East Lancashire Hospitals NHS Trust

Blackburn Birthing Centre

Inspection report

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Ratings

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

Our findings

Overall summary of services at Blackburn Birthing Centre

Good

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

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

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

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

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received 23 feedback forms from women. We analysed the results to identify themes and trends.

Blackburn Birth Centre is a stand-alone midwife led birth centre. It has 4 birthing rooms, 2 of which have pools and a 4-bedded rest area. Ante and postnatal clinics are also provided at this location and it is the base for community midwives. It provides maternity services to women in the Blackburn, Burnley, Pendle, Rossendale, Hyndburn and Ribble Valley areas.

The local maternity population come from higher levels than deprivation than the national average with 34% in the most deprived decile compared to 12% nationally. More mothers were Asian or Asian British (24% compared to the national average of 14%) and fewer were White than the national average. Since February 2022, the trust has been in the upper 25% of all organisations for women who were current smokers at booking appointment.

Maternity services across the trust delivered 5,857 babies between January and December 2021. Blackburn Birth Centre delivered 94 babies between April 2021 and March 2022.

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

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

Burnley General Hospital – https://www.cqc.org.uk/location/RXR10

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

How we carried out the inspection

Our findings

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

Maternity

Good

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

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- Not all staff completed level 3 safeguarding adults training.
- There was damage to some furnishings and paintwork and disposable curtains did not have first date of use recorded.
- The birth centre did not have a local, specific vision or strategy underpinning it to develop future birth centre services.
- Managers could not analyse performance against key indicators easily as the maternity dashboard was service wide and did not break down information specific to the birth centre. Nor could managers always access reliable data to inform local audits due to the way information was recorded in the electronic care record. However, following our inspection managers told us they could pull information for each location from the trust systems to assess performance against key indicators.

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

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

Nursing and midwifery staff received and kept up to date with their mandatory training. Compliance with core skills training was 96% against a service target of 90%.

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

Maternity

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Staff completed training on perinatal mental health as part of the maternity specific mandatory training. 93.7% of midwives had completed dementia awareness training.

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

Safeguarding

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

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. The service provided information that showed core skills training included safeguarding children level 3 and safeguarding adults level 2. However, staff told us they completed level 3 adult and children safeguarding training. 84.4% of staff had completed safeguarding children level 3 and 98.4% safeguarding adults' level 2. Therefore, we could not be sure all staff completed the most appropriate level of adult safeguarding training.

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

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

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

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

Staff followed the baby abduction policy and undertook baby abduction drills. All areas were secure and visitors were buzzed in and out by a member of staff. The reception was staffed whenever the birth centre was open. However, staff had not undertaken any baby abduction drills on site.

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

The unit was clean and had suitable furnishings which were clean and mostly well-maintained. All areas we visited were visibly clean and dust free. We found some minor damage to furnishings and paintwork. Cubicle curtains were disposable but did not have dates to show when they were first used. This meant some furnishings were more difficult to keep clean and may pose a risk of spreading infection.

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

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff submitted checklists to matrons each Monday for audit purposes. Cleaning records included an audit of mattresses to check they were clean and in good working order and staff completed these weekly.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was available and staff and visitors wore surgical face masks to reduce the risk of spread of infections such as COVID-19. Hand hygiene sinks were available each individual birthing room and alcohol hand gel available at the entrance. Staff completed training on infection prevention and control as part of core skills training.

Domestic staff flushed taps and water outlets weekly to reduce the risk of water-borne infection such as legionella.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned.

Environment and equipment

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

The design of the environment followed national guidance. The birth centre had 4 birthing rooms, 2 of which had a pool. The birthing rooms had access to a large, secure outside area for women and families to use which allowed women to move about during labour. The unit had a large community room which could be used to deliver group sessions for women and families such as pilates.

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

Staff carried out daily safety checks of specialist equipment. We reviewed checks of neonatal and adult resuscitation equipment and saw they were completed daily except when the unit was closed.

