East Sussex Healthcare NHS Trust

Conquest Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Conquest Hospital

Outstanding ☆ ➔➔

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

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

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

The obstetric led unit at Conquest Hospital was part of the East Sussex Healthcare NHS Trust. The unit provides antenatal, postnatal, early pregnancy unit and obstetrics. Doctors were available 24 hours a day to perform epidurals for pain relief, assisted and emergency births. Women who had medical conditions, complications during their pregnancy for themselves and their baby were advised to give birth at the consultant led unit.

The unit had a 10-room delivery suite, 1 theatre and 2 recovery beds. There was 24-hour cover from obstetricians and anaesthetist to assist women. Elective caesarean section lists were on a Monday, Tuesday, Wednesday and Friday.

The postnatal ward has 3 bays of 4 beds, total 12 beds and 3 side rooms, total 15 beds. (4 postnatal beds are ring fenced where possible for transitional care).

The antenatal ward is co-located with the postnatal ward consisting of 8 beds in 2 bays. Induction of labour is undertaken in this area

The maternity day assessment unit has four beds for seeing women throughout each day. Triage was a telephone triage system and based within the Eastbourne midwifery unit based in Eastbourne Hospital.

From April 2021 to March 2022 there were 2937 births across all trust sites.

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

We also inspected one other maternity service run by East Sussex Healthcare NHS Trust. Our reports are here: Eastbourne District Hospital, Eastbourne Maternity Unit: https://www.cqc.org.uk/location/RXC02

How we carried out the inspection

This maternity thematic review was a focused inspection; we inspected the domains of safe and well led using the CQC's established key lines of enquiries (KLOES).

Our findings

We visited all areas within the consultant lead maternity unit. We spoke with 11 women,15 staff members to understand what is was like working for the service, including consultants, anaesthetist, doctors, midwives, maternity care assistants and housekeepers.

We interviewed leaders to gain insight into the trust's leadership and governance model of the service.

We reviewed 6 sets of patient care records. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments and recently reported incidents.

After the inspection we requested further documentary evidence to support our judgements including policies and procedures, staffing rotas and quality improvement initiatives.

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 the maternity service stayed the same. We rated it as good because:

- Staff received regular safeguarding advice and supervision at daily ward huddles and rounds, as well as safeguarding supervision.
- The unit had in place 2 continuity of care services, the Lighthouse team who worked with young vulnerable pregnant people and the Ivy team who worked with low risk women.
- Leaders used a maternity dashboard and performance was monitored monthly via the governance and accountability and the maternity assurance meeting.
- The lead safeguarding midwife told the inspection team that they had worked alongside NHS England National Maternity Safeguarding Network, other agencies and volunteers to develop 'HOPE Boxes' for women who were to be separated from their babies due to safeguarding concerns. The HOPE Boxes contain photographs, footprints a letter and poem for both mother and baby prior to their separation to promote an ongoing connection during safeguarding proceedings and support the mother through potential grief.

However:

- The service did not always have enough staff to keep women safe.
- Medical staff did not keep up to date with their mandatory training. Medical staff were well below the trust target for eight out of the 12 mandatory training subjects,
- Trust data showed midwives, staff and doctors did not meet the trust target training compliance for Safeguarding adult and children's level 3.
- Women had long waits to access the day maternity assessment unit when they needed it. Women had long waits to be triaged, medical review or to be admitted or treated. During this time, women were not always monitored.
- Day assessment unit did not have in place a standard operating procedure.
- Midwives did not always record arrival times of all women.
- Staff in the day assessment unit did not use a consistent approach to assessing risk. The service had not yet implemented a triage assessment tool in triage.

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

The service did not always provide mandatory training in key skills to all staff and not all staff had completed it.

Maternity

Staff received and mostly kept up-to-date with their mandatory training. The service had a training needs analysis protocol for mandatory training. This included skills and drills training and was available via the intranet for all maternity staff. Staff were alerted to when their training was due via email and the matrons for maternity areas were responsible for ensuring staff attended.

The mandatory training was comprehensive and met the needs of women and staff. The training delivered by the service included trust wide mandatory training, maternity specific training and simulated maternity emergency training.

Mandatory training was delivered via e-learning and face to face and training included fire safety, equality and diversity, information governance, and emergency skills and drills.

Managers monitored mandatory training and alerted staff when they needed to update their training. All training across the service was reviewed monthly by the quality improvement and assurance lead midwife.

Compliance reports for training were sent to the governance and accountability meeting which allowed the leads of the specific areas to see what teams needed support with attendance or completing the required training.

Data received from the trust showed the midwifery team at Conquest Hospital had completed 66% for basic life support for adults, paediatrics and neonatal babies and 68% compliance for blood transfusion training. This was well below the trust target of 90%. However maternal and neonatal life support was also taught on the divisional blue mandatory study day (PROMPT), for which over 90% compliance was achieved.

Medical staff did not keep up-to-date with their mandatory training. Medical staff were well below the trust target for 8 out of the 12 mandatory training subjects, with 40% for basic life support for adults, paediatrics and neonatal babies, 54% infection prevention and control, 45% information governance, 55% mental capacity act and 50% deprivation of liberty standards was the training subjects with the least compliance.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia with 91% of midwifery staff completing the training. However, the medical staff were not compliant with the trust target.

Midwifery and obstetric staff received training on interpreting and acting upon outcomes of cardiotocograph (CTG) monitoring. Cardiotocography is the monitoring of the fetal heart and assessing the fetal wellbeing during pregnancy. Training was completed yearly, and all staff were required to complete an assessment following the training. The training consisted of antenatal and intrapartum fetal monitoring as well as, CTG equipment training, intrapartum risk assessments, situational awareness, human factors and escalation. In September 2022 92% of staff had completed both the CTG training, and the mandatory CTG assessment. The data received did not break down staffing into specific groups.

PROMPT (practical obstetric multi-professional training) and skills and drills training were multi-disciplinary, and the design of the training was responsive to staff needs.

