North West Anglia NHS Foundation Trust

Peterborough City Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Peterborough City Hospital

Requires Improvement ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Peterborough City Hospital.

We inspected the maternity service at Peterborough City 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.

Peterborough City Hospital is based in Peterborough and is part of the North West Anglia NHS Foundation Trust. The hospital provides maternity services to women living in the city of Peterborough, North Cambridgeshire, areas of east Northamptonshire and Rutland.

The Peterborough City Hospital maternity unit comprises of a maternity day care unit, antenatal clinic, maternity ward (antenatal and postnatal), transitional care ward, triage unit, delivery suite, maternity led unit, home birth service and a community midwifery service. Additional antenatal and postnatal services are provided at the sister site, Hinchingbrooke Hospital. From March 2022 to February 2023, there were 4,111 deliveries at the trust.

We last carried out a comprehensive inspection of the maternity service in 2019. The service was rated requires improvement for safe, good for effective, caring, and responsive and inadequate for well-led. The service was judged to be requires improvement overall.

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

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

We did not review the rating of the location therefore our rating of this hospital stayed the same

Peterborough City Hospital is rated Requires improvement.

We also inspected the other maternity service run by North West Anglia NHS Foundation Trust. Our reports are here:

Peterborough City Hospital - https://www.cqc.org.uk/location/RGN80

Hinchingbrooke Hospital - https://www.cqc.org.uk/location/RGN90/

Maternity

Good ↑

Our rating of this service improved. We rated it as good because:

- There has been significant improvement to the maternity service since the last inspection and the trust had addressed our concern around risk assessments, storage of medicines and oxygen, documentation and storage of patient records and infection prevention and control. There has been improvement in the management of equipment, governance, development of a maternity strategy, appointing a maternity non-executive director, addressing long term plan to resolve long term risks and leaders' oversight on issues in the service.
- Staff had training in key skills, and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- Not all women received one to one care during active labour.
- Not all women were seen in a timely way on arrival in triage.
- There was inconsistency in the documentation of women's arrival and admission time in the triage paper and electronic records.
- Although staff were up to date with their safeguarding training, not all staff had attended their formal safeguarding supervision.
- Training updates did not always meet trust targets such as for fetal monitoring competency.

Is the service safe?

Good ↑

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Ninety-two per cent of staff had completed all 38 mandatory training courses against a trust target of 90% as of 03 April 2023.

Maternity

The service made sure that staff received multi-professional simulated obstetric emergency training. Training data showed 92% overall compliance as of 3 April 2023. Ninety-one percent of staff had completed the neonatal resuscitation training during inspection. However, data showed that 84% of staff had completed the fetal monitoring study days and 79% had compliance with the fetal monitoring competency test against the trust target of 90%.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training. The service aligned training modules to the requirements of the Clinical Negligence Scheme for Trusts (CNST) which contained the saving babies lives care bundle and recommendations from the Ockenden review. The education team and senior managers reviewed the staff training needs analysis to ensure it reflected the needs of the service and learning from complaints and incidents. The education team monitored training compliance and kept a record of the maternity services trust-wide data.

The service had trained all midwifery support workers and health care assistant working on the postnatal wards in safe bathing of babies and breastfeeding to support women, birthing people, and babies.

At the time of the inspection, 3 midwives had completed the postgraduate midwife sonography course and 1 midwife had completed the 3rd trimester sonography training programme. Two midwives had also completed the birth trauma training to support women that had experienced trauma during delivery.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that 88% of staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. Data also showed that 98% of staff had completed the prevent radicalisation awareness training. However, not all staff fully engaged with the safeguarding supervision. Records showed that safeguarding supervision for midwives was poorly attended from June 2022 to March 2023.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Maternity

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. The service had specialist safeguarding midwives with designated roles such as in female genital mutilation (FGM), substance misuse, autism, prison and learning disability. The safeguarding team carried out daily walkarounds within the service to support staff and to capture any safeguarding cases or concerns. They also supported staff with discharge planning meetings, drafting safeguarding reports and attending safeguarding meetings such as crisis management meetings and case conferences.

Care records detailed where safeguarding concerns had been escalated in line with local procedures. Where there were safeguarding concerns, a safeguarding flag was put on women and babies' electronic records and highlighted any safeguarding concerns they had in the confidential notes section on the patient record.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted, within the 12 months before inspection.

The service held regular safeguarding and mental health clinics to support women and birthing people with safeguarding and mental health concerns.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were systems to ensure the deep cleaning and decontamination of rooms following a discharge or transfer.

