children level 3 at 84% which did not meet the target of 90% compliance. However, staff we spoke with could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act 2000. In addition, following the inspection the trust provided additional information to show they were on target to achieve compliance within the next 3 years.

Staff followed the hospital's safeguarding policy to review potential safeguarding concerns and worked with other agencies when required, to protect adults and children at risk of or suffering, significant harm. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Additionally, the service offered education and support around female genital mutilation (FGM), including further to those affected by or at risk of. Where there were concerns staff would make referrals to both internal and external safeguarding teams ensure actions are taken in order to ensure women and children are safeguarded effectively.

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

Staff we spoke with told us they were aware of the trusts baby abduction policy and had recently completed a baby abduction drill within the last 12 months. We found that the ward areas were secured with the doors monitored.

Maternity

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards were furnished to the latest national standards. Cleaning audits were completed, and records were up to date demonstrating that all areas were cleaned regularly.

The service generally performed well for cleanliness across multiple audits; for example, a cleaning audit completed on 11 May 2023 on the Maternity ward showed 97.97% overall compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). Internal handy hygiene audits completed March 2023 showed maternity staff were 94% compliant.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use. Staff regularly checked birthing pool cleanliness following a standard operating procedure and tested the water for legionella.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Although systems were in place to regularly check emergency trolleys, we found gaps in records and out of date equipment. Staff managed clinical waste well.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

Staff mostly carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment outside maternity theatres was checked daily. Emergency medicines and equipment was available on site, however we found some items had expired and there were gaps in the checks lists. We raised this staff during the inspection and checks were completed immediately to ensure no further items were out of date. Staff were aware of where the emergency trolley was stored and had access to it in the event of an emergency. In addition, easy to read additional guidance was located near the emergency trolley with actions, staff would have been able to use these guides during an emergency situation.

The service had suitable facilities to meet the needs of women and birthing people and their families. The service had enough suitable equipment to help them to safely care for women, birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called. Signage in other languages was not visible in patient waiting areas, however patients could access further information in their own languages via the maternity app used by the trust and could access additional translation services via their Non English Speaking passes.

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

Assessing and responding to risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. However, some staff used outdated methods of cardiotocograph interpretation meaning the process was not fully imbedded.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 10 MEOWS records and found staff completed them and knew how to escalate concerns to senior staff. Staff regularly completed quarterly MEOWS audits, between February and March 2023 where 20 records were checked to assess if they were fully completed and escalated appropriately. The audit showed that 100% of staff had completed MEOWS for all women and birthing people. However, it was identified that staff had not escalated the care of 1 woman in line with trust guidance. In response to their findings the trust carried out staff training and planned spot-checks by manager ensure staff are following guidance.

Staff knew about and dealt with any specific risk issues. For example, staff used the fresh eyes approach to safely and effectively carry out fetal monitoring. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The August 2022 to March 2023 audit showed clear interpretation and management plans following CTG in 100% of cases and staff did 'fresh eyes' at each hourly assessment in 100% of cases. However, we found staff did not always interpret CTG's in line with national guidance and trust policy occasionally using an outdated method.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. A maternity triage audit had been completed on a sample of 10 women and birthing people presenting to triage per month from January 2023 to March 2023. Results showed the 29/30 women and birthing people had been assessed within the target time of 15 minutes, with 1 woman waiting 15-20 minutes. Recommendations following the audit outlined that the implementation of a 24-hour triage service would further reduce the likelihood of reoccurrence, a follow up audit to had not yet been completed at the time of our inspection.

Staff completed psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. Women and birthing people who did not meet the high-risk criteria were offered additional support. Where appropriate staff made referrals to specialist services to ensure women and birthing people were offered the support they needed. This included the psychological recovery team, perinatal mental health team, 'building attachments and bonds' team (BABS) which is a service used to support parents to build secure and loving attachments with their babies through the use of specialist, therapeutic parent to infant mental health support during pregnancy and in the postnatal period. Additionally the trust also offers a wide variety of therapies including a wellbeing course, cognitive behavioural therapies including support for individuals who have experienced trauma. The service also worked within the local community to provide a parents loss support group, to further support bereaved women and birthing people.

In addition to metal health support, there was a local team who provided care to the most complex and vulnerable women and birthing people within the local population. This included support for women and birthing people with

mental health issues, substance misuse, domestic abuse, teenage pregnancy, complex safeguarding support, child sexual exploitation, asylum seeker and refugee support. It also included support for women and birthing people with learning disabilities support and support for women and birthing people who have suffered from adverse childhood experiences.

We observed that shift changes and handovers included all necessary key information to keep women, birthing people and babies safe.

The service provided transitional care for babies who required additional care.