The training ensured compliance with the following national maternity standards:

- Saving Babies Lives Care Bundle
- Fetal Surveillance in Labour

Maternity

- Maternity Emergencies and multi-professional training
- Personalise Care
- Care During Labour and the Immediate Postnatal Period
- Neonatal Life Support
- Covid-19
- Local Learning from incidents, complaints and claims.

Staff told us the training was responsive to their needs. Live drills were unannounced and involved all members of the disciplinary team working at the time of the drill. Emergency skills drills enabled staff to practice emergency obstetric situations, update their knowledge, understand their specific role and responsibility as well as developing a team approach to emergency situations. Following the drill all staff received a debriefing, to support with learning and reflection.

The team present during the drill completed a summary of the drill and lessons learnt were fed back to the labour ward forum, further PROMPT training, emails and staff meetings. Information was also shared through the risk newsletter within the theme of the fortnight.

Trust information showed that since September 96% of all acute maternity staff and 100% of consultants and all other level doctors had completed their PROMPT and neonatal life support training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff did not always attend training on how to recognise and report abuse. However, they did know how to report it.

Maternity staff received training specific for their role on how to recognise and report abuse. The service had a designated lead safeguarding midwifery and alongside the lead there was a deputy and administration support. They worked as part of the wider safeguarding trust team. The safeguarding lead was trained up to a safeguarding level 4.

All maternity staff including midwives and obstetric staff were required to be trained to safeguarding level 3. However, trust data showed us the training compliance for safeguarding level 3 was low and did not meet the trust target of 90% with midwives and maternity staff having 81% compliance, consultants 74% and all other doctors were 36% compliant.

The training comprises of e-learning assessed training which all staff must complete prior to attending a virtual facilitated session. The e-learning component focussed on the legislative frameworks and categories of abuse and key safeguarding topics such as domestic abuse and female genital mutilation (FGM).

The training used the ‘Think Family approach’ to safeguarding, which focused on the adult, child and family. Safeguarding training was offered monthly to incorporate new staff and the trust facilitated domestic abuse training every four months.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to access and complete safeguarding referrals online. A copy of the completed referral was sent to the safeguarding maternity lead for further review and staff felt they could access safeguarding support or guidance when they required it.

Maternity

Specialist and community teams received regular one-to-ones and group safeguarding supervision. Ward midwives received regular safeguarding advice and supervision at daily ward huddles and rounds. Safeguarding supervision supported staff in their case planning, information sharing, learning and debriefing. The safeguarding team worked closely with social services, perinatal mental health teams and GP's to support discharge planning and as well as pre and postnatal mothers whose children were under child protection.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff followed the baby abduction policy and undertook baby abduction drills. The maternity unit had swipe cards and cameras throughout each corridor and door to the department, preventing people from entering and exiting the maternity unit freely.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff mostly used equipment and control measures to protect women, themselves, and others from infection.

Records showed the trust monitored staff compliance to infection control and produced divisional quarterly reports to present at the trust infection prevention and control group. The most recent report showed the service did not always perform well for cleanliness and had not met the trust target of 98% for cleaning audits.

The report noted there was a lack of detail collected within the cleaning audits and therefore matrons were unable to determine where there were cleaning concerns. On the day of inspection, we saw that weekly cleaning records were up to date and areas were clean. However, we saw boxes stored on the floor of the dirty utility room. This meant that there was no free access to the floors and shelves for cleaning.

Nosocomial and sepsis infections were monitored, and records showed during July to October 2022 there was only one incidence of Gram-Negative Bacteraemia's.

During the inspection we saw staff follow infection control principles including the use of personal protective equipment (PPE). Aprons and gloves were stored on wall mounted displays throughout the unit.

Hand sanitiser gels were available throughout the areas. Staff were bare below the elbow and washed their hands appropriately. The maternity ward scored 100% hand hygiene compliance in all areas.

Staff told us equipment was cleaned after contact with women, however, the unit did not label equipment to show when it was last cleaned. There was no sluice in the day assessment unit and staff tested urine samples in the patient toilet. The service did not have a risk assessment in place.

Side rooms were available for women who had infection and needed isolation on the antenatal ward and within the postnatal and labour wards.

Environment and equipment

There was a lack of design, maintenance and use of facilities, premises due to the merger of the antenatal and postnatal wards. Staff were trained to use equipment and staff managed clinical waste well.

Maternity

The design of the environment did not follow national guidance. There was a lack of clinical space in the maternity environment due to the merger of the antenatal and postnatal ward and relocation of the day assessment unit. The lack of clinical space and the environment being inefficient and overcrowded was on the maternity services risk register. Senior leaders told us they recognised the concerns and there was a plan and financial bid in place to increase the maternity footprint.

There was no triage area within the day assessment unit. The maternity service had a dedicated triage telephone line only.

The day assessment unit when full was not able to accommodate women attending and these women were asked to wait in a corridor outside of the clinical area and out of sight of staff working within the day assessment unit. The lack of space and only having four beds meant the day assessment unit environment was not suitable for women who could be in labour, as it was difficult for staff to maintain women's privacy and dignity. However, staff told us women arriving in labour were mostly sent to the labour ward.

Labour ward had 10 delivery rooms, one of which included a pool. Delivery rooms included a computer so staff could maintain contemporaneous notes, without leaving women. Each room also contained a cardiotocograph (CTG).

The infant resuscitaire was place in the assessment room within the antenatal area. The room was cramped, and it was not possible to remove the resuscitaire from the room. Staff recognised that the resuscitaire could not be easily moved. However, staff told us the resuscitaire was used to place baby on during neonatal assessments. If there was an unwell baby the current procedure would be to bring unwell babies to the resuscitaire or straight to the special care baby unit.

Emergency equipment was checked daily, and we saw that all checks had been completed.

Theatre and the recovery area were within the labour ward. The need for an additional theatre to accommodate additional surgical activity had been identified. Main theatres were currently used for emergencies, if unable to use the obstetric theatre. However, we were told on occasions where both theatres were in use the service used the anaesthetic room as a second theatre.

The anaesthetic room was not fully compliant with theatre standards due the small space. It was difficult to get the required equipment into the area as well as the risks of air quality and gas exchange. This was recorded on the maternity risk register; the anaesthetic room was only identified as being for used if there was a threat to life of mother or baby. Senior leaders had submitted a business case for a second theatre and recovery area. There was no current incidence of having to use the anaesthetic room as a second theatre within 2022.