The service generally performed well for cleanliness. From September 2022 to February 2023, the service achieved an overall 96% compliance in the cleaning audit.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last year, compliance was consistently above 98% for the hand hygiene audit and 97% for the infection prevention and control audit.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas for staff, patients, and visitors to use. We observed staff applying hand sanitising gel when they entered clinical areas.

Environment and equipment

Maternity

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the bereavement room was not soundproof and did not fully comply with national guidance.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system, which reduced the risk of baby abduction. This was an improvement from the last inspection.

The service carried out regular risk assessments including an environment ligature and self-harm risk assessment of the maternity areas. A ligature risk assessment was last carried out 14 March 2023.

Staff carried out daily safety checks of emergency and specialist equipment, this was an improvement from the last inspection. Records showed that resuscitation equipment outside maternity theatres was checked daily.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment such as sonicaids and bladder scanners to help them to safely care for women and birthing people and babies. For example, in the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

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

The service had a dedicated and furnished bereavement suite to care for bereaved mothers and their families up to discharge. The suite included a cold cot, cuddle cot, Muslim family boxes, memory boxes, hand and footprints kit, blankets and Moses' baskets, to support bereaved mothers, birthing people, and families in line with national guidance. However, this facility was not soundproof in line with national guidance and located between the triage waiting room and triage area and labour ward. This meant that bereaved women, birthing people, and their families could hear conversation of women as triage is a busy area. Staff told us there was plan to move the bereavement suite to another area of the service but they were not sure of the timeframe for the improvement.

There was a mortuary fridge on the labour ward next to the bereavement suite for the safe keeping of a deceased baby whilst the parent was still admitted on the ward.

Labour ward had a designated room to care for high risk and twins' babies. The labour ward also had a designated latex free room to care for women that may have allergic reactions to latex.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration. This was an improvement from the last inspection.

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. Staff also used the Newborn Early Warning Trigger and Track (NEWTT) national tools to assess and identify deterioration in newborn babies. We reviewed 7 MEOWS records and 5 NEWTT records and found staff correctly completed them and had escalated concerns to senior staff. Staff completed a regular audit of records to check they were fully completed and escalated appropriately. Staff achieved 100% compliance in the March 2023 MEOWS audit. Audits from November 2022 to March 2023 showed 100% compliance in the NEWTT audit.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage. The service had implemented a new system in December 2022 for the prioritisation of women that presented to triage. This was an improvement from the last inspection. The service had a maternity helpline located in the service which was manned by two midwives between 8am to 8pm and outside hours, this was directed to triage. The maternity triage waiting times audit for November 2022 to March 2023 showed 65% of women were seen within 15 minutes and 83% of women were seen within 30 minutes of arrival. We note that the percentage of women seen within 30 minutes has increased by 23% compared to the average 9 months before the implementation of the new triage prioritisation tools.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. For example, service data showed 99% compliance on venous thromboembolism (VTE) assessments from November 2022 to March 2023. Staff used the 'fresh eyes' approach to carry out fetal monitoring safely and effectively. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The 2022/2023 quarter 3 maternity trust wide audit showed clear indication of CTG and management plans following CTG in 100% of cases however staff completed 'fresh eyes' at each hourly assessment in 79% of cases. Action plans were in place to improve outcome.

There was evidence of carbon monoxide testing in the women records we reviewed. This was an improvement from the last inspection however the trust was not meeting this outcome in the CNST audit. The trust CNST live data showed 90% compliance in carbon monoxide testing of women. There was an action plan in place to address this. For example, the trust had purchased new monitors and reminded staff on adherence to the documentation of this test on patients records.

From December 2022 to March 2023, staff achieved 100% compliance in the World Health Organisation (WHO) surgical checklist audit. This was an improvement from the last inspection.

Women were offered screening for infectious diseases, such as hepatitis B and syphilis. Women were also offered influenza (flu) and pertussis (whooping cough) vaccination in pregnancy, which was in line with national recommendations (NICE Antenatal care for uncomplicated pregnancies: CG62, updated January 2017). The antenatal handheld records we reviewed confirmed this.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

Maternity

The service provided transitional care for babies who required additional care in a designated 14 bedded transitional ward.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets.

The service ran regular specialised clinics to support women identified with risks to ensure patient safety and improved outcomes. This included high risk consultant clinic for diabetes, fetal medicine service, glucose tolerance test service, preterm clinics, multiple births clinic, anti-d clinics, mental health, vaginal birth after caesarean clinic, smoking cessation service, and breast feeding.

