Countess of Chester Hospital NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Inspected but not rated
Are services well-led?	**Inspected but not rated**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We carried out this focused inspection of services provided by this trust as part of our continual checks on the safety and quality of healthcare services. We inspected Maternity services, we also inspected the well-led key question for the trust overall.

The Countess of Chester Hospital NHS Foundation Trust consists of a 600 bedded large district General Hospital, which provides its services on the Countess of Chester Health Park and a 64 bedded Intermediate Care Service at Ellesmere Port Hospital. It also hosts and delivers an integrated care partnership. The Trust has over 5,100 staff and provides a range of health services to more than 445,000 people per year from an area covering Western Cheshire, Ellesmere Port, Neston and North Wales.

The Trust is the main trust serving Western Cheshire and also provides services to approximately 30% of the population covered by Betsi Cadwaladr University Local Health Board in Wales. Welsh patients represent one fifth of the workload of the trust. At the time of the inspection the trust was arranged into three clinical divisions: urgent care, planned care and diagnostics and pharmacy division, plus support services.

We carried out this unannounced focused inspection because at our last inspection we rated the Well Led question overall as inadequate. Concerns were found in relation to maternity and trust-wide governance processes, which meant we served the trust with two warning notices under Section 29A of the Health and Social Care Act 2008. The warning notices told the trust that they needed to make significant improvements in the quality and safety of governance and safety process across trust services and significant improvements in governance systems relating to referral to treatment processes, implementation of the electronic patient record system and around the management of incidents, learning from deaths and complaints.

Please refer to our February 2022 inspection report for our findings about this service and the actions we have taken.

We did not inspect all the core services provided by the trust as this was a follow up inspection. We continue to monitor all services as part of our ongoing engagement and will re-inspect them as appropriate.

Our findings

We did not rate this inspection. We found:

Mortality reviews were not completed in a timely manner. There was limited overview and scrutiny of mortality reviews; this had resulted in reviews not been completed in a timely manner leading to delays in learning.

There were some systems in place for both strategic and operational governance, however these were not always operated effectively or completed in a timely manner, and there was a lack of support and overview at a higher level.

Whilst there were some systems in place to manage risks, there was an inconsistent.

application of risk management strategies and of operational oversight at board and senior level.

Clinical and internal audit processes were inconsistent in their implementation and impact.

The complaints system was not yet managed consistently and there was limited evidence of the learning applied to practice within the service.

The Electronic Patient Record system implementation had encountered a number of difficulties, which the trust was still working through regarding training, hardware and immediate functionality issues.

However:

Performance in relation to cancer care between March and May 2022 had improved the trust was in the middle when compared with other trust in the area for cancer treatment waits of less than 62 days at 67.9% of patients treated within the appropriate times.

Risks relating to medicines management through the EPR system, which were identified at the last inspection had been addressed by the trust, we noted that the system had been amended to ensure only those staff who were suitably qualified could prescribe and dispense medications.

There were significant plans in place to increase governance support across the trust and to improve risk management.

How we carried out the inspection

We carried out this unannounced follow up inspection of maternity services and elements of how well the trust was well led as part of our continual checks on the safety and quality of healthcare services. At our last inspection we rated the trust overall as requires improvement, we also inspected the well-led key question for the trust overall which we rated as inadequate.

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

Our findings

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements. This action related to all core services.

Trust wide

The trust must ensure recruitment to governance posts is completed to ensure oversight and monitoring of the service. (Regulation 12 (1)(2))

The trust must implement quality improvement systems and processes such as regular audits of the service's provided and must assess, monitor and improve the quality and safety of services. (Regulation 17 (1)(2)(a)).

The trust must ensure that significant improvement is made in relation to effective governance systems and processes relating to the timely identification, investigation and learning from incidents, complaints and patient death reviews. (Regulation 17 (1)(2)(a)(b)(e)).

The trust must ensure that staff are suitably trained on the electronic patient record system so that completed risk assessments can be accessed and patient safety is not put at risk. (Regulation 18 (2)(a)).

Maternity service

The trust must ensure that a rotational thermoelectrometry (ROTEM) machine for analysing blood samples to determine blood loss during a post-partum haemorrhage is available for point of care testing on the central delivery suite. (Regulation 12(1)(2)

Is this organisation well-led?