They had enough suitable equipment to care for high and low risk women during labour and birth.

Frank Shaw ward combined both antenatal and postnatal care for women, with antenatal being at one end of the ward and postnatal on the other. The antenatal area had eight designated beds, and each had a CTG machine. The postnatal area had 12 beds within four bays which included beds for transitional care babies. There were also three isolation rooms available.

Staff on the postnatal ward had access to a bilirubinometer which is a non-evasive equipment that monitors babies for jaundice. This is in line with best practice guidance.

Maternity

In all areas there was correct segregation of clinical and non-clinical waste. This was in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. Sharps bins were labelled, and no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks.

The service had a dedicated bereavement suite which provided private accommodation separate from where the baby was born, for bereaved families.

Assessing and responding to patient risk

Staff completed but did not always update risk assessments for each woman and did not always take action to remove or minimise risks. Staff did not always identify and or act upon women at risk of deterioration

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used a Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration. Staff completed and recorded MEOWS observations electronically. However, they did not record subsequent observations on a chart. This meant staff might not identify a trend and there could be a risk deterioration that may not be identified in a timely way.

Triage was not based within the day assessment unit. Triage was a telephone line manned by an experienced midwife. Specific care pathways were followed for directing the care of women. However, we found that the triage line was also being used for non-emergency calls to access for example, blood results and appointment times for women, community midwives and GP's due to difficulties in getting through to other areas of the maternity departments. The non-emergency calls were not audited. However, staff told us there was a large volume of calls which were non- emergency and took time away from answering emergency calls.

Midwives did not always record actual arrival times of all women. In particular the arrival time of women who were asked to wait in the corridor due to a lack of space within the DAU, was not recorded until they were eventually on the unit.

This meant during busy periods women did wait in the corridor for several hours. Women were not reviewed within agreed time frames and national targets. Staff could not identify how long women had been waiting from the time they arrived to the time they were able to come into the unit. Women waiting in the corridor did not have observations taken and were not visible to staff. There was no way of identifying how long had women waited to be seen prior to having their observations completed.

Following our inspection, senior leaders told us they had implemented a white board in the department where arrival times would be documented and women waiting within the corridor would have regular observations completed

Staff did not complete risk assessments for each woman on admission, using a recognised tool. Staff in DAU did not use a consistent approach to assessing risk. The service had not yet implemented a triage assessment tool in triage. However, the unit was in the process of working towards introducing the system. DAU staff did not use a RAG (red, amber or green) traffic light care bundle to risk assess women coming into the department.

Maternity

Staff monitored fetal well being using a cardiotocograph (CTG) machine. Staff used a fresh eyes approach to review CTG progress. Staff used the CTG to monitor any potential risk to unborn baby. Staff told us they completed CTG's every 15 minutes although during busy periods this was not always possible. Staff did not use an SBAR (situation, background, assessment, and recommendation) process to handover care to other areas within DAU.

There was a lack of obstetric reviews for women within the DAU after 5pm when the medical day staff finished, because the service relied upon the on-call team who covered the whole of maternity which meant reviews could be delayed. When reviewing the DAU appointments for the day we inspected, we saw there were five women waiting to be seen for a clinical review past the time the clinician finished in the clinic. These women would have had to have waited to be seen by the on-call team who covered obstetrics, gynaecology, and obstetric theatre.

Managers did not monitor waiting times. Women could not always access emergency services when needed and did not always receive treatment within agreed time frames and national targets.

Waiting times for women had not been monitored or audited therefore there was a lack of oversight regarding the potential risk of women waiting within the DAU.

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. The service had clear processes for staff to follow which included the contact details of the onsite and out of hours psychiatric liaison teams. The service had a consultant obstetrician who specialised in perinatal mental health and a perinatal mental health midwife. They worked closely with the perinatal mental health team and women had the opportunity to access a perinatal counselling service.

Safety huddles took place in the labour ward and each area had a handover. There was an overview of staffing and acuity across the unit. High risk antenatal women who were in-patients were discussed and women waiting for induction of labour. Some safeguarding issues were highlighted which could be clinically relevant. The handover also included a discussion about high-risk women. Staff were encouraged to contribute, and there was effective communication and shared learning.

Staff used the 'Saving Babies' Lives Version Two (2019), a nationally recognised care bundle to assess women during pregnancy. Saving babies lives is an evidence-based bundle of care designed to reduce the numbers of stillbirth and early neonatal deaths bringing together areas identified as best practice, these included reducing smoking in pregnancy, raising awareness of reduced fetal movement and effective fetal monitoring during labour.

The shift leader within the labour ward completed hourly review of CTG charts for all women in labour acting as fresh eyes. The reviews were recorded on the electric notes system and we saw this had been completed within the hourly time frame.

There was 2 documented occasions during the reporting period, when the labour ward co-ordinator was not supernumerary.

Women requiring high dependency care following birth were transferred to the high dependency unit (HDU) or intensive therapy unit within the trust. The maternity unit offered a higher level of care on labour ward for women who had, had a post-partum haemorrhage. They were not transferred to the postnatal ward.

Maternity

The service followed the ‘Five Steps to Safer Surgery’ World Health Organisation (WHO) checklist which included a sign in, time out and sign out checks. Patients had a copy of the 'Five Steps to Safer Surgery' WHO checklist in their notes and is recorded on the theatre database. Data received showed that from April 2022 to September 2022 there was 100% compliance in completing the WHO checklist within maternity.

The unit ran a clinic for high-risk women and for women who had, had previous complications from anaesthesia. The elective c-section lists were organised based on risk.

There was not a specific transitional care bay for babies who needed additional care in line with the ‘Avoiding Term Admissions into Neonatal units Programme’ (ATAIN). Staff told us that beds within a bay closest to the main desk were designated for transitional care babies where possible. The service used a newborn RAG rated risk assessment using appropriate coloured hats to show what level of treatment the baby required. Babies under transitional care were cared for by the nursery nurse who completed regular observations. Unwell babies were transferred to the special care baby unit.