Staff had completed several specific trainings on various topics such as sepsis, blood transfusion, fire safety, immediate and advanced life support, neonatal resuscitation skills to ensure they were competent to manage and minimise safety risks to women, birthing people and babies.

Newborn checks were mainly completed by the paediatrician and advanced neonatal practitioner. The service had also trained some midwives on the 'Newborn and Infant Physical Examination' (NIPE) programme which was carried out within 72 hours of birth. Staff told us there was always a trained NIPE midwife on each shift. Women were given a scheduled time for the newborn checks of their baby which helped improved access and flow in the service and ensure timely checks of newborn to minimise risk.

Contraception was available in the service to give to women following birth and midwives had been trained on how to administer contraception.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers. Staff used the SBAR (Situation Background Assessment and Recommendation) algorithm in the initial intrapartum risk assessments and to update their colleagues and handover care throughout the unit and recorded this on the electronic patient records. From December 2022 to 14 February 2023, staff achieved 91% in the SBAR audit against a trust target of 90%.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles in a shift to ensure all staff were up to date with key information. An electronic handover board was used during handovers and each member of staff also had an up-to-date handover sheet with key information about women and birthing people. However, the handover did not consistently share information using a format which described the situation, background, assessment, recommendation for each person during handover. The morning safety huddles, and ward rounds did not use a formal proforma and were not protected from interruptions. Following the inspection, the trust informed us that the service had a proforma which was displayed on the wall of the handover meeting room and should be used by staff during the safety huddle and documented on the electronic record system. However, we observed the format of the huddle did not cover the expectations of the proforma poster during inspection.

Discussion during ward rounds was not always focused, coordinated and half of the multi-disciplinary staff present were observed having conversations that was not work related.

Although there has been significant improvement in triage however there were areas of improvement identified during inspection. There was inconsistency in the documentation of women's admission to triage in the paper and electronic record. We observed that while staff documented the time of arrival and admission of women on the paper records this was not always documented in the electronic records. This was not in line with the trust maternity triage guideline. The midwives did not always record the time they assessed women on the paper and electronic records. The audit lead only pulled information for the triage audit on the electronic record.

We also observed that some women that presented to the day assessment units and required a scan review were sometimes directed to triage for review at the request of some doctors. This sometimes had an impact on access and flow in triage when the unit was busy. This was not in line with the triage exclusion criteria detailed within the trust triage policy.

Midwifery Staffing

The service mostly had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment on each shift. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. In December 2022, the service reported 10% red flag shifts incidents, which was an improvement from October 2022 (37%). The red flags were reviewed regularly throughout the shift and gaps were covered using temporary staff or redeployment of staff to clinical areas. This resulted in 98.3% shift covered in December 2022 following escalation.

For the period of November 2022 to March 2023, 95% of women received one to one care during active labour against the trust target of 100%. The service had action plans in place to address this. We note that compliance had increased by 3% compared to the previous 8 months (April to October 2022).

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. They completed a maternity safe staffing workforce review in line with national guidance in November 2021. This review recommended 137.32 whole-time equivalent (WTE) inpatient midwives Band 3 to 7 compared to the funded staffing of 129.52 WTE, a shortfall of 7.8WTE staff.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. From January to February 2023, the service reported an average 98% compliance in the supernumerary status. The maternity dashboard showed that the service achieved 99% compliance in January 2023, which was slightly lower than the 100% CNST standard but greater than the trust target.

The service also had a manager of the day cover on each shift, which was implemented in September 2022 as part of the trust mitigation to ensure safe staffing in the service.

The ward manager adjusted staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas and acuity.

During inspection we noted that the number of midwives and healthcare assistants matched the planned numbers.

The service had high vacancy rates, sickness rates and high use of bank nurses. At the time of our inspection, the vacancy rate was 18 whole-time equivalents (WTE) for midwifery staff. Staff told us there had been an increase with staff sickness and were related to stress. As a result, the service had implanted a pocket size booklet with information on the available mental and occupational health provision in the trust. The service also had mental health first aiders available to support staff and a return to work support programme to support staff.

The service had a recruitment and retention plan and had recently recruited some preceptor midwives and 9 international midwives.

The midwifery staffing for inpatient areas had improved in recent months as managers used temporary staff to fill gaps in rotas or unfilled shifts due to sickness. There were available incentives for bank and agency staff to ensure unfilled shifts were covered. The service had recruited new midwifery staff, but some were still in the supernumerary period.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. The overall appraisal rate for the maternity service was 71% at the time of inspection. We note that compliance for the antenatal ward was 94% during inspection. Staff we spoke to during inspection had completed or booked their annual appraisal. A practice development and education team supported midwives.