The service had suitable facilities to meet the needs of women's families. Birthing rooms were large with access to secure outside space.

The service had enough suitable equipment to help them to safely care for women and babies. Each room had a resuscitaire which was checked daily. Staff could access equipment to help them evacuate a woman safely from the pool in event of an emergency and practiced this through skills and drills training.

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

Staff disposed of clinical waste safely. Staff disposed of sharps, such as needles, correctly in appropriate containers and in line with national guidance. rooms.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff recorded observations using modified early obstetric warning scores (MEOWS) and we saw all were completed fully and correctly in the 3 records we reviewed. Managers audited compliance with use of MEOWS and audits showed 90% compliance in October 2022.

Staff knew when to escalate women and babies for medical review or transfer to the main maternity unit in line with trust policy. Staff told us they would call for an ambulance transfer in some emergency situations such as if the fetal heart rate dropped.

Managers monitored waiting times and mostly made sure women could access services when needed and received treatment within agreed timeframes and national targets. However, the unit had been closed several times in 2022 to maintain safe staffing at the main maternity services site at Burnley General Hospital. This was reported via the online incident reporting system and women sent an apology letter and an offer made to contact leaders for further explanation. Feedback received from some women expressed disappointment that they were not able to give birth at their preferred location.

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

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 3 care records and saw risk assessments were completed at booking appointment and updated at every contact. We saw risk assessments identified key factors such as disability, age, and diabetes.

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

Staff knew about and dealt with any specific risk issues. All women were assessed for risk of developing a venous thromboembolism (VTE). VTE is a condition where a blood clot forms in a vein.

The service policy stated all women should be given anti-embolism stockings, however the service told us this related to women admitted to the induction suite and not women attending a birth centre. We found 2 women were not given these but had their risk of VTE assessed and were low risk.

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

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

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

Shift changes and handovers included all necessary key information to keep women and babies safe. Managers responsible for the birth centre attended the safety huddle held 4 times daily where key safety information on high-risk women was shared.

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, and gave bank and agency staff a full induction.

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

The service had enough staff to keep women and babies safe. The birth centre had a supernumerary midwife coordinator Monday to Friday and a rota for weekend cover. Midwives worked in the centre led clinics in the community.

The birth centre had recently been allocated a named consultant. They attended team meetings to update staff and answer any queries or questions staff had. Staff told us they found it helpful to have a named medical consultant to discuss any risks and update on new guidance. All women who were giving birth at the centre outside of guidance had a named consultant.

Birthrate Plus recommended an establishment of 10.93 whole time equivalent midwives and 2 midwives on each shift. Birthrate Plus is a nationally recognised tool for workforce planning and decision making in maternity services.

The service policy stated all women should be given anti-embolism stockings, however the service told us this related to women admitted to the induction suite and not women attending a birth centre. We found 2 women were not given these but had their risk of VTE assessed and were low risk.

The establishment for the birth centre was 2 midwives and 1 maternity support workers with a supernumerary ward manager Monday to Friday. We saw this had been achieved on all shifts except 1 the week before our inspection. Where the shift was missing 1 midwife the manager had acted up.

Staff reported any staff shortages through the online incident reporting system and managers reported this through a safer staffing report. However, the unit was closed at times to move staff to Burnley General Hospital maternity services to ensure safe staffing levels could be reached there. During this time women booked to give birth at the centre were diverted to Burnley General Hospital.

Maternity

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The Birthrate Plus report for the service was completed in September 2022 and the annual report and plan presented to the trust board.

Managers could adjust staffing levels daily according to the needs of women. Staffing was reviewed 4 times in each 24-hour period at a staffing safety huddle attended by ward managers and matrons across the maternity service. Staffing was reviewed based on staff numbers and acuity of the women needing care and given a risk rating. Managers agreed actions such as staff moves and use of bank staff to maintain safe staffing levels. A manager was on call between 8am and 4pm to address any staffing concerns and attend the local maternity system calls to escalate any staffing issues across the system.