We reviewed six sets of maternity care records. The lead professional was confirmed in all of them. Risk factors were highlighted. For example, a high body mass index, living in a deprived area, or co-morbidities. Women were allocated to the correct pathway to ensure the correct team were involved in leading and planning their care. Their risk assessments were completed at every contact and there was evidence of appropriate referral.

Carbon monoxide screening was performed in each set of notes reviewed in line with best practice guidance. Staff risk assessed every woman’s risk of venous thromboembolism at booking, on arrival in labour, and during post-natal care. This was in line with national guidance.

The service used a maternal sepsis care bundle to identify women at risk of sepsis.

The trust submitted the maternity dashboard monthly to integrated care boards and local maternity and neonatal systems. Maternity dashboards allow maternity teams to compare their performance with other maternity services.

From April 2022 to September 2022 there had been 111 maternal readmission's and 18 of those were due to sepsis. The service completed an incident reporting form for each postnatal readmission, and these were reviewed in the multi-disciplinary daily incident review meetings. In 2 of the postnatal readmission's there had been no consultant review within 14 hours of readmission. This did not follow trust guidance. We did not see a process for escalation for the delay in consultant review.

From April 2022 to September 2022 there were 71 neonatal readmission's with the common themes being feeding issues and jaundice. The infant feeding specialist reviewed all incident reporting forms regarding jaundice and feeding issues.

Midwifery Staffing

The service did not always have 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.

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.

Maternity

The service did not always have enough nursing and midwifery staff to keep women and babies safe. The COVID-19 pandemic had impacted negatively on the maternity workforce resulting in staffing gaps and the well being of staff, which had resulted in additional strain on the service. The number of midwives and healthcare assistants did not match the planned numbers.

Evidence provided by the trust showed in September 2022 the midwifery vacancy rate was 9.4% vacancy rate, 2.8% of maternity staff were off sick and 23.2% off maternity staff were on long term sickness which was classed as sickness over 28 days and 6.4% of maternity staff were on maternity leave.

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. Workforce requirements were reviewed each morning within a safety huddle and safe staffing levels were reviewed. Staff told us that midwives were meant to work on rotation around the maternity unit, spending three months within one area. However, due to staffing issues, staff told us they rarely worked within their rotational post. With midwives not finding out which area they were working within until they came onto shift that day, most midwives we spoke to found this difficult and preferred to know where they would be working in advance.

A weekend plan was developed each week and shared with senior midwives on call, divisional and trust on call staff.

The required number of registered midwives per shift at Conquest acute unit was 8 registered midwives. Where staffing falls below requirements the escalation policy was to redeploy staff to maintain one-to-one care in labour.

The service recorded any missed target as a red flag on the maternity dashboard. There were 49 red flags reported during July 2022 to September 2022, due to maternity staffing, these were due to delays or re-scheduling of induction of labour to maintain safe services, the labour ward co-ordinator was not supernumerary and not all women in established labour received one to one care.

An internet application was used to report and monitor acuity and red flag incidents. Staffing, acuity and red flag information was entered onto the acuity app every four hours by the shift co-ordinator. The target for entering the information onto the acuity app was 85%. However, the unit reported due to ongoing workforce challenges the compliance rate was currently 75%.

In September 2022 98% of women received one-one care in labour. A supernumerary labour ward coordinator was allocated to all shifts. The service reported that twice during the reporting period there were 2 night shifts where there was not an allocated supernumerary labour ward co-ordinator. On both occasions a band 6 midwife acted as the supernumerary labour ward co-ordinator and additional support was available from an on-call senior midwife.

Data showed us that when acquity was extremely high the labour ward coordinator would oversee the care of a postnatal woman on labour ward but did not lead care for labouring woman.

Safe staffing in maternity was reported quarterly to the trust board as part of the CNST (Clinical Negligence Scheme for Trusts Maternity Incentive Scheme) and workforce issues were placed on the divisional risk register.

To support the unit with staffing specialist midwives, matrons and the senior midwifery management team have supported the acute clinical area by working a rostered six-hour shift, Monday to Friday. The unit reported that this had impacted on their ability to complete their own workload.

Maternity

The Day Assessment unit had extended the opening hours to assist with mitigating staffing pressures out of hours

The service used bank and agency staff to back fill shifts and requested staff familiar with the service. Bank shifts were usually filled by the maternity unit's permanent staff. The unit reported that this was due to higher rates of pay offered in other trusts. Although financial incentives had been offered to permanent staff to work additional hours.

There was a preceptorship programme for newly qualified midwives to progress from a band 5 to band 6 grade. The preceptorship period could be up to 18 months. However, staff were encouraged to complete their preceptorship period by 12 months. The programme adopted a blended learning approach. It included study days, electronic learning modules and reflective sessions. The learning supported their transition from student to qualified practitioner. Newly registered staff were appointed a preceptor by their line manager.

Data showed that as of September 2022 the unit currently had 18 midwifery vacancies across the service. The trust had recently employed 6.92 full time equivalent newly qualified midwives who were due to start employment. The trust had a rolling advert for the remaining band five and band six midwife vacancies It is anticipated, by early October 2022, 6.92 whole time equivalent newly qualified midwives would start employment with the Trust. There was a rolling advert for remaining vacancies for band 5/6 midwives.

Managers support for staff to develop through yearly, constructive appraisals of their work was not consistent. Records showed appraisal rates for staff for the maternity unit at conquest out of 88 staff were 65.9%. The day assessment unit at Conquest Hospital had 10 staff working within the department and 50% had received an appraisal.

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.

The service mostly had enough medical staff to keep women and babies safe. Consultants were available 24 hours, seven days a week. Consultant obstetricians provided 72-hour presence on delivery suite to support junior staff. The unit had in place 16 consultants, 2 associate specialists, 12 registrars and eight senior house officers.

The on-call consultant was present on the labour ward from 8.30 am to 8.30 pm 7 days a week. Outside of these hours they were on call from home within 30 minutes of the hospital. A registrar and senior house officer (SHO) were on call and on-site 24 hours a day, in addition to a dedicated additional registrar and SHO available on site from 8:30 am to 5 pm.