Midwifery Staffing

The service had enough maternity staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers adjusted staffing levels in a way to ensure that there were enough maternity staff with the right skills, qualifications, and training to keep women safe from avoidable harm and to provide the right care and treatment. In addition, staffing At the time of the inspection, the services was in the process if purchasing a recognised staffing tool used to assess staffing levels to ensure safe staffing for delivery suite and maternity ward activity. Through using this tool, the service had identified as of April 2023, there were 15.05 whole time equivalent (WTE) clinical midwife vacancies against a budgeted baseline of 144.46 WTE midwives which also recommended a further 1.71 WTE staff should be employed. In an attempt to enable staff to maintain training compliance management planned to recruit past the recommended 20% staff to 25%. At the time of inspection plans were in place to recruit staff including plans to recruit 3 international midwives as part of the international recruitment programme. Following the inspection, the service told us they had been successful in recruiting to all current vacancies, with newly qualified Midwives due to commence in September upon successful completion of their training.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people when staffing was particularly tight. However, managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice, and they were expected to work in areas unfamiliar to them. The service employed supernumerary shift co-ordinators who had oversight of the staffing, acuity, and capacity to offer 1:1 care during active labour. Managers could access additional staffing via bank staff and could move staff according to the number of women and birthing people in clinical areas on a priority basis allowing the service to mitigate risks more effectively.

A nationally recognised report completed by the service had identified that there were higher levels of staff sickness across the service and staffing levels falling due to staff retirement, relocation, promotion, and limited education opportunities due to reductions in training budgets from National Health Service England. However staff sickness levels had shown steady improvements with a reduction in the percentage of staff off sick.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings' (2015). A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. In April 2023, there was 1 red flag reported.

Managers limited their use of bank and agency staff where possible to ensure the staff they used were familiar with the service.

The service made sure staff were competent for their roles.

Managers supported staff to develop through yearly, constructive appraisals of their work. The Practice Education lead and Practice Development team supported midwives. The service had a Band 7 preceptorship Lead Midwife, and a Band 4 preceptorship midwifery support worker in post. The service ensured staff were competent for their roles and included a preceptorship programme for newly qualified midwives, and competence assessments. The preceptorship staff were in place to support the recruitment process for newly qualified midwives and upskilling midwifery support workers. The service had identified areas of staff attrition and the trust had identified staff succession planning as a way to improve staff retention rates for Band 6-7 midwives.

Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Records showed 95.5% of midwifery staff had completed their appraisal in May 2023.

Specialist midwives and staff were given specialist training appropriate to their role.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number and a skill mix to ensure safe practice at all times. The service had low vacancy, turnover rates for medical staff.

The service had low rates of bank and locum staff and Managers could access locums when they needed additional medical staff. Locums completed a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Records showed 100% of medical staff had completed their appraisal in May 2023.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

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

Records

Maternity

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed a total of 12 patient records however some information was only recorded electronically which was not accessed in 3 sets of notes. Throughout the sample of 12 sets of notes we found records were clear and complete.

Women and birthing people's notes were comprehensive, we reviewed a sample of 9 full patient records (both electronic and paper based) and found that women and birthing people had been given the opportunity to discuss domestic abuse and safeguarding concerns. Staff could easily access the notes and the trust used a combination of paper and electronic records.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff locked computers when not in use and paper records were stored in staff only areas.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people used paper prescription charts for medicines administered during admission. We reviewed 7 medication records and found staff had completed them correctly.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed as well as the management of controlled drugs. These checks were recorded, and any concerns were escalated where required.

Staff completed medicines records accurately and kept them up to date. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored prescribing documents safely and managed all medicines safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Staff completed daily medicine stock checks to ensure medicines were in date and stored at the correct temperature. Staff monitored and recorded fridge temperatures and knew to how to take action if temperature had varied outside the ideal range. A review of fridge temperature checks showed all checks had been completed and that fridges had remained within the ideal range.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Of the 7 sets of medicine records, we looked at we found all 7 had been fully completed, were accurate and up to date.

Staff learned from safety alerts and incidents to improve practice.

Incidents

Maternity

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

Staff we spoke explained how they identified and reported serious incidents. Staff raised concerns and reported incidents and near misses in line with trust policy. The completed immediate 72-hour reviews to identify any immediate actions they must take as well as service held monthly 'Serious Incidents Requiring Investigations' meetings where serious incidents were discussed in order to identify potential immediate actions. Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers investigated incidents thoroughly. We reviewed a sample of 15 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 15 investigations, managers had completed an investigation and implemented actions where learning could be completed, including changes to electronic information systems and changes to staff educational material and training.

Managers shared learning with their staff about never events that happened elsewhere. The service had a team consisting of an Intra-Partum Safety lead, Fetal Surveillance Midwife, Deputy Head of Governance and Head of Governance who were responsible for sharing learning from incidents with staff.