The number of midwives and healthcare assistants matched the planned numbers. In September 2022 the average fill rate (the number of actual staff on shift against the planned numbers) for midwives was 87.4% during the day and 91.7% at night. The rate for maternity support workers was 100% during the day and at night.

The service had low vacancy rates of 2.5% for midwifery staffing and 0.25% across all staff groups. The service had plans to recruit international midwives and all international recruitment midwives had to pass an English test before being accepted into employment.

However, the service had high turnover rates of 9.7%. The service had a recruitment and retention midwife who completed exit interviews for staff and supported staff wellbeing initiatives to improve retention.

The service had low sickness rates. Overall sickness for the midwifery, obstetric and gynaecology directorate was 5.58%. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us they did not use agency staff, only an internal bank. Managers made sure all new starters and bank and agency staff had a full induction.

Managers supported some staff to develop through yearly, constructive appraisals of their work. The number of staff having completed an annual appraisal was 70%. Managers told us the decision was made to halt appraisals during the COVID-19 pandemic and there was a plan to ensure appraisals were conducted with compliance recently rising.

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

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

Records

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

Maternity

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

We reviewed 3 set of care records and saw they were fully completed with all relevant information and risk assessments recorded. The electronic care record had a system of alerts so staff could see at glance if a woman was high risk or there was a safeguarding concern. Documentation could not be closed on the electronic system unless all mandatory field and information was completed. Managers completed audits of care records focusing on key elements. In September 2022 the audit showed 100% compliance with recording the lead professional in care records and 89% compliance with recording the preferred place of birth at booking.

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

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

Medicines

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

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

Staff completed medicines records accurately and kept them up to date. Staffed scanned paper medicines charts onto the electronic care record once complete. Medicines charts could be accessed on the electronic record if women moved between units or to other services.

Staff stored and managed all medicines and prescribing documents safely. We reviewed the storage of controlled drugs and saw they were in date, stored securely and an accurate record kept. Staff checked the temperature of fridges used to store medicines daily and report any temperatures out of range.

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

Incidents

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

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

Maternity

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

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

Staff reported serious incidents clearly and in line with trust policy. The trust was an early adopter for the Patient Safety Incident Response Framework (PSIRF). This is a new incident reporting framework being developed by NHS England to replace reporting to the Strategic Executive Information System (StEIS). From January to October 2022 the birth centre reported no serious incidents to StEIS. Managers carried out rapid reviews of the incidents to identify immediate learning and shared this with staff.

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

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. The policy for temporary suspension of birth centre services guided staff to send duty of candour letters to apologise to women for the impact on their birth choices and we saw letters were sent following a closure in April 2022.

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

Staff met to discuss the feedback and look at improvements to the care of women. Staff discussed incidents and updates on action plans at the weekly quality and safety group meeting. The meeting reviewed all incidents reported that week and any never events or serious incidents from across the service. Managers produced a 'Share to Care' update with learning from incidents which was shared with staff and a paper copy kept in a folder in the staff office.

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

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

Is the service well-led?

Good

Maternity

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

Leadership

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

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

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

Leaders were visible within the birth centre, staff knew who they were and told us members of the senior management team attended meetings at the centre regularly. Staff reported good clinical leadership and support from the named consultant.

During interviews, local leaders demonstrated awareness of the key issues faced by the birth centre and talked through actions taken to address some of the challenges. For example, the centre had a pod to keep babies warm who may require an ambulance transfer due to the risks of maintaining babies' temperatures during transportation.

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

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, there was no specific vision or strategy for the birth centre.

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

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

Maternity

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

However, there was no specific vision or strategy for the birth centre. Staff told us they wanted to do more to promote use of the centre but felt this had been impacted by the number of closures due to staffing issues at the main maternity service.

Culture

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

Throughout the service we saw a positive culture with staff happy in their roles and proud to work for the service. Staff told us they felt teams worked well together to support women and families. Staff could record positive feedback received and thanks to staff who had gone the extra mile on, an online reporting system. This feedback was shared with individual staff by managers.