There was a local guideline in place detailing the 'Hot Week' consultant. The 'hot week' system enabled consultants to be part of a 1 in 10 rota system where they would provide continuous care over one week at a time.

The unit was compliant with the requirement for twice daily consultant ward rounds, seven days a week. This was monitored and reported back to the trust board.

Women attending the day assessment unit (DAU) did not always have timely medical reviews as medical staff also provided cover for obstetrics, day assessment unit and theatres.

A duty anaesthetist was available for the obstetric unit 24 hours a day. A separate anaesthetist was allocated for elective obstetric work.

Maternity

Records

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

Women could access their antenatal records electronically. However, some women had handheld antenatal records which they took to all appointments. staff recorded care contemporaneously and we could see the women's antenatal journey.

We reviewed six women's records following their journey from antenatal through to discharge.

Women's notes were comprehensive and all staff could access them easily. All patient records including the discharge process were electronic. Confidential information could not be accessed without a password and all computer screens we saw were kept locked at all times.

Records were fully complete, and the electronic system was easy to navigate. Woman had individualised care plans for pregnancy and labour, there was an antenatal screening and assessment of risk to promote safe treatment.

The trust ensured the allocation of named midwives or consultants to women. Venous thromboembolism (VTE) score checklist, partogram (a composite graphical record of key maternal and fetal data during labour), World Health Organisation (WHO) checklist used in theatres, charts for growth and early warning scores were completed.

Potential safeguarding issues were flagged electronically so all clinicians could recognise and act on safeguarding concerns.

Medicines

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

Staff did not always follow systems and processes to prescribe and administer medicines safely. They received mandatory training in medicine management every year. Obstetric and midwives completed medicines training. Training compliance was 100%.

All medicines stock was reviewed by the pharmacist and controlled drugs were checked twice daily, by 2 ward staff.

Staff did not always complete medicines records accurately. There were 16 incidences for prescribing, with 14 related to errors in the trusts electronic prescribing system.

Staff did not always store or manage all medicines and prescribing documents safely. We found within the delivery suite treatment room lock was broken, and the door was left unlocked. The general medicines cupboard was overstocked and untidy, with no logical order for storage. Tablets were not kept in original packaging and liquid medicines did not have the date the bottle was opened.

Medicines for women discharged were still in the drug cupboard and there was no obvious documentation that a local stock check had been completed.

Staff on the postnatal ward completed regular medication rounds to make sure women had their medicines on time. We reviewed four prescription charts and medicine were recorded accurately and were up to date.

Fridge temperatures were checked daily in all clinical areas. This was to make sure fridge temperatures were maintained between a minimum and maximum recommended temperature.

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 mostly knew what incidents to report and how to report them. Staff knew how to escalate their concerns and how to report incidents. However, staff told us they did not always complete incident reporting forms due to not having the time. For example, staff in the day assessment unit did not complete incident reporting forms for women who had been waiting long periods of time without being reviewed by a clinician.

Staff followed trust guidelines on how to identify and report incidents. The service used an online incident reporting system and updated national Strategic Executive Information System (STEIS) if a serious incident was declared.

Incidents meeting the incident review trigger was brought to the daily review meeting. The meeting was multidisciplinary, and the incident review was updated. The review identified if there were care or service delivery issues and the team agreed how to share learning.

Data showed us there were five common themes within maternity incidents, these were.

- Maternal postnatal readmission's.
- Postpartum obstetric haemorrhage.
- Small for gestational age.
- Prescribing errors.
- Electronic patient record system.

For each of the common themes of incidents, the service looked at how managers would share information and disseminate learning, with clear actions noted.

Managers investigated incidents thoroughly. Incidents were to be reviewed within 72 hours. However, we were told by the governance lead that this was not currently achievable due workload and availability of staff. At the time of the inspection there was over 100 incidents which had not been reviewed and were over 60 days old, 14 patient safety review cases awaiting review and four amber incidents which could be closed but the investigations were incomplete,

There were five reported STEIS incidents from January 2022 to September 2022. These included a never event and a maternal death. Three incidents related to a still birth or intrauterine death. The maternal death was reported to MBRRACE, however, was downgraded once the cause of death had been established.

Maternity

The service monitored stillbirths, fetal loss, neonatal and post-neonatal deaths using the Perinatal Quality Surveillance report. This report was fed into the monthly women, children's, sexual health and audiology governance and accountability meeting.

The minutes for the last governance and accountability meeting showed that during August 2022 there were 77 incidents reported for obstetrics and maternity across the trust. The minutes showed the trends were the same as recorded in previous months. These were 57 incidents reported within the acute maternity department which included the delivery suite, obstetric theatre, antenatal and postnatal ward and the day assessment unit. Incidents included post-partum haemorrhage, unexpected maternal readmission to hospital and small for gestational age at birth.

The trust had 32 babies born before the arrival of a midwife from April 2022 to October 2022. Information received from the trust showed incident reporting forms and ongoing follow up telephone calls were not completed. Therefore, leaders were unable to identify how many of these women had planned to give birth at home, length of time it took for the midwife to arrive and follow up care following birth.

Managers debriefed and supported staff after any serious incident. Staff received a hot debrief immediately following an incident. Hot debriefing is a form of debriefing which takes place 'there and then' following a clinical event and has the advantage of earlier intervention, improved participation and improved recall of events. The process for investigating and managing incidents was based on learning and improvement, not or apportioning blame.

The service had in place a monthly governance newsletter which shared learning from incidents. However, the last newsletter was June 2022.

Managers shared learning about never events with their staff and across the trust. Staff told us they received feedback from investigation of incidents. Learning and actions were shared with staff via interactive boards, emails and on staff message groups. Matrons and specialist midwives disseminated quarterly messages amongst staff which included learning from incidents.

Staff met to discuss the feedback and look at improvements to patient care. Leaders met quarterly to discuss improvements and update actions plans and records confirmed this.

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 staff. They supported staff to develop their skills and take on more senior roles.