Not rated at this inspection

Leadership

Senior leaders demonstrated the necessary knowledge and skills. However, there were several new appointments to the board and the plans the board had developed had not yet had time to fully embed in order to provide evidence of their impact or sustainability.

At our previous inspection in February and March 2022 we saw that there had been several changes in the executive leadership, that the board had not yet fully developed clear oversite and that risks were not always effectively identified and managed by the board.

Our findings

At this inspection we noted that this continued to be the case. We found that there has been further movement and instability within in the board with a number of new board members relatively inexperienced within the NHS and at Board level.

At the time of the inspection, the substantive CEO was on extended leave and there was an acting chief executive in post until the end of ; they had joined the trust as director of nursing in May 2021. The deputy director of nursing was acting as director of nursing (DON) until the end of August 2022.

An acting medical director (MD) was in post following the previous MD leaving the trust in June 2022.

The trust had also recently recruited a new chief operating officer (COO) and director of human resources (HR), both commenced employment in March 2022. The previous HR director and COO had both worked at the trust in interim capacities.

The trust had also recruited a director of maternity [DoM] following the previous inspection; this provided a stronger voice for maternity at senior and board level. However, at the time of inspection, the DoM was only three weeks in post and had not yet attended a board meeting.

There had been board development days, but these were relatively new and had not yet fully impacted or developed to allow for a coherent senior leadership approach. Risks not previously cited to the board such as serious incidents were now cascaded through the trust and to the board. This was only effectively implemented in July 2022 and the practice and monitoring of outcomes had not yet embedded.

Since the last inspection the trust, a System improvement board had been put in place, led by NHSI/E. This board brought together senior leaders from the trust and key stakeholders to support and ensure delivery of the required improvements. The principle purpose of the System Improvement Board was to:

- oversee delivery of all outstanding actions arising from CQC inspections
- ensure the health and social care system works collectively to address the findings of the CQC , with partnership working core to delivery of improvements
- support the system with the development of a short, medium to long term costed improvement plan which can be delivered at pace and focuses on outcomes
- ensure there is appropriate governance and assurance for delivery of the system improvement plan
- support improving the culture in the organisation, ensuring the improvement plan has detailed approaches for cultural change inclusive of all staff
- ensure that quality improvements are aligned with financial recovery plans NHS England and NHS Improvement
- facilitate Trust and system assurance linked to delivery of the single improvement plan priorities and assess sustainability of improvement once resources/support is removed

Governance

There were arrangements for governance, however these were not always operated effectively or completed in a timely manner. External support had been obtained to review and assist in the improvement of governance processes throughout the trust. We found several areas where practice and improvements were not yet embedded.

Our findings

At our previous inspection in February and March 2022 we noted that governance arrangements were not fully developed.

There was a minimal governance team in place that mainly consisted of staff undertaking parts of governance roles in addition to their normal roles. At this inspection we noted local governance arrangements were having a minimal positive impact. However, there were significant plans to increase governance support with additional posts approved for recruitment. The recruitment for these posts had commenced but was not completed. Leaders within the organisation had determined and implemented a plan to increase governance capacity and to provide increased assurance and risk management to the board.

In some areas we saw that local governance arrangements were functioning but there was a lack of support and overview at a higher level. A number of new arrangements had increased reporting to the board in July and the board were cited on the risks that had previously not formed part of the assurance approach. Whilst plans were in place to improve these areas, at the time of inspection there was insufficient information over a 12-week period to allow a coherent understanding of patterns and trends in order to identify areas of improvement.

The trust had undertaken a procurement exercise to source a company to undertake a Well-Led review. This review was due to take place during February and March 2022; the outcome of this had not been completed at the time of this inspection.

Following the concerns identified at our previous inspection in 2022 the trust had produced a development plan. Some actions from this development plan were still in the process of being implemented at the time of the inspection. Some of the actions identified as being completed such as refresher training for staff in EPR which, was to commence on 27 June 2022 were found to have not commenced at the time of this inspection in July 2022. The trust was not meeting the actions they had outlined in their improvement plan and had not updated it to reflect the changes in their completion. Following the inspection, the trust updated their action plan to provide clarity of what had been achieved and the areas that still required additional input.