Managers made sure staff received any specialist training for their role. For example, some midwives had received funding for specialist training including masters level courses in advanced midwifery practice, professional midwifery advocate course, sonography courses and contraception courses.

The service held a daily student safety huddle to support student midwives in the service. This initiative was implemented in response to previous concerns raised by student midwives and the Health Education England action plan. Student midwives and staff spoke positively about this initiative and how it has helped improved student experience.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff.

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

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. Leaders followed the Job Planning Policy for Consultants and SAS Doctors Version 7.

The anaesthetic rota was compliant with ACSA standard 1.7.2.1 and the maternity service had a dedicated anaesthetist 24 hours a day, 7 days a week to cover labour ward for elective and emergency caesarean sections.

The service always had a consultant on call during evenings and weekends. The service made sure there was a consultant on site from 08:30 am to 9.30 pm from Monday to Sunday in the maternity service. There was a separate onsite consultant cover for early pregnancy unit from 8.30am to 1pm and a separate cover for the elective section list Mondays to Fridays. Out of hours, consultants managed the rest of the on-call cover from their home location which was within 30 minutes of the hospital site.

Data supplied by the trust showed there were 13 whole time equivalent (WTE) consultant obstetricians based at Peterborough City Hospital and 2 additional consultants worked cross site. There were 14 WTE registrars and 9 WTE senior house officers (SHO) working in the maternity and gynaecology service at the time of this inspection. The service was in the process of appointing 1.6 WTE registrars. After the inspection the trust advised that they have recruited and expect a full establishment of doctors by August 2023.

The service had 1 senior house officer (SHO) covering and 2 registrars covering the maternity wards, labour ward, gynaecology wards and early pregnancy units with the support of a consultant. There was a separate SHO that covered the gynaecology service until 5pm weekdays and 12pm on weekends. The service also had an additional SHO covering the maternity triage. Junior medical staff felt supported by the consultants and consultants responded promptly to any obstetric concerns.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 7 paper records and found records were clear and complete.

Women and pregnant people accessed their care records electronically, unless they were booked at another hospital that only used paper records in which case those patients bought their care records to each appointment. This was in line with the NICE Antenatal care for uncomplicated pregnancies guideline (2019).

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

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets. This was an improvement from the last inspection.

We observed and staff told us they had enough mobile computers which were used to document patient's records by the bedside.

Staff achieved an overall 97% compliance on the spot-check documentation audit from November 2022 to March 2023.

Medicines

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

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

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

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

Staff stored and managed all medicines, oxygen cylinders and prescribing documents safely. This was an improvement from the last inspection. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems for the 7 sets of records we looked at were fully completed, clear, accurate and up-to-date.

Staff learned from safety alerts and medicines incidents to improve practice.

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 and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic

reporting system. Training data showed that 99.8% of staff had completed major incident training and the electronic incident reporting system training at the time of inspection. Staff reported a healthy incident reporting culture, and we observed incident trends and lessons learnt were displayed in the clinical governance staff notice boards in all areas during inspection. From February 2022 to February 2023, the service reported 2,162 incidents.

We reviewed 4 incidents reported in the 3 months before inspection and found them to be reported correctly.

The service had no 'never events' on any wards.

Staff reported serious incidents (SIs) clearly and in line with trust policy. From July 2022 to January 2023, the trust reported 12 SIs in the maternity services. This related to still births, neonatal deaths, intrauterine deaths, babies born in poor condition and baby cooling.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. The service held monthly risk meetings where they discussed serious incidents and incident reviews including those referred to the Health and Safety Investigations Branch (HSIB) and the National Perinatal Mortality Review Tool (PMRT) which is designed to provide parents with high quality investigations and highlight lessons learnt.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 3 investigations, managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. For example, the rate of women who had a post-partum haemorrhage (PPH) of 1,500 millilitres or more was higher than the national average and in the highest 25% of all organisations. Further education and training were completed. To reduce the risk and incidence the leadership team had approved an external review by utilising their external obstetrician and an external midwife. The lead anaesthetist for maternity was also involved in the review.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed. The March 2023 maternity report showed 100% compliance in completion of duty of candour from February 2022 to February 2023.