Maternity

The maternity team leadership structure was formed of the director of nursing, divisional director of operations for women and children's services, director of midwifery and the head of midwifery. The director of midwifery and the head of midwifery were fairly new in post.

The team was also supported by a deputy head of midwifery, 2 consultant midwives, seven midwifery matrons, with labour ward having six band 7 matrons. There were 13 specialist midwives who sat under the quality and improvement lead. The service manager oversaw eight midwives which led on ultrasound, bereavement, screening and debriefing. A maternity transformation lead who was responsible for a deputy transformation lead, maternity data analyst and pelvic health midwife.

Some of these appointments were new and yet to be fully embedded. We found some leads had multiple roles and responsibilities for examples band 7 matrons led for multiple key areas within the service, or multiple roles.

Monthly maternity performance indicators formed part of the trusts integrated performance report. This fed into the Women and Children's Divisional meetings, and this was reviewed by the board and or the executive team.

The director of midwifery attended board meetings and was able to provide updates in response to maternity outcomes.

The non-executive director (NED) was a maternity safety champion and was there to provide objective and external challenge. Their remit was to understand the current outcomes of the service, review services, current maternity risks and report to board. The NED visited the maternity unit and liaised with outside representatives such as the maternity voice partnership group to review services and provide the board with a report of maternity services.

Staff told us senior managers were visible and available, but not all staff felt they were listened too. Senior managers completed daily walk-rounds of clinical areas. Staff found the area leads/matrons were approachable and keen to drive improvement.

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.

There was a strategy in place for maternity services called the Maternity Strategy. The strategy 'Better Care Together for East Sussex' set out the direction for services over the next five years and had specific plans relating to pregnancy, childbirth and care of new born children. The plan set out a working collaboratively with partners within primary care as well as perinatal services and East Sussex maternity voices partnership (MVP). MVP is a working group of women, birthing people, their families, commissioners and midwives and doctors working together to review and contribute to the development of local maternity care. The plan was based on four national aims:

- Maternity safety
- Continuity of carer
- Personalised Care
- Safe staffing

Maternity

The maternity set out high aims within the vision to be achieved within the next five years and was keen to be the first choice for families and staff.

Leaders were clear that they wanted to offer a safer, more personalised and centred around the individual needs and circumstances of each woman and their baby. The service already had two continuity of care services the Lighthouse team who worked with young vulnerable pregnant people and the Ivy team who worked with low risk women.

There were four fundamental values the trust promoted staff to use within their working practice, which were:

- Working Together - To build on people's strengths
- Improvement and Development – To strive to be the best
- Respect and Compassion – Acting with kindness
- Engagement and Involvement – Involve people in planning and decision making

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.

The most recent staff survey was part of the Women and Children's directorate and took place between October and November 2021.

There were areas identified within the survey where staff provided negative feedback in regard to staff health and well being. For example, staff felt they were working over their contracted hours without being paid, work related stress levels were high, a third of staff reported muscular and skeletal injuries and there were high levels of exhaustion which was leading staff coming to work unwell. Staff also reported that they there were large volumes of work due to staff shortages which created stressful environments and feedback from managers could be improved.

However, staff felt trusted to do their job, staff respected each other and were compassionate and teamwork results were positive.

During our inspection staff told us they had felt able and supported to professionally challenge clinical decisions and this included junior members of staff. However, band 7 leads within the service were responsible for multiple roles within their clinical areas and found it difficult to have full oversight and felt they were not always listened to by senior leaders within maternity.

Maternity leadership had put together a maternity staff survey action plan in response to the staff survey. The action plan had four priorities which followed the following themes:

- The maternity workforce was feeling emotionally exhausted and burnt out because there are not enough staff to do the job well.
- Community teams felt neglected.
- Staff want to see their management team/ Managers want to go back to the floor where possible.

- The Trust wants all staff to feel safe at work.

Each of the four priorities had action needed, who was responsible, progress made and updates and the data showed us that the most of the priorities had been actioned with a review of the current vacancies, the service had seven newly qualified midwives due to start at the end of October, specialist midwives were working one clinical day a week to help support staffing and six weekly listening events for staff to share updates and to enable staff to share concerns.

The trust employed a Freedom to Speak up Guardian (FTSuG), to support staff who wished to speak up about a concern or issue. The FTSuG reported to the chief executive and ensured any issue raised was listened to and feedback was provided to them on any actions or inactions because of them raising an issue.

Civility saves lives training was part of the maternity teams practical obstetric multi-professional (PROMPT) training. The aim of the training was to provide staff with a greater insight into how rudeness or lack of consideration for others can affect staff mental health, anxiety and emotional well-being.

Women, pregnant people, relatives and carers knew how to complain or raise concerns. The service had a complaints process and the deputy head of midwifery and unit matrons reviewed all complaints. The maternity voice partnership group also reviewed complaints themes and trends to discuss with the maternity leads.

The service clearly displayed information about how to raise a concern in maternity areas. We saw posters clearly displayed on the unit and on the trust's website on how women and families could make a complaint. Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. The matrons worked with the quality improvement midwife to investigate complaints, speak to staff involved and write formal responses within set times frames.

We spoke with 13 women during our visit. Eight women were happy with their care and experience. Five women we spoke with in the postnatal ward were happy with the care they had received from the midwifery team. However, they were unhappy about the information provided by the medical team in regard to ongoing postnatal care.

Following our inspection, we received seven feedback forms from women who had used maternity services. Five of the feedback forms gave both positive and negative feedback and two of the feedback forms were negative. Common themes from feedback was the lack of support postnatally and attitude and manner of medical staff.

The service received feedback from the MVP team in regard to themes and trends given by women who had used the service. Some of the themes identified were:

- Feedback related to the language used and women felt persuaded to make a decision by healthcare professionals.
- Visiting restrictions for partners or support person on the antenatal and postnatal ward was distressing for women.
- Lack of feeding support within the community.

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

Staff did not always follow up-to-date policies to plan and deliver care according to evidence-based practice and national guidance most of the time. During the inspection, staff found it difficult to access and find policies on the trust database.