Management of risk, issues and performance

At our previous inspection in February and March 2022 we noted that risks, issues and poor performance were not always dealt with robustly and the trust was not safely and effectively managing the risk to some service users. At this inspection we noted that there were improvements in how risks were recognised, managed and monitored. However, the systems in place were not sufficiently embedded to ensure sustainable practice.

Whilst there were some systems in place to manage risks, there was an inconsistent application of risk management strategies and of operational oversight. This meant that timely action at board and senior levels in the trust to effectively manage concerns and reduce the risks, was not yet fully embedded.

However, risks, issues and poor performance were improving with some risks managed robustly and effectively. There were fresh systems to manage performance, however, these had not yet embedded and matured.

Examples included staff understanding and managing the EPR system. Training had not taken place across all staff at the time of inspection and there were limited audits as to the quality of the records. However, we found that staff had gained in confidence in using the system. There remained an inconsistent approach in making sure that patent risks were appropriately managed with some managers at a local level reviewing the risk management of every patient on their wards daily and other areas following the managers' daily audit of sample checking five ward patients each day.

Our findings

Risks relating to medicines management, which were identified at the last inspection, such as lack of controls or restrictions within the EPR system had been addressed by the trust. We reviewed 10 sets of patients records and noted that the system had been amended to ensure only those staff who were suitably qualified could prescribe and dispense medications.

We saw that there were minor improvements since the last inspection in reducing the number of patients waiting from referral to treatment. The trust had appointed an individual to lead on its recovery and ensure that they monitored how patients were supported whilst waiting for treatment.

NHS England data showed the total number of patients on the referral to treatment (RTT) waiting list at the trust had decreased slightly from 40,705 patients in total in March 2022 to 40,487 in May 2022.

The monthly average proportion of patients waiting less than 18 weeks from referral to treatment was 42.5% in March 2022, this had increased slightly to 43.7% in May 2022.

The trust had reduced all waits for 104-week open RTT pathways by end of June to 104 patients; all those outstanding had a clinical need or had requested later treatment. Information showed that by the end of August 2022, there was a plan to reduce this to four patients with a clear rational and support input for the remaining four patients The trust was also on target to reduce 78 weeks waiting by end of March 2023; the data demonstrated that the trust was on target to achieve this.

Performance in relation to cancer care between March and May 2022 had improved; the trust was in the middle when compared with other trust in the area for cancer treatment waits of less than 62 days at 67.9% of patients treated within the appropriate times. National data confirmed that the trust is currently sitting within the bottom quarter of trusts nationally at 57.5 in terms 62 day waits for treatment following referral.

The previous recovery plans developed during 2020 / 2021 had led to improvement in referral to treatment waiting times focusing in particular on those waiting for a significant period.

Trust data showed clinical validation of patients on the referral to treatment pathway waiting lists was still on-going across a number of specialties; including general surgery, orthopaedics and ear, nose and throat (ENT) surgery. Patents on the waiting list had been assessed to determine any risk factors associated with the extended waiting times for their treatment.

Information Management

At our previous inspection in February and March 2022 we identified significant concerns following the implementation of a new electronic patient record (EPR) system which had been launched in July 2021. Following that inspection, the trust produced an action plan as to how it would implement training support and auditing of the EPR system in order to provide relevant and safe support to patient care.

Some staff reported that they found the system unsafe as it did not identify risk assessments were due for review and did not provide an opportunity to plan, record and deliver patient centred care. Also, some staff continued to accessed data on multiple electronic and paper platforms. This meant that, for some staff, information was difficult to access promptly and might have provided limited assurance of effective information management. However; we did note that of the records we reviewed, only one had out of date risk assessments which was a significant improvement from the previous inspection.

Our findings

The system did not highlight special needs such as dementia, learning disabilities, individuals subject to a deprivation of liberty safeguard (DoLS). There was an additional tele tracking system that was available on each ward; this did contain some information such as forget me not flower to indicate someone with dementia care needs. However, the two systems were not integrated, and the tele tracking relied on staff inputting this information in the first instance. On some wards they were still using paper records and assessments as the staff were unsure what electronic records were available in the EPR system.

At the previous inspection there was risks identified regarding medicines management and the EPR. There was a lack of controls or restrictions within the EPR system which meant that all nursing staff and pharmacy staff had access to prescribing within the EPR system. This had been addressed and only staff who required access for prescribing could now access this part of the system. Staff were also able to check if prescribed medicines had been administered. The trust had developed and implemented a standard operating procedure to provide guidance for staff.