Staff received feedback from investigation of incidents, both internal and external to the service. This was an improvement from the last inspection. For example, learning and themes from recent serious incidents and HSIB reports include escalation, psychology safety, CTG and importance of sepsis 6 care bundle. Staff had also received training on Sepsis 6 care bundle and 94.2% of staff had completed the sepsis face to face and competency training. The December 2022 patient safety newsletter included lessons learnt around sepsis and importance of calculating birth centile. Throughout the maternity areas, we observed that the maternity safety champion board education and PMA teams updated the quality boards with current information, shared learning and the most recent themes highlighted in recent reviews. The trust was carrying out a maternity trust wide thematic review on CTG from 2021 onwards to review obstetric cases to learn from incidents, review their process and monitor quality assurance.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people.

Maternity

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medication incident. The education team had also introduced an initiative where learning from incidents were shared with staff in a video format via their closed social media pages. Staff spoke positively about the videos and how it has helped kept them in the loop and met their learning styles.

Managers debriefed and supported staff after any serious incident. The professional midwifery advocate, managers and consultants debriefed staff after serious events. The trust had introduced a pastoral service for staff who may need additional support.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

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

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

There was a clearly defined management and leadership structure. The hospital maternity leadership team consisted of an interim director of midwifery, a clinical director, a general manager, and a head of midwifery. The team had been appointed within the last year and worked together to review the maternity vision and strategy to ensure it was aligned to national policies and processes. A new permanent director of midwifery had been recruited and planned to start in May 2023. A business co-ordinator, matron, specialist midwives and several personal assistants supported the maternity leadership team. Thirteen consultant leads worked trust-wide and were assigned to various aspects of maternity and gynaecological care. The service included 8 lead midwives a named midwife for safeguarding and various departmental managers.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matron. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were. Staff felt there had been improvement in the service due to change in the service leadership team.

The service was supported by maternity safety champions and non-executive directors. Since the last inspection the maternity service now had a non-executive director attached to the service. The chief nurse was one of 15 safety champions who worked across obstetrics and neonatal services, and they were supported by a non-executive director. Their role was to act as ambassadors for safety and facilitate communication from ‘floor to board’. Staff told us the maternity safety champions regularly carried out a walkaround of the maternity service.

The service leaders told us they had good direct access to the trust board, and this worked very well. We saw from the minutes of board meetings that the trust board had oversight of the maternity service performance and received presentations regularly on the service progress to national maternity safety recommendations. For examples some midwives have completed master's programme in advanced clinical practice (ACP), leadership safety course, advanced sonography course and leadership courses.

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

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and had reviewed and written a draft of an updated vision and strategy to include these recommendations.

The maternity strategy focused on patient safety, embedding women's voice and individual needs in patient care, and delivering an outstanding service through an outstanding team. The vision and strategy were focused on positive and safe experience for women, sustainability of services and aligned to local plans within the wider health economy. This was an improvement from the last inspection where the service did not have a maternity strategy.

The strategy was supported by digital solutions, system working, robust governance and accountability frameworks and learning. Meetings had been planned so that the updated draft vision and strategy could be discussed with the local Maternity Voices Partnership (MVP) and a final version was due to be published during April 2023.

Leaders and staff understood and knew how to apply them and monitor progress.

Culture

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

There were high levels of staff satisfaction across all equality groups. Staff were proud of the organisation as a place to work and speak highly of the culture. Staff including students and junior doctors felt respected, supported, and valued. Staff were positive about the service and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

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Staff spoke positively about the safety culture, collaborative working, and supportive relationship between multi-disciplinary team (MDT). There were opportunities to learn together and staff said there was no hierarchy among MDT staff. Staff told us there was equal opportunity to progress in their career. Several junior and senior staff had been working at the trust for years and staff felt that there were opportunities to progression and career development. We saw examples of staff who had progressed to a leadership over the years from junior staff, student midwives, and trainee doctor roles.

The professional midwifery advocate (PMA) had an open door policy and fostered positive working relationships. Their role was to provide visible leadership and act as a role model to promote effective safe care and treatment. The PMA listened to staff and would draw upon their knowledge skills and experience to empower staff in both their professional and personal development. They supported revalidation attended weekly meetings and had monthly catch-up sessions with the head of midwifery and produced a quarterly report for the clinical governance team.

The service cared about its staff and because of issues with retention and staff satisfaction had produced and implemented a cultural framework which was monitored by leaders and human resources. There were accountability pathways and different work streams to help recruit and retain staff and ensure they were well supported. The trust supported locum staff with accommodation that came to work in the service for a few shifts that lived outside the region. The service supported staff and their well-being through various medium such as access to occupational health, health and wellbeing midwife and preceptor and retention midwives.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice. Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

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The service celebrated staff and team success and supported good staff practice through an appreciation board initiative system, thank you cards and staff awards. Leaders implemented recognition boards and encouraged the implementation of a staff council.