The day assessment unit (DAU) did not have in place a standard operating procedure. Senior leaders told us the team followed the Clinical Guidelines for the Management of Reduced Fetal Movements and the standard operating procedure for short notice obstetric clinic guidelines for unforeseen circumstances. However, staff we spoke to were not aware of specific guidelines used within the DAU.

The maternity dashboard captured information on workforce, maternity morbidity, perinatal morbidity and mortality, readmissions, maternity safety, test endorsement and public health data. This information was reviewed at the maternity clinical governance meetings.

Specific maternity papers relating to national schemes and reports such as the Saving babies lives and Ockenden report were presented to the board.

There was a standard operating procedure for Women and Children's Guidelines Implementation Group. The group reviewed the database for guidelines, through a red, amber and green rating to identify which guidance was for review.

There were clearly defined maternity governance process for reporting. The process reviewed perinatal meetings and minutes, women's risk, the midwifery improvement forum, and additional clinical governance such as audits. An integrated performance review was then fed into the quality and safety committee, governance and accountability meeting, maternity board and trust board.

The governance and accountability meeting were monthly. The group had a standing agenda which included monthly reports for governance, clinical negligence scheme for trusts (CNST), safeguarding and maternity dashboards.

An action plan was in place to review the trusts Ockenden Assurance Insight visit. The visit took place on 24 June 2022 and reviewed against seven immediate actions from the Interim Ockenden Report (2020). Meetings were held with members of the executive team, senior leadership team and front line staff representing a range of midwifery, obstetric, anaesthetic and support roles to ensure actions were embedded into the maternity service.

The head of midwifery had governance accountability for risk and responsible for maintaining risk management strategy and procedures this included risk assessments, incident reporting and the risk register.

Maternity services held daily maternity risk meetings cross-site via Video link software. Matrons and clinical service managers attended these meetings, as well as the head of midwifery and clinical governance lead. Risk meetings were open for all staff to attend if they wanted to. Staff were often too busy to attend, but they received feedback from meetings.

The service had a divisional governance lead, deputy governance lead and two governance officers. The governance lead Is responsible supported the clinical lead and head of midwifery to implement trust policies. Reviewing maternity standards, benchmarking against national maternity reviews and then reporting this back to the governance and accountability meeting and board.

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Maternity

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.

A risk register was used to identify and manage risks to the service. The risk register included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, it's possible impact and the review date were also included.

The risk register had four top risks, three of which were related to Conquest Hospital. The risks were, the lack of available clinical space in the maternity unit due to overcrowding following the merging of the antenatal and postnatal ward during COVID-19 along with a relocation of the day assessment unit, reduction in provision of midwifery services due to a depletion in the midwifery workforce and the lack of suitable space within the obstetric theatre.

Leaders reviewed risks within the women's risk meetings and updated risk register entries and entered dates. However, we did not see that the risk register and maternity dashboard shared with staff and the public in clinical areas.

Leaders used a maternity dashboard and performance was monitored monthly via the governance and accountability and the maternity assurance meeting. Records showed the dashboard was being reviewed to reflect national reporting categories which reflected ethnicity and the percentage of black and ethnic minority women reaching 29 weeks and placed on a continuity of carer pathway.

From April 2022 to September 2022 the service had identified capacity issues and had activated the trust escalation procedure to manage the demand of the service. However, there were no requirements to divert pregnant women to other trusts and no unit closures within Conquest Hospital.

From April 2022 to September 2022 the service reported one serious incident, which was reported to Healthcare Safety Investigation Branch (HSIB). The report was shared with Local maternity and neonatal systems (LMNS) for feedback. Following the closure of the serious incident the serious incident was shared within the quality and safety meeting to share learning.

Minutes from the Women's Risk meeting minutes showed a quarterly update regarding HSIB referrals were discussed and actions updated.

The service reported 81 incidents in September 2022 for the maternity unit. An example of a common theme of incident reported during this time were prescribing incidents. There were 16 prescribing incidents and 14 were related to the trusts electronic prescribing system. Information provided by the service showed appropriate actions were put in place with all electronic prescribing charts stopped and to use paper prescription charts reintroduced to mitigate risk until the problems with the electronic system were resolved.

The service last completed audits on Cardiotocography (CTG), electronic fetal monitoring in 2019 and 2020. The audits were completed by the fetal wellbeing and surveillance specialist midwife. A further audit was due to be completed. Through the electronic patient record system, the trust audited 10 CTG's through a quality check in August 2022. The audit reviewed:

- Assess compliance.

- Monitor record keeping.
- Provide assurance that hourly CTGs reviews and fresh eyes were being performed.
- Provide assurance that the guideline recommendations were embedded in practice.
- Provide reassurance that CTG's were only being used in high risk cases.
- Provide reassurance that appropriate escalation occurs when needed.

The cases reviewed were from women who gave birth in August 2022. 100% of the case were appropriately risk assessed.

Staff understood the duty of candour (DoC). They were open and transparent and gave women and families a full explanation when things went wrong. Staff explained what had happened and apologised. They assessed the application of the DoC against all incidents and maintained and monitored compliance through their maternity dashboard.

Information Management

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

The maternity service measured key performance through the maternity dashboard. The dashboard was presented to enable it to be used to challenge and drive forward changes to practice. The dashboard had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts.

The service had fully implemented a national maternity electronic patient record. The service employed a digital midwife who supported staff with training and updates on the electronic patient record. This enabled managers to draw relevant data to use towards key performance indicators, however, some managers we spoke to did not have access to this aspect of the electrical patient record system. This meant information to improve outcomes was not easily available to all managers.

Managers told us the system was continuously updating, therefore the workload was increasing for the digital midwife. The service was in the process of recruiting support to enable quicker teaching of updates to staff.

Women and pregnant people had password protected access to a personalised care guideline with their personalised pregnancy records. Information included diagnostic results, and patient information leaflets and could be accessed via smart phones.

The trust had internal intranet systems, which were password protected, all staff could access policies and guidelines. However, during our inspection several staff had difficulty finding policies and told us this was a common theme. The impact of this meant staff may not always have access to updated guidelines and standards.