We found some risks relating to the implementation of the EPR had been logged as key risks in trust-wide and divisional or departmental risk registers. The improvement plan received from the trust highlighted a number of areas had been completed and addressed. We found that at this inspection these actions were not always accurately recorded as being completed.

The EPR implementation had encountered a number of difficulties, which the trust was still working through regarding training, hardware and immediate functionality issues. This meant that the trust did not have effective systems and processes to identify, assess and mitigate key risks associated with the implementation of a new electronic patient record (EPR) system.

Learning, continuous improvement and innovation

The management of complaints was not meeting the trust's own policies and procedures. There was a lack of embedded processes in the trust's management of complaints and mortality reviews. Leaders were aware and did state that there was significant progress to be made. Plans they had developed identified the areas for improvement and these were shared and monitored through the System improvement board.

Mortality reviews were not completed in a timely manner. There was limited overview and scrutiny of the mortality reviews, and this had led to delays in learning. Whilst on site, the trust found significant difficulty in accessing the reviews to submit to CQC. Two of the 17 reviews requested were made available and these took two to three days to be produced by the trust.

A review of these showed differing formats and no quality sign off either from the person completing the review or the Medical Director [MD] recorded on the document. However, the trust did produce a spreadsheet monitoring these reviews that highlighted how and when these had been reviewed. It was acknowledged by leaders that there still improvements required in order to increase capacity and effective review of any patient deaths.

Staff we spoke with were able to access and keep up to date information relating to patient risk assessments from the EPR. Staff monitored the number of completed risk assessments within the EPR. However, several reported that this was excessively time consuming and when they needed to undertake incident management reviews this could take a significant amount of time. We also noted that there was a lack of investigators within the trust to undertake reviews and this often took staff on the wards away from their daily duties in order to undertake time consuming reviews within their own areas of practice. These arrangements were not supporting staff to provide a robust, timely and objective review of those incidents that required it.

Our findings

We did see improvement in how the trust reported and investigated some serious incidents. In maternity services we found concerns in relation to managing the risks of Post-Partum Haemorrhage (PPH) and unplanned hysterectomy. The trust had reclassified these incidents, reviewed some incidents previously closed and put into place at a local level arrangement to review incidents in a timely manner. This had led to maternity services as an example improving their ability to understand patterns and trends and identified learning. However, these arrangements were not provided with support beyond the local level. Staff reported a lack of support to take quality improvements forward in a structured and meaningful manner.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Not rated	Not rated

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Countess of Chester Hospital	Requires improvement Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022
Ellesmere Port Hospital	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Overall trust	Requires improvement Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Not rated	Not rated

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for The Countess of Chester Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022
Services for children & young people	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Critical care	Good Jun 2016	Good Jun 2016	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016
End of life care	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Requires improvement Jun 2016	Requires improvement Jun 2016	Requires improvement Jun 2016
Outpatients and diagnostic imaging	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Surgery	Requires improvement Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022
Urgent and emergency services	Requires improvement Jun 2022	Good Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022
Maternity	Not rated	Not rated	Good Jun 2022	Requires improvement Jun 2022	Not rated	Not rated
Overall	Requires improvement Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022

Rating for Ellesmere Port Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Outpatients and diagnostic imaging	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016

The Countess of Chester Hospital

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Description of this hospital

Inspected but not rated

We did not rate this service at this inspection. The previous rating of inadequate remains.

How we carried out the inspection

We carried out this unannounced focused inspection because at our last inspection we took enforcement action and rated the service overall as inadequate. Concerns were found in maternity services and trust-wide governance processes, which meant we served the trust with two warning notices under Section 29A of the Health and Social Care Act 2008. The warning notices told the trust that they needed to make significant improvements in the quality and safety of healthcare provided in maternity services and significant improvements in governance systems relating to referral to treatment processes, implementation of the electronic patient record system and around the management of incidents, complaints and learning from deaths.

Please refer to our previous inspection report for more detailed findings of our February 2022 inspection and the actions we have taken.