The trust introduced a daily student safety huddle system to offer support and receive feedback from students to improve their learning experience in this service. This was put in place following poor experience from students in the past which resulted in the service being put on the Health Education England (HEE) action plan. Following significant improvement on the student's experience, the service had been taken off the HEE improvement plan.

One of the midwives in the Peterborough Hospital created the 'Raham Project' aimed at engaging with mothers and their partners from ethnic backgrounds who had recently used or currently using maternity services to improve their experience and tackle health inequalities. Women and birthing people from ethnic backgrounds were provided with support and information relating to pregnancy, childbirth, post birth and emphasized on maintaining and improving maternal mental health and wellbeing. The project also focused at providing advocacy, create mental health and cultural awareness for healthcare professionals and public, provide a support network and create a non-judgemental and safe space for mothers and partners from ethnic backgrounds to access support. The project had engaged with the women and birthing people through social media, listening events, private support group and sharing their annual reports. Since the project was launched, the service had also offered support to women and birthing people across the United Kingdom.

Governance

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

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

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

The service held various governance meetings which fed into the maternity quality committee and were reported to the trust board. This include serious clinical incidents governance group meetings, maternity safety champions meetings and maternity quality committee meetings. The review of risk management, guidelines and audits fed into the quality committees quarterly report.

Governance meeting agendas included discussion around all aspects of governance and oversight of the service such as performance data, audits and training, feedback, guidelines, and research update. Governance meetings were well attended with full multidisciplinary attendance from the minutes reviewed, and actions were highlighted and reviewed at each meeting. Outcomes of governance meetings and service dashboards were shared with staff through emails, newsletters, and posters. This was an improvement from the last inspection.

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The governance team carried out a daily surveillance of the electronic incident reporting system and any incidents graded 3 and above were discussed at the weekly MDT rapid review meetings. The service also carried ad-hoc MDT review meetings to ensure any serious incidents or never events were initially reviewed within 72 hours in line with national guidance. The MDT review meetings were attended by MDT staff such as obstetrician, anaesthetist, fetal monitoring, neonatal team as well as external representatives from their local maternity system.

Moderate risk was reported to the trusts quality committee and high risk was reported and reviewed by the MAC. High and significant risks were reviewed and challenged at the hospital management committee to ensure service leaders had meaningful conversations that highlighted gaps in care.

The assistant chief nurse managed the governance lead who was also responsible for overall governance and compliance. Their role was to have full oversight of the service and manage the governance team.

The education team was managed by the consultant midwife specialist midwives and clinical educators as well as a lead professional midwifery advocate and local professional midwifery advocates. The team supported the governance team to implement changes to practice and devise a training needs analysis that reflected the needs of the service. Also, the team ensured that staff were competent and had the knowledge and skills to carry out their role.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date.

The service had also organised 'never event' training for staff as the managers identified gaps in staff understanding of what might constitute a 'never event' particularly for the maternity service.

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.

The service participated in relevant national clinical audits such as the Perinatal Mortality Surveillance report, and the National Maternity & Perinatal Audit (MBRACE) and National Pregnancy in Diabetes Audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes. For example, the trust had acknowledged that its postpartum haemorrhage (PPH) and Obstetric Anal Sphincter Injuries (OASI) were higher than the national average. Actions were in place to improve outcomes and as a result the education team had implemented additional education and monitoring to improve outcomes.

The maternity dashboard from February 2022 to January 2023 showed that the service was meeting the target on booking at 10 weeks, maternal readmission, maternal deaths, antenatal steroids, unexpected term admission to neonatal intensive care unit, National Perinatal Mortality Review Tool (PMRT) reviews, skin to skin contact and breastfeeding rate at delivery. However, the service was not meeting national targets on 3rd and 4th degree tear and post-partum haemorrhage (PPH) above 1.5litres. Action plans were in place to improve these outcomes.

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The maternity safety team comprised of a band 8a risk midwife who was supported by 2 band 7 midwives, a band 6 midwife and a band 5 analyst to support compliance analysis to the Clinical Negligence Scheme for Trust (CNST) and the Ockenden Review. Also, the service had recently employed a band 4 administrator to support the governance team. Their role was to investigate when things went wrong and to share learning and drive improvements to the service.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The patient safety team monitored patient safety through audit and measured outcomes to prevent incidents from reoccurring and they worked closely with the education team. The leadership team were responsive when staff identified where improvements could be made and took action to make changes.