Midwives told us medical staff and managers were easily accessible and they felt confident to raise concerns or contribute ideas. Staff could access support from a trust Freedom to Speak Up Guardian. A Freedom to Speak Up Guardian works alongside the trust's senior leadership team to ensure staff have the capability to speak up effectively and are supported appropriately if they have concerns regarding patient care.

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

Women, relatives, and carers knew how to complain or raise concerns. Following our inspection, 23 women sent feedback about their maternity care at Blackburn Birth Centre. All praised the staff in the birth centre; however several women were unhappy with the attitude of staff in the scanning department. We saw that issues women raised regarding staff attitude through the complaints process were addressed.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints and learning from them was shared at the weekly quality and safety group.

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.

Maternity

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

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

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

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Managers held a divisional briefing every two weeks with matrons and ward managers to ensure feedback was provided both from staff and to staff. Each area held a staff forum to share information about performance and learn from any incidents or feedback.

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

Management of risk, issues and performance

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

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had a unit accreditation scheme called nursing assessment and performance framework (NAPF). Audit teams attended wards and units to assess performance against core standards.

The service participated in relevant national clinical audits. The service reported outcomes to the NHS Digital Maternity dashboard, the National Neonatal Audit Programme, the National Maternity and Perinatal Audit and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiry).

Leaders monitored performance against key outcomes through a maternity dashboard. The maternity dashboard was comprehensive and captured 28 different metrics such as stillbirth rates, 3rd or 4th degree tears and eclampsia cases. The dashboard was RAG rated red, amber and green so leaders could see at a glance any metrics which were outside of expected ranges and showed a monthly trend graph so leaders could see if performance was changing over time. However, it was not possible from the maternity dashboard to see information only for Blackburn Birth Centre.

Maternity

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

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

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

The service had assessed compliance against the most recent Ockenden report and used the self-assessment to complete a gap analysis. The gap analysis was updated regularly and had been presented through governance structures to board. A maternity safety business case had been agreed to address some of the workforce issues arising out of the gap analysis. The updated gap analysis in October 2022 showed 95% compliance with Ockenden essential actions with action still ongoing to ensure funding for maternity staff training was ringfenced.

The service used the nationally recognised perinatal mortality tool to review all baby deaths and conducted a rapid review into all deaths. In line with Ockenden recommendations, the service provided a report to trust board with details of all deaths reviewed and action plans. Perinatal mortality review meetings were held twice a week with an additional perinatal meeting monthly for full multidisciplinary team review of deaths. Each of the obstetric leads was assigned a case to investigate and report with the report going through the obstetric risk governance structure and presented to the perinatal board.

Leader and managers monitored risk through the local risk register. The risks on the register aligned with risks and concerns highlighted by staff and managers.

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

Information Management

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

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

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

Staff were supported by a dedicated digital midwife who delivered training and ad hoc support as required. However, the introduction of a new electronic care record in November 2021 had increased the need for digital support for staff.

We found that though the digital midwife was proactive in supporting staff more work was required to ensure all staff were fully compliant in the use of the new system. Managers told us they encouraged staff to use paper copies of document if they struggled to input into the electronic care record, to ensure documentation was completed and care remained focused on the woman.

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

Engagement

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

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

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

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

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

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

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

Learning, continuous improvement and innovation

Maternity

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

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

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

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

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

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

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

Outstanding practice

We found the following examples of outstanding practice:

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

Areas for improvement

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

Action the trust SHOULD take to improve:

Maternity services

Maternity

- The trust should ensure all staff complete level 3 safeguarding adults and children training, in order to protect women from abuse and improper treatment.
- The service should take action to ensure furnishings are clean and in a good state of repair to prevent the risk of cross infection.
- The service should consider developing a local vision and strategy for the birth centre.
- The service should consider developing a specific maternity dashboard for the birth centre to allow managers to easily assess and improve performance.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a Specialist Advisor and 2 other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.