During this inspection, we visited the delivery suite. We spoke with 15 staff including registered midwives, health care assistants, doctors, and senior managers. We reviewed five sets of patient records that covered patients who had experienced a post-partum haemorrhage, staff training and competency records and a range of policies, procedures and data.

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

Inspected but not rated

Is the service safe?

Inspected but not rated

Mandatory training

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

PROMPT training for post-partum haemorrhage (PPH) and unplanned hysterectomies now included a multidisciplinary team approach including anaesthetists. PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies.Staff confirmed that live scenario training was taking place with a full complement of staff including operating department staff from the main theatres who were rostered to provide support. Data received from April 2021 to March 2022 Obstetric Emergency Training Compliance by staff group was Midwives 91%, Obstetricians 96%, anaesthetists 100%, operating department personnel 93% and maternity support 100%. Leaders said training had now been fully implemented. All staff we spoke to including consultants confirmed that they had undertaken training. Information shared with the local maternity system (LMS) in July 2022 confirmed training requirements were compliant and the service had a validated training programme.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep women safe. Staff were trained to use them.

At our last inspection it was found the service did had enough suitable equipment to help them to safely care for women. On this inspection we found that the service had taken action to ensure both the main and maternity theatres had the necessary equipment to undertake an unplanned hysterectomy with staff who were appropriately trained to use them. Trained theatre staff were rostered to cover surgical procedures in the maternity theatre and could be bleeped in an emergency with twenty four hour cover, seven days a week. Midwives and doctors said this had worked well since implementation. This was an interim measure until the maternity had its own trained staff.

However, a rotational thromboelastometry (ROTEM) machine was only available in the main hospital theatre. ROTEM provides a rapid assessment of the efficiency of blood coagulation at the point-of- care (POC). It is performed near the patient during surgery or when admitted following trauma. Staff told us a business case was going forward to purchase a second ROTEM machine that will be permanently situated in the central delivery suite to assess the blood of women experiencing a post-partum haemorrhage (PPH). In the interim the service had theatre runners to ensure that should the ROTEM test be needed this did not remove maternity staff at the point of care on the central delivery suite. A risk assessment for this was said to have been undertaken by the senior leadership team and could be performed in approximately seven minutes. Staff reported this was not the recommended pathway as determined by the point of care testing as the test determines the pathway the clinicians follow to manage the PPH. Managers said it took several minutes to get the blood sample results. Evidence of a risk assessment was requested but not received. There was now signage to ensure staff could locate the equipment.

Assessing and responding to patient risk

Maternity

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

We reviewed five patient records of women who had experienced a PPH and noted risk assessments for women at risk of a PPH had been documented at the booking ante-natal appointment.

Appropriate monitoring and escalation management of PPH had been implemented using the all Wales pathway which is a recognised tool developed by the Obstetric Bleeding Strategy (OBS) Cymru (Wales).

There was access to additional twenty-four seven emergency surgical intervention with a new standard operating procedure which had been written by a multidisciplinary team of surgeons and vascular surgeons to support maternity procedures. This has been peer reviewed and was waiting imminent ratification.

Theatre staff were rostered to cover surgical procedures in the maternity theatre and could be bleeped in an emergency with twenty-four hour, seven day a week cover. Midwives and doctors said this had worked well since implementation.

The service had worked with the blood transfusion service; the major haemorrhage protocol has been amended to ensure women at risk of PPH were screened for blood antibodies should they require an emergency blood transfusion. An electronic blood match could be completed in five minutes to avoid delay and units of blood stored for an emergency. The blood fridge was to be moved to central delivery suite for quicker access.

Incidents

The service recognised and managed all incidents that were significant in relation to post-partum haemorrhage (PPH) and hysterectomies. Managers could not always investigate incidents and share immediate lessons learned with the whole team and the wider service. When things went wrong, the service could not always carry out a timely duty of candour and could not evidence that women were involved in incident investigations.

At our last inspection the service could not be assured that it recognised and addressed incidents that were significant in relation to PPH and hysterectomies, appropriately classifying them or learning lessons from them.

Following an exercise of complete PPH mapping the service had made significant progress and now recognised and addressed incidents that were significant in relation to PPH and hysterectomies. There was a clinical obstetric lead for all PPH and unplanned hysterectomy incidents with weekly update reports produced as to their progress.