Managers shared and made sure staff understood information from the audits. The maternity dashboard which contained audit data was displayed in all areas and used to measure performance and identified where improvements were needed.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make changes where risks were identified. This was an improvement from the last inspection. Managers attended monthly risk meetings, and these were well attended. Records showed that there was a clear agenda that reviewed outstanding actions, included a 'Maternity Risk Tracker' and mitigations.

The maternity service had a risk register which included risks such as staffing, delay in triage due to staffing, medical staffing and venous thromboembolism (VTE) risk assessments scores audit. The risk register contained control measures in place, assurance actions to mitigate risks, any progress made and the risk approval status.

The service proactively monitored any backlogs of overdue serious incidents and complaints to manage and minimise risk to women and birthing people. Senior staff told us they had 45% overdue backlogs 15 months ago which had since been reduced to 15% at the time of inspection.

The maternity safety team delivered various awareness days like the 'Shout out to safety' training awareness day and planned to hold sessions throughout the year. The sessions included but were not limited to, never events and the learning, sepsis update, safety huddle and how to help you escalate and the golden hour for PPH – preventing maternal collapse or death. There were quality and safety boards and staff newsletters in all areas. Also, in December 2022 the maternity safety team held a 12 days of safety show. Each day they presented a different theme and walked the unit providing updates and key information.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

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 service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. Key information from the dashboard, audits and performance data was displayed across the service for staff, women, birthing people and public to access. This was an improvement from the last inspection.

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 and staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff used electronic patient records which were password protected to access all the information they needed, this included screening results and safeguarding information.

Data or notifications were consistently submitted to external organisations as required. The service submitted data sets to third party organisations like the Clinical Negligence Scheme for Trusts (CNST), the Perinatal Mortality review tool, the local Integrated Care Boards and the CQC.

Women and birthing people had access to digital wellbeing information pack. The service encouraged women to use QR codes displayed across the maternity areas to access information leaflets, surveys, and the maternity websites. Women could translate information on the maternity website to other languages.

The service had animated videos on perinatal positivity on their website and an information leaflet on what is perinatal mental health which was available in 5 different languages.

The service has electronic devices in the department which was used for virtual translation services during clinics.

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care and improvement in the maternity service. Service leaders had built meaningful relationships with the local MVP and encouraged them to attend meetings on site, such as the labour ward forum and monthly women's experience committee meeting. The MVP were passionate about their role, had regular engagement with leaders to make a difference to services provided to women and birthing partners who accessed the service. The MVP had regular meetings with the trust and easy access to the senior leadership team to escalate any concerns promptly.

The Maternity Voices Partnership had completed a 15 steps tour of the maternity department in November 2022 to review service provision on behalf of service users. They produced a report on the aspects they felt were good and the aspects that could be improved in each area of maternity. The recommendations were submitted to leaders for consideration so that improvements could be made to enhance services for women and pregnant people. The MVP had

been involved in co-production of leaflets and pathways such as the co-production of the induction of labour pathway which was still in the draft stage. The MVP also worked with digital midwives on new initiatives and been involved in the development of personal care plans. The MVP also held listening event every fortnight and covered various topics such as language and communication, induction of labour, pelvic health, and consultant midwife talk.

The service also held a recent listening event for the South-East Asian population to capture their views to drive improvement in the service.

The service also engaged women and public via their social media and created live videos and frequently asked questions on various topics such as infant feeding, baby buddy and best beginnings, antenatal films with COVID introduction, and antenatal journey video. The service engaged and received feedback from women and birthing people during ward rounds, birth reflection meetings and face to face resolutions following a complaint received.

Leaders understood the needs of the local population and knew their demographics. They strived to engage the local community and service users in various ways such as virtual tours of the service, social media pages and through the trust website maternity pages. There were numerous ways the public could engage with the service. At the time of inspection, the trust was carrying out an ongoing women's' survey, which will help capture the demographics and needs of women and birthing people who accessed the service.

The trust had appointed an equality, diversity, and inclusion midwife to care for the diverse population and hard to reach community including the local females prison to improve patient outcomes.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. The service used a digital online interpreting service that was accessed via smart tablets in all areas to facilitate safe conversations with non-English women and pregnant people.

Managers engaged with staff through various staff meetings, forums, listening events and newsletters.

The service engaged with key organisations including other NHS trusts and local authorities and charities to improve on patient outcomes.

From November 2022 to February 2023, the trust maternity friends and family test (FFT) survey result showed 95% of women and birthing people were satisfied with the care and received. This was similar to the trust target of 95%.