Managers debriefed and supported staff after serious incidents. Staff told us they felt supported after a serious incident and received feedback to improve their professional development.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if things went wrong. As part of the investigation process patient ethnicity was recorded however it remained unclear how this information was being used to identify trends or themes around incidents and ethnic minority and vulnerable groups?

Is the service well-led?

Good 

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

Leadership

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

Leaders had the skills and abilities to run the service, they were aware of the challenges to quality and sustainability within the service and had taken action to manage them. For example, when planning to increase staffing numbers in line with nationally recognised recommendations, the service had set themselves a higher target to ensure that staff stay up to date with their required training alongside unexpected absences and staffing pressures.

Maternity

Leaders were visible and approachable throughout the service for both staff and for women and birthing people. Staff we spoke with told us that leaders were well respected, approachable, and supportive.

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

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels.

Leaders had considered the recommendations from the Ockenden 2022 review and had taken actions in response to its review of maternity services and recommendations. An action plan had been created in response to the Ockenden findings and progress was measured against them. For example, the trust aimed to recruit an additional 5% above the 20% as recommended by the report to better provide protected learning time for staff.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The service worked alongside the Local Maternity and Neonatal System (LMNS), Maternity Voices Partnership and Healthcare Safety Investigation Branch in addition to other services to better respond to the needs of the local population.

Leaders and staff understood and knew how to apply them and monitor progress and reported on progress related to plans.

Culture

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

The service had identified and taken actions to address communication barriers between women and birthing people and staff working at the trust. This was done through implementation of Non-English-Speaking women (NES) passes that allow women and birthing people to attend triage without calling first and assist staff to identify what interpretation services might be required. Staff are then able to use this information to source the right interpretation services based on the individual's needs.

According to Maternity Services Data Set (MSDS) via National health service Digital (NHSD) Maternity Dashboard (December 2022), there were a higher proportion of white mothers compared to the national average, A lower proportion of mothers were Asian or Asian British (3%) compared to the national average (15%) and more women were White, 84% compared to 67% nationally).

Maternity

The trust had taken actions to address the higher risk health inequalities associated with women and birthing people using maternity services from ethnic minority groups. These included a lower threshold to admit women and birthing people and escalate concerns for multidisciplinary review, and ensuring vitamin supplements such as vitamin D were offered as appropriate.

There were responsive systems and processes to support identified needs of the local population including domestic abuse, safeguarding, substance misuse, mental health, and disadvantaged groups. For example, the service offered smoking cessation to reduce adverse outcomes for women and birthing people. An audit completed by the service in quarter 3 of 2022 showed that an additional 18% of women and birthing people using the services and who were smokers, were discharged smoke free.

Staff we spoke with told us they felt supported and valued. Staff reported feeling safe to escalate their concerns within a supportive culture. Staff were focused on the needs of women and birthing people receiving care.

The service had an open culture where women and birthing people, staff told us they could raise concerns without fear, and knew who the freedom to speak up guardian was. Staff we spoke to told us they were encouraged to speak with them or other specialist members of staff if they required support.

Women and birthing people, relatives, and carers knew how to complain or raise concerns. We reviewed 12 complaints which had been made between January 2023 and May 2023. Concerns were responded to in accordance with their policy with complaints being processed via a formal documented approach. Staff knew how to acknowledge complaints made by women and birthing people, complaints were investigated by managers and the outcome was fed back to individuals. Following investigations managers fed feedback and learning with staff in order to improve the service.

Governance

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

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

Maternity safety champions and non-executive directors supported the service. Safety walkabouts were undertaken every two months by the Non-Executive Director who specifically asked staff if they had any safety concerns offering additional opportunities for staff to voice their concerns.

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

The service used a variety of methods to share learning with staff including case study discussions during practical obstetric multi-professional training (PROMT) sessions, direct feedback and support for those involved in serious

incidents, information shared through line managers and updates via internal communications such as email. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored key safety standards of policies such as "Saving Babies Lives Care Bundle" updating policies as part of their review process to make sure they were up to date.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The trust had an up-to-date maternity dashboard which was used to monitor performance and key indicators and participated in relevant national clinical audits. Leaders took part in quarterly perinatal mortality review tool (PMRT) meetings. PMRT meetings aimed to ensure emerging themes and trends from local incident reviews are disseminated throughout healthcare services in order to benefit future babies and their parents. The meetings were held regularly as part of the Clinical Negligence Scheme for Trusts (CNST) which is a scheme for handling clinical negligence claims against NHS trusts. The PMRT meetings were used to monitor trust performance and identity areas of learning opportunities and improvements.

As part of the National Perinatal Maternity Audit (2021), the trust was shown to have lower than expected rates of neonatal deaths excluding congenital anomalies, and births remained within the group average for stillbirths and extended perinatal deaths. This was an improvement since the previous PMRT audit data collected in 2020 where stillbirths at the service were noted to be more than 5% higher in comparison to services of similar size.

The service carried out audits to monitor staff performance and to identify areas where positive changes could be made. For example, documentation audits completed in March 2023 showed that improvements had been made with more staff completing modified early obstetric warning score (MEOWS) charts, escalating any identified concerns, taking maternal history and completing risk assessments for women and birthing people using the services compared with previous years. However, the trust identified staff did not always use documented handover prompts used to ensure patients care was handed over in a reliable consistent process to facilitate concise, clear, focused communication. This was not in line with trust guidance. In response to these findings the trust had created an action plan which included further staff training and monitoring process to ensure staff are following trust processes.

Audits were carried out to ensure that World Health Organisation (WHO) Surgical Safety Checklist were being completed correctly and these were found to be 100% compliant in all instances.

Additionally, the service had completed an audit on Newborn Early warning Trigger and Track (NEWTT), which is used to detect subtle deterioration in clinical conditions leading to earlier intervention and reduced newborn morbidity risk. A NEWTT audit completed April 2023 found that management plans had not always been completed at birth, however risks had been identified to ensure babies were given the care based on their needs.

An audit to review triage processes completed between January and March 2023 found that 97% of women and birthing people were seen within the first 10 minutes of arrival with 3% being seen outside of target times of 15 minutes.

Leaders regularly carried out safety walkabouts were undertaken twice a month by the Non-Executive Director who specifically asked staff if they had any safety concerns offering additional opportunities for staff to voice their concerns.

Managers shared and made sure staff understood information from the audits.

Information Management

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

The service collected reliable data for analysis. Senior managers had access and used a live dashboard to review performance data. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Staff had access to information required to assess performance, make choices, and make improvements could be found in readily available formats.

The service used password-protected IT systems to safeguard and integrate the information systems.

When necessary, data or notifications were routinely sent to outside agencies, such as the Local Maternity and Neonatal System (LMNS) and Healthcare Safety Investigation Branch (HSIB).

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The trust activity works with women and birthing people from refugee families as well as support being offered to individuals from economically deprived families. Links to the MVP were available on the trust website and women and birthing people could raise concerns via social media. The service and the MVP had completed a 15 step walk around and identified facilities in the birthing pool environment could be improved further, in response to this the trust have fed back to their board in order to make improvements such as environment lightings and murals on the wall.

Staff also complete regular hourly round checks for women to ensure their needs can be met at an earlier opportunity. Regular audits were completed with the aim to increase staff compliance. An audit completed in 2023 found that 10/10 patients were satisfied reporting all of theirs and their babies needs had been met, however documentation was not always completed. In response, leaders discussed results with staff in order to identify possible solutions in addition to monitoring and reminders in staff meetings.

Partner organisations had been involved in changes made to information leaflets and included changes to education material and discussions surrounding vaccine promotion including information on encouraged to have flu, whooping cough, and COVID booster during pregnancy and how to book them. Changes had been implemented to improve antenatal education for women and birthing people, via increased reading and teaching materials including face to face antenatal classes.

Maternity

The service received 71 responses to the Maternity Survey (2022). Comments included women and birthing people were not given enough information during their antenatal check-ups to help them decide how they wanted to have their baby; women and birthing people felt partners/someone else's were not involved in their care as much as they would like, including not being able to stay in the hospital; and staff were not aware of the individual's medical history during antenatal check-ups. Approximately half of the feedback received was positive, the remainder negative around the experiences and interactions with staff, psychological support and choices available to women and birthing people.

We received 20 responses as part of the give feedback on care campaign completed as part of the inspection reflected those of the Maternity Survey 2022 with approximately half of the feedback being positive with the remainder negative. Similar comments were made regarding negative experiences and interactions with staff, psychological support and choices available to women and birthing people.

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.

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. The service was committed to improving services by learning when things went well or not so well and disseminated learning throughout the service and ensured staff were up to date with their training. They had a quality improvement training programme and a quality improvement lead who co-ordinated development of quality improvement initiatives.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure staff are up to date with maternity practical obstetric multi-professional training and safeguarding adults' level 3 and safeguarding children level 3. Regulation. (12 (2)(c)).
- The service must ensure staff are up to date with maternity pool evacuation training Regulation. (12 (2)(c)).
- The trust must review systems and processes to ensure emergency equipment are available to staff at the time of need, as well as to ensure medicines and equipment are in date Regulation. (15 (1) (c)).

Action the trust SHOULD take to improve:

Royal Albert Edward Infirmary

- The trust should continue to review proposed action plans to ensure staff are following handover processes as outlined in trust guidance and to ensure patients are seen within target timeframes Regulation. (12 (2) (ab)).

Maternity

- The trust should ensure all staff use cardiotocograph interpretation methods as outlined in trust policy Regulation. 12 (2) (ab)

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care. In addition, the team comprised of three Midwife specialist advisors.