There was new guidance and training for staff to ensure PPH was appropriately identified, categorised and reported. For example, all PPH of over 500mls was automatically incident reported and reviewed. All PPHs over 1.5 litres was investigated using a rapid review tool known as 72 hour review to identify learning and take immediate measures if required.

Managers investigated incidents. Staff said women and their families were involved in these investigations at the point from a duty of candour. Weekly incident meetings were held with senior clinical staff to ensure oversight of incidents and the undertaking of 72 hour reviews. All logged incidents were reviewed, prioritised and checked for correct classification to ensure they were allocated to the most appropriate clinical lead for investigation. We reviewed meeting minutes, datix logs and a sample of rapid review reports that confirmed oversight and management of incidents. However, staff said there was a back log of 20 incident investigations due to staff capacity to complete them.

Maternity

All incidents classified as moderate or above followed the duty of candour process and patients and relatives were invited to be part of any investigation. Information and support was said to be offered to patients and/or their families involved in investigations as met their needs. Staff gave us examples when this occurred.

However, this was not always timely due to capacity and a backlog in incident investigations and staff could not provide clear documentation to confirm this process was effective. Leaders said this was because new appointments to the governance team were not yet in post. Senior clinical staff with oversight of incidents did not always have capacity to progress 72 hour reviews and incidents for root cause and analysis. Issues regarding escalation of serious incidents was highlighted in June 2022 in the women and children's governance meeting report. Serious incidents were said to be prioritised. Senior leaders said staff were being supported and have had some input from a midwifery experienced agency staff and band 5 to support on the data work. A new appointment to the governance maternity team would be in post by early September. A business case has also been approved to appoint two band six midwives on secondment to support the governance team.

Audits for incident data in May 2022 showed there were 10 incidents of PPH of more than 1500mls compared with six incidents of PPH of more than 1500mls in March and in April. Although this was an upward trajectory, implementation of the all Wales pathway, improved blood loss measurements, weekly incident reviews and correct classification meant that there was better recording and monitoring of PPH incidents. However due to the back log of incidents for review staff said it would take more time to determine a sustained downward trajectory of PPH incidents.

It was confirmed there have been no unplanned hysterectomies since April 2022 following a PPH indicating improved management of PPH.

Although data indicated there had been three unplanned hysterectomies since the last inspection, we found that these three incidents had been reopened and reinvestigated as they were initially classified as no or low harm. The service had determined that unplanned hysterectomies would now be classified as moderate harm or above and appropriately investigated.

The was a clinical oversight lead for all PPH and unplanned hysterectomy incidents. Incidents had to be reviewed and quality checked at triumvirate meetings before being closed.

Since the last inspection a dedicated spotlight on PPH was featured in the monthly news bulletin for obstetrics and gynaecology for sharing and learning together. There had also been labour ward meetings and monthly maternity events. Staff said incidents and learning was shared in daily handover meetings, safety huddles and emails. Single point of learning had also been introduced in the form of single page bulletins with pictorial images to support learning. Information boards and posters were clearly displayed to reinforce information and learning. Safety briefings we reviewed also showed discussion with staff had taken place.

Is the service effective?

Inspected but not rated

Staff were improving monitoring the effectiveness of care and treatment and were using the findings to make improvements to outcomes for women.

Maternity

The service was making progress in monitoring the effectiveness of care and treatment but this was still work in progress due to staffing pressures and the pending appointment of a dedicated maternity governance team.

The service was working towards improving its maternity dashboard and had appointed a data midwife who was ensuring the digital team were prioritising the maternity information required.

As part of the monthly care metrics audit, which were based on a range of best practice reports and recommendations including Saving Babies Lives, senior staff audited a sample of 10 sets of patient records to ensure staff also completed and updated risk assessments and followed the PPH pathway. Records were audited from booking and reviewed in labour to ensure that women at higher risk were consistently reviewed.

The appointment of a digital midwife has made positive progress in using information from data sets and returns.

However, until such time that there was robust data available from repeated audits and completed incident investigations, managers and staff could not be completely assured of the impact improvements had made.

Competent staff

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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

The service has updated competencies and training for all staff relevant to their roles.

Staff confirmed that PROMPT training, including the management of a PPH, had a full complement of the required multidisciplinary team members including mandatory attendance for anaesthetists. Staff confirmed they had undergone a range of additional training including, reporting and classifying incidents, introduction of the All Wales pathway, Bakri balloon insertion and correct measurement of blood loss.

Level one incident training as of June 2022 was 70% in the women and children directorate since its roll out in April. Figures requested were not broken down or provided for maternity staff specifically.

We reviewed five staff competency records and found them to be up to date.

Multidisciplinary working

Doctors, midwives, theatre staff nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care

Staff said that multidisciplinary working had improved significantly since our last inspection with a multidisciplinary involvement in implementing the PPH pathway. Changes included, theatre staff providing scrub support twenty four hours a day and a change to the bleep system to include operating department personal (OPD) and scrub nurses to attend in an emergency. A standard operating procedure (SOP) has been written by a MDT of surgeons, anaesthetists and vascular staff. It included the provision of two additional consultants who could be called in an emergency from surgical or vascular to support in the management of a PPH if required. This SOP was waiting for approval and sign off from the board.

Maternity

Inclusion of haematology and blood transfusion staff in multidisciplinary training has facilitated the quick turnaround of blood sample assessments and blood cross-matching in the event of a PPH.

Is the service well-led?

Inspected but not rated

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

The service had recently appointed a head of maternity (HoM) and a director of midwifery (DoM). Staff said they were visible, approachable and supportive. We were told that the DoM HoM would be present at all board meetings to ensure representation on maternity service delivery.

The maternity action plan was monitored by the women and children's committee. A monthly report was produced by the quality governance manager for women and children directorate and reported to the quality and safety committee. The DoM had accountability for a number of actions on the action plan.

Governance

Leaders were implementing effective governance processes, throughout the service and with partner organisations. Staff at service level were clear about their roles and accountabilities and had regular opportunities to meet. However, these changes were yet to be embedded and required additional staff to ensure this happened.

The service has recognised and addressed incidents that were significant in relation to PPH and Hysterectomies. Local governance meetings made up of senior staff from the maternity unit were held weekly. Staff said this was an interim measure until a dedicated maternity governance team was in post. Two posts had been advertised with one successful candidate due to start in September. The service had a business case approved to second two band 6 midwives to band 7 governance posts until further permanent posts were appointed to. Senior clinical staff had current oversight of incidents and 72 hour review investigations. Clinical leads told us they were struggling to keep on top of incident investigations due to clinical work pressures with a reported back log of around 20 incidents. Without the oversight of the governance team it was difficult for leaders to extract data to assess the effectiveness of any improvements implemented or to ensure the right themes could be identified.

Staff said monthly PPH implementation multidisciplinary team meetings were taking place to discuss and update the action plans.

Management of risk, issues and performance

Leaders and teams were improving the use of systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Maternity

Since our last inspection, the service had implemented the All Wales pathway in April 2022 and was following the updated guidance. The service had updated policies and procedures for PPH and hysterectomy management. It had put processes in place to manage risk and was recognising and escalating risks. The all Wales pathway has been implemented with appropriate learning and training implemented.

An action plan, following the warning notice from our last inspection, was in place which was reviewed and updated monthly to determine effective progress and mitigate potential risks. The action plan in July 2022 showed 13 of the 26 tasks had been completed with a further 12 actions on track to be fully completed in the time scale set. One action was completed but needed ratifying by the board.

Staff we spoke with confirmed that the all Wales pathway was being followed. We reviewed five records of women who had experienced a PPH and found that the pathway had been followed from ante-natal booking, with appropriate risk assessments. PPH management following labour including escalation was well documented and datixed where required.

Evidence reviewed demonstrated that the service was reporting incidents to external stakeholders with incidents being correctly datixed and reported as needed. All PPH and hysterectomies were being reported and shared with external stakeholders

Senior staff audited 10 patient records monthly to ensure all were staff following the policy for the PPH pathway.

Information Management

The service was improving the collection of reliable data and analysed it. Progress was being made so that staff could find the data they needed, to understand performance, make decisions and improvements. Improvements were being made to the availability of data to submit to external organisations as required.

There had been the appointment of a digital midwife who had made positive progress in using information from data sets and returns and improving the maternity dashboards.

Senior staff said initial findings from data over a three month period was indicating that there was a reduction in PPH incidents. However, delayed incident investigations and the lack of available data meant that the service could not always be assured that measures implemented were being effective.