Data was collected to support higher risk women at all booking appointments. This included women's ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced maternal age and co-morbidities. This data was used in planning women's care. Managers also used this information to inform decisions around service delivery such as continuity of care teams and community caseloads.

Maternity

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.

In the 2021 CQC maternity survey, East Sussex Healthcare NHS Trust scored best for communication with the antenatal period. For example, women during the antenatal check-ups were given enough information from midwives and doctors to help decide where to have their baby and women were given enough information about coronavirus restrictions and implications for their maternity care.

However, they did not score so well in engaging with women postnatally. For example, women did not always have the opportunity to ask questions about their labour and birth after their baby was born, women did not always feel they were taken seriously if they raised a concern during labour and their birth and staff did not always introduce themselves when treating and examining women during labour and birth.

The service collaborated with groups to help improve services for women. The service took account of the views of women through the Maternity Voices Partnership (MVP). The service had a well-established relationship with their MVP. The service had quarterly MVP meetings which included the head of midwifery and MVP leads. The MVP chair lead held regular meeting with the Infant feeding lead and antenatal education to provide feedback and information from women.

The MVP team use a live online survey which notified the team every time it had a response. Results of the survey were collated three monthly. Although the team were looking to provide feedback six monthly alongside deep dives of the maternity areas. However, the deep dives had not taken place due to the maternity units low staffing.

There were a team of volunteers which worked with the MVP team to support with engagement with women in the community during parent groups such as breast-feeding counsellors and during antenatal classes. Volunteers fed back monthly to MVP chairs.

MVP worked with the service to develop an equality and equity work stream, to improve the engagement with Black, Asian and mixed communities, young parents and those who live in areas of social deprivation.

A monthly newsletter had been developed for staff who worked on the antenatal and postnatal ward. The aim of the newsletter enabled staff to be notified of developments, awareness of current risk flags, changes to practice, learning and patient feedback.

The governance team provided a governance newsletter which provided information on trending incidents, birth statistics and current risk register and learning from incidents. Doctors on induction received a governance newsletter which provided them with information on how to incident report and what incident indicators and the process on how to complete an incident reporting form.

Maternity listening events had been in place since February 2022, with the last one being held in August 2022. The events were set up to give staff the opportunity to be open and share their thoughts and comments on the current issues within the unit. It was also an opportunity for the leadership team talks around the negativity feedback received from staff. For example, staffing and estates such as combining the antenatal and postnatal ward.

There were information boards on corridor walls in most clinical areas. There was a summary of user feedback, comments and actions taken. Details of how to get different types of support, make a complaint and give feedback. Boards also included photographs of staff with their name and role.

The service responded to the needs of grieving families. The bereavement midwife worked with women and families who had experienced a tragic loss during pregnancy or childbirth. They liaised with third party organisations, arranged cultural ceremonies, and provided parents with momentous to remember their babies. Leaders had identified an area off the labour ward to care for bereaved parents. The facilities provided a home from home setting where parents could seek solace and grieve with support. The area was well maintained, quiet and included the 'cold' cots so that parents who chose could see their babies.

Learning, continuous improvement and innovation

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

Leaders were committed to promote innovation and continuous learning to strengthen improvement. The unit had a project lead to oversee the maternity transformation programme and worked closely with integrated care systems for the local area. The unit used statistical tools to determine current changes the maternity service was making resulted in improvements.

Trends were monitored within clinical outcomes and key national initiatives such as Each Baby Counts (EBC), Saving Babies Lives Care Bundle (SBLCB2) and Avoiding Term Admissions into Neonatal Units (ATAIN).

Specialist midwifery services provided support for stop smoking and public health and contraception, pregnancy growth scanning, infant feeding and tongue tie, birth stories and debriefing, perinatal mental health, bereavement and baby loss and safeguarding for adults and children.

The service aimed to work within the vision of Better Births and on improving the safety of maternity services by working with external regulators, the Local Maternity and Neonatal Systems (LMNS) and the Clinical Negligence Scheme for Trusts (CNST).

There was specialist support for: home birth; young parents; and people with a history of diabetes. The trust had also introduced the continuity of carer model. Maternity services reported that they had achieved all 10 safety standards for CNST and personalised care plans had been launched for all women.

The PETALS project was launched in 2020 to support maintaining perineal health. The project was to reduce the incidence of obstetric anal sphincter injuries which can occur at birth.

The lead safeguarding midwife told the inspection team that they had worked alongside NHS England National Maternity Safeguarding Network, other agencies and volunteers to develop 'HOPE Boxes' for women who were to be separated from their babies due to safeguarding concerns. The HOPE Boxes contain photographs, footprints a letter and poem for both mother and baby prior to their separation to promote an ongoing connection during safeguarding proceedings and support the mother through potential grief.

Maternity

Outstanding practice

We found the following outstanding practice:

- The lead safeguarding midwife told the inspection team that they had worked alongside NHS England National Maternity Safeguarding Network, other agencies and volunteers to develop 'HOPE Boxes' for women who were to be separated from their babies due to safeguarding concerns. The HOPE Boxes contain photographs, footprints a letter and poem for both mother and baby prior to their separation to promote an ongoing connection during safeguarding proceedings and support the mother through potential grief.

Areas for improvement

Action the trust MUST take to improve:

- The trust MUST make sure that a formal prioritisation risk assessment tool is introduced on the triage telephone line and in the day assessment unit to safely assess women and pregnant people. Regulation 12.
- The trust MUST make sure women who were waiting to be seen within the day assessment unit have arrival times noted and are regularly reviewed with observations completed. Regulation 12.
- The trust MUST make sure medical and midwifery staff meet the trust target of 90% for safeguarding level 3 training. Regulation 12.
- The trust MUST make sure it improves 90% trust target staff compliance for basic life support, blood transfusion and mental capacity act training so that it meets trust targets. Regulation 12.

Action the trust SHOULD take to improve:

- The trust SHOULD make sure there is a standard operating procedure for the day assessment unit and for staff to be aware of the guidelines.
- The trust SHOULD makes sure all medicines are stored securely and safely.
- The trust SHOULD make sure all incidents are reviewed within 72 hours.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four CQC inspectors and two specialist advisors.

The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.