In the 2022 CQC Maternity Survey, the trust performed worse or somewhat worse than expected on 6 standards when compared with most other trusts and about the same on 37 standards performed.

In the 2022 General Medical Council national training survey (GMC NTS), the hospital maternity service scored worse than average on workload and similar than average on the other standards.

The Health Education England (HEE) initiated an improvement action plan of the trust maternity service in response to the feedback from student midwives. Actions were put in place to address the concerns and improve students experience, which include a daily student safety huddle. Staff including student midwives spoke positively about this new initiative and how it has improved student experience. Senior managers told us the HEE had taken the trust off the improvement action plan following feedback received from students and evidence of improvement to student learning experience.

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Learning, continuous improvement and innovation

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

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

The trust maternity services had recently implemented the '3 peas in a pod' initiative in collaboration with the emergency department following a serious incident. The initiative reminded staff to think 'Chest' during pregnancy to rule out Cardiac conditions, lung disorders and venous thrombo-embolism. 'Think head' in the postnatal period to rule out neurological and mental health conditions and for to 'think high risk' and pick up the problem and escalate when required. Think 3 peas in a pod posters were in all areas. Also, when a high risk of complication was identified, a pink pea was assigned to their patient records which remained after they had had their baby and highlights to staff throughout the hospital to consider complications associated with childbirth.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. The trust had been shortlisted in the HSJ 'Digital Awards 2023 in the Digital Clinical Safety Category for the Digital Fetal Early Warning Score system initiative.

The maternity service had achieved the final UNICEF baby friendly level 3 status, which is considered gold standard to improve the infant feeding and relationship building experience of mothers and babies.

The service's current model of fetal surveillance to identify fetal hypoxia (restricted oxygen during childbirth) included a 'Hypoxia in labour tool' which was shortlisted in the Maternity and Midwifery initiative of the year category of 2021 of the Health Service Journal (HSJ) patient safety awards.

A consultant gynaecologist trained midwives to give contraceptives to women and not all NHS trusts currently offered the contraception service as part of the maternity pathway.

The service had a separate Transitional care ward with 14 beds, which was the first initiative of its kind in the country. The transitional care was assessed at outstanding in the last internal assessment carried out by the trust.

We saw several examples of initiatives and quality improvement carried out by the antenatal and postnatal ward staff to improve patient outcome and experience. This included implementation of discharge videos, interpreting service available on smart electronic tablets, booked appointment system for newborn checks and on-going review of discharge process.

Outstanding practice

We found the following outstanding practice:

Maternity

- The trust maternity safety team and education team for working in partnership which was validated when they won team partnership for the region in the East of England Maternity awards held in March 2023.
- The service had implemented a Digital Clinical Safety tool called the Digital Fetal Early Warning Score system to make sure staff acted on known risks to fetal health during labour. This year the system had been shortlisted in a health publication digital award 2023.
- The trust maternity education team won the East of England award in March 2023 and a regional award for collaborative working with the practice development team and emergency department in relation to implementing the 'Three Peas in a Pod'. This Three Peas in a Pod focused on patient safety and aimed to highlight conditions that are overlooked because the person is pregnant or just had a baby.
- All midwifery support workers and health care assistants working on the postnatal wards were trained in breastfeeding and bathing to support women, birthing people, and babies.
- The 'Newborn and Infant Physical Examination' (NIPE) booking appointment service at Peterborough City Hospital was evidence of quality improvement for the benefit of patients.
- The trust was the first NHS trust to set up a dedicated transitional care ward in Peterborough City Hospital.
- The Raham Project created by one of the hospital midwives had been shortlisted for the HSJ patient safety award and came up as the runner up for the PENNA award.

Areas for improvement

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

Action the trust SHOULD take to improve:

Peterborough City Hospital

- The trust should ensure all women receive one to one care during active labour.
- The trust should review the triage process around the documentation of women's admission unto patient records and the transfer of women from day assessment unit to triage.
- The trust should ensure staff are up to date with their fetal monitoring competency test training.
- The service should ensure staff receive safeguarding supervision and appraisal as necessary to carry out their duties.
- The trust should continue to address the vacancy and sickness rates in maternity staffing.
- The service should ensure that handovers, ward rounds and safety huddles are structured and not interrupted so that patient reviews are comprehensive and completed safely without distraction.
- The trust should consider ensuring the bereavement room is soundproof to improve the experience of bereaved women and families who have experienced a loss.
- The trust should ensure that it continues to improve the waiting times of women and birthing people attending the triage unit.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 3 other CQC inspectors and 3 midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation