Bedfordshire Hospitals NHS Foundation Trust

Bedford Hospital

Inspection report

South Wing
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Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Bedford Hospital

Inspected but not rated

We carried out this unannounced focused inspection to follow up on concerns from our inspection in November 2020. At our last inspection we rated the service as inadequate and issued the trust with a section 29A warning notice which gave instructions for the trust to significantly improve the areas identified.

Since the COVID-19 outbreak we have been adapting our approach to inspection whilst addressing risks, which delayed our return to the service.

Bedford Hospital is operated by Bedfordshire Hospitals NHS Foundation Trust and provides maternity services to women living across the county of Bedfordshire.

The maternity unit at Bedford Hospital provides a comprehensive range of inpatient and outpatient services from pregnancy, birth and post-natal care.

The maternity unit is located in the Cygnet wing at Bedford Hospital. The service provides consultant and midwife-led care for both high and low risk women. The consultant-led delivery suite is located on the first floor and has eight delivery rooms, one dedicated obstetric theatre and a two-bedded recovery bay for post-operative women. There is also a dedicated bereavement suite called the Butterfly room.

The Acorn suite is the midwife-led birthing unit and consists of three low-risk birthing rooms and is situated at the far end of the delivery suite.

There is a 24-bedded joint postnatal and antenatal ward, called the Orchard ward located on the second floor of the Cygnet wing. This ward consists of five four-bedded bays and four side rooms, two of which are amenity rooms, which are normally available to women who wish to pay for a private room, although this option had been suspended during the COVID- 19 pandemic. Orchard ward also contains the four-bedded maternity day assessment unit.

The maternity service also has an antenatal outpatient department situated on the first floor of the Cygnet wing. The department includes screening services, the early pregnancy assessment clinic, and antenatal clinics. Community midwives provide care for women and their babies both during the antenatal and postnatal period. They also provide a home birth service.

The maternity service is managed through the trust's maternity clinical service line which is part of the women's health and sexual health clinical service line. The current leadership structure includes a clinical director, a senior general manager, and a director of midwifery. This triumvirate is replicated on both hospital sites with a clinical lead, general manager and head of midwifery. Obstetricians, matrons, and senior midwives also support the senior leadership team.

We last inspected the maternity service at Bedford Hospital in November 2020 when we identified a number of concerns regarding staffing numbers, staff competency, poor triage and escalation processes, poor multidisciplinary team

Our findings

working, records were not held securely, and the culture did not encourage staff to share concerns. As a result, a section 29A warning notice was issued under the Health and Social care Act 2008 which required the trust to make improvements to reduce risks. The service was rated as inadequate overall; safe and well led were rated inadequate and effective was rated as requires improvement.

We did not rate this inspection as we used our focused methodology. Consequently, the rating for the service remains inadequate.

We did not rate this inspection. Our previous rating of inadequate remains:

- The service compliance with mandatory, safeguarding and competency based specialist training was generally below the trust target.
- Not all staff maintained effective infection control and prevention for all patients.
- The maternity triage area was not fully suitable to the service needs.
- Safety tools were not always fully used or recorded.
- The service did not have enough midwifery staff; however, we did not see any evidence of this impacting negatively on women's safety.
- The service did not always have enough medical staff with the right qualifications, skills, training and experience, although we did not see any evidence of this impacting negatively on women and baby's safety.
- Women's care and treatment records were often loose papers with no structure.
- Women were not always able to access specialist nutritional support in a timely way.
- The leadership team were relatively new and had not had sufficient time to embed changes.
- Staff did not always feel supported and valued. Some staff reported that they did not raise concerns as a result of challenges by some leaders.

However:

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service generally controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff generally 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.
- Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept records of women's care and treatment. Records were stored securely and easily available to all staff providing care.

Our findings

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- 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 patients honest information and suitable support.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment. They used findings to make improvements and mostly achieved good outcomes for women.
- Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.
- The service made sure staff were competent for their roles.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.
- The service was accessible seven days per week.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- Leaders had the skills and abilities to run the service. Service leads understood and managed the priorities and issues the service faced. They were visible and approachable in the service.
- Staff were focused on the needs of women receiving care.
- 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 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.
- Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.
- All staff were committed to continually learning and improving services.

How we carried out the inspection

We visited clinical areas in the service including the delivery suite, Acorn suite, Orchard ward and the maternity day assessment unit. We spoke with 29 staff, including service leads, midwives, medical staff and maternity care assistants. We reviewed nine sets of women's records and observed staff providing care and treatment to women.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. We carried out a focused inspection related to the concerns raised, this does not include all of our key lines of enquiry (KLOEs). As a result of this inspection ratings for this service remain unchanged. Safe and well-led are rated inadequate, and effective rated as requires improvement. Overall, the service was rated as inadequate.

Our findings

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

Maternity (inpatient services)

Inspected but not rated

We did not rate this inspection. Our previous rating of inadequate remains:

- There continued to be concerns with midwifery and medical staffing which impacted negatively on staff morale and ability to complete training. Compliance in most mandatory topics and safeguarding training was below the trust target. Staff did not always ensure infection control and preventions was maintained and records and risk assessments were not always completed. The triage area was not entirely suitable to the needs of the service. However, service leads were working to address the areas of concerns and there were plans in place to improve staffing and training compliance. Locum and agency staff were used where possible and full induction was given. Staff reported incidents and there was a robust process for ensuring learning.
- The service ensured that policies were reviewed regularly and reflected best practice and national guidelines. Staff worked collaboratively and there was evidence of effective multidisciplinary team meetings. Staff competencies were reviewed regularly, and they were supported to develop. However, staff appraisal rates were below the trust target. Specialist services such as infant feeding advice was not always readily available, and women were not always orientated to inpatient areas which meant that they did not always have access to meals and refreshments. Although the service welcomed feedback from women there were some delays in changes made to the service in response to feedback.
- Leaders had the skills and abilities to manage the service. There had been changes and new roles added to the team since our last inspection which had improved the governance structure, management of risk and improved oversight. Staff felt that managers had the ability to make changes and were confident that they shared a vision for the service. However, the leadership team was relatively new and had not had sufficient time to ensure changes to the service were embedded. There also continued to be some concerns regarding staff culture, as some staff did not feel supported and valued and some were reluctant to raise concerns.

Is the service safe?

Inspected but not rated

We did not rate safe at this inspection. Our previous rating of inadequate remains:

Mandatory training

The service provided mandatory training in key skills to all staff. However, compliance with mandatory training was generally below the trust target.

The mandatory training was comprehensive and met the needs of women and staff. Topics covered clinical and risk based subject matter and were completed either via online training sessions or through classroom training depending on the topic.

Staff received and kept up-to-date with their mandatory training where possible. Local data (Quality Improvement Plan for March 2021) showed that mandatory training compliance varied between topic and staff groups. Midwives compliance was above the trust target of 90% for fire safety (90.8%), infection prevention and control level one (97.7%) and safeguarding adults training (93.1%). Compliance in all other topics ranged from infection prevention and control level two (58.2%) to manual handling level one (84.7%). This was a slight improvement on the training compliance at our last inspection and in line with the services planned trajectory for compliance.

Maternity (inpatient services)

Medical staff compliance was recorded as part of the obstetrics and gynaecology staff data.

Obstetrics and gynaecology staff compliance was below the trust target of 90% for all topics ranging from 43.5% for information governance training and 75% compliance for safeguarding children level 2. This was similar to our findings at the last inspection.

Staff told us it was difficult to find a balance between ensuring staffing levels were met and ensuring training was completed. Staff gave examples of when training had been cancelled in response to activity and staffing levels. Mandatory training compliance had also been restricted during the COVID-19 outbreak due to the inability to complete face to face training (due to social distancing restrictions) and staff shielding.

Staff reported that they often accessed training at home (through personal choice) as they did not have time within their working hours to complete mandatory training. Staff told us that they did not receive time back for training completed in their own time, however, the practice development matron (PDM) confirmed that staff could claim for time spent completing training.

Staff were able to access a one day mandatory training session which covered safeguarding training level 3, mental health and infection control and prevention training levels 1 and 2. These were held monthly and where possible staff were rostered to attend.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Staff we spoke with had a good understanding of these conditions and knew how to access additional support as necessary.

Managers monitored mandatory training and reported on compliance monthly. Compliance data was displayed and reported to the board through performance meetings. Staff were alerted to the need to complete training by their manager or the practice development midwife (PDM).

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, compliance with safeguarding training was below the trust target.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding training compliance was slightly worse that at the last inspection. Training compliance for safeguarding adults' level 2 was 91% for midwives and 75% for medical staff.

Safeguarding children level 1 training had been completed by 100% of all staff. Safeguarding children level 2 and 3 training compliance was 94% by additional clinical service staff, 91% of midwives and 81% of doctors. Level 3 safeguarding children training was below the trust target of 90% with 66% additional clinical service staff, 35% for midwives and 88% for medical staff. Service leads told us compliance was directly linked to staffing levels.

Despite poor training compliance, staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. We saw staff discussing women at risk and action that had been taken in response to concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We saw that there was a named midwife for safeguarding and named contacts across the trust for escalation purposes. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us the safeguarding team were easily accessible and that they could discuss any concerns in a timely manner. We saw that incidents reported reflected any concerns regarding women and children's safeguarding.

Staff followed the baby abduction policy and undertook baby abduction drills. We saw that the communication folder on Orchard ward contained the draft abduction policy and prompted staff to read it in preparation for a drill. Staff confirmed that a drill had been completed and that they were planned to be repeated on a regular basis.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well, although not all staff maintained effective infection control and prevention for all patients. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which appeared clean and well-maintained. We saw that equipment was cleaned between women and some items were labelled as being clean and ready for use. However, we saw that the cleaning checklists for equipment were not always completed. On Orchard ward there was a checklist designating tasks for midwifery care assistants and midwives. Of the records reviewed we saw that there were some gaps in the support worker tasks and the midwife's tasks were seldomly signed as being completed.

Ward cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Each clinical area had designated cleaning staff who were responsible for ensuring the environment was well maintained. We saw that these staff took pride in their work and were included in the team.

Staff generally followed infection control principles including the use of personal protective equipment (PPE). However, there were some exceptions. We observed that staff on the delivery suite did not always wash their hands or wear gloves and aprons when attending women who were potentially at risk of having COVID-19. Staff were observed entering women's' rooms without protective equipment and did not always sanitise their hands when moving between women.

Service data showed that hand hygiene audits generally confirmed good practice, with one exception within the delivery suite where a doctor did not follow best practice.

Hand sanitiser was readily available on entry to clinical areas and near bed spaces. Handwashing sinks were located across all areas. Women and visitors were encouraged to use these.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, not all clinical areas were fully suitable to the service needs.

Maternity services at the hospital consisted of a consultant led delivery suite, a midwife led birthing unit, bereavement suite, post-natal ward (Orchard), day assessment unit (DAU), triage area, and outpatient clinics. There was one obstetric theatre, plus a delivery room that could be used as a theatre, a recovery area, and the special care unit was nearby for easy access.

The design of the environment followed national guidance. We saw that clinical areas were largely suitable and appropriate for the service which was being managed in them. The exception was the triage area which consisted of one

room within the delivery suite. We saw and were told that the service often had multiple women waiting to be triaged and therefore one room was insufficient to meet demands. Women would be asked to wait in a seating area by the entrance to the ward if the triage room was occupied or in use. Similarly, the Day Assessment Unit (DAU) was located on Orchard ward and consisted of four beds, with a seating area outside the bay for women waiting for assessments. Staff reported these areas were often busy with women waiting to be seen. Leads told us that the service was planned to be reviewed in terms of pathways and location of services, which included an estates review.

Women could reach call bells and staff responded quickly when called. Staff reported on Orchard ward that there could be delays in attending a woman due to staffing levels and activity. Staff told us that women often commented that they knew they were busy, and they apologised for the calls. However, during inspection all calls were managed in a timely manner and no women were kept waiting for any assistance.

The service had suitable facilities to meet the needs of women's families. There had been changes to visiting in response to COVID-19, however, we saw that mothers were able to be accompanied or visited by designated persons. There were quiet areas and a bereavement suite which could be used.

The service had enough suitable equipment to help them to safely care for women and babies. Staff reported that equipment was readily available. Staff carried out daily safety checks of specialist equipment. We saw that the resuscitation trolley was checked on a daily basis. Records showed that daily checks were completed, and trolley contents checked either weekly or after use. We saw that expiry dates were recorded, and any issues were escalated to the ward manager.

We saw that baby tag alarms and emergency alarms were tested twice weekly, however, compliance with this varied. For example, we saw that some tests had failed due to staff being unaware of where alarms were located or that they could not hear them. During inspection, we saw that alarms were triggered by the weekly generator test. Staff confirmed that all babies were present before voiding the alarm.

We saw that the ward fridges were monitored to ensure that temperatures did not exceed recommendations. Temperatures were recorded as being between 3.7 and 9.2 degrees Celsius. Staff knew how to escalate if temperatures were outside acceptable ranges.

We saw that birthing pools were tested regularly for water borne infections. Data showed that there were no reported cases of legionella in the twelve months preceding the inspection.

Staff disposed of clinical waste safely. Clinical waste was segregated from domestic waste and disposed/ collected accordingly.

Assessing and responding to patient risk

Staff generally completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. However, safety tools were not always fully used or recorded.

Staff used nationally recognised tools to identify women at risk of deterioration and escalated them appropriately. However, we saw that there were a variety of the same risk assessments in different formats in use. This made specific assessments difficult to identify and would be time consuming for staff trying to locate or complete.

Maternity (inpatient services)

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Records clearly identified completed risk assessments, however there were some gaps in information. For example, we saw that there were gaps in recording domestic abuse risks, risk levels and allergies. There were also gaps in recording 'fresh eyes' which is an additional individual formal cardiotocography (CTG) assessment which should be completed hourly, by any midwife, labour ward coordinator or obstetrician.

Staff completed booking risk assessments identify any social medical or obstetric issues which increase the risks of the pregnancy. We saw that women with high risk pregnancies, such as pre-eclampsia, diabetes were reviewed by the obstetricians and monitored closely.

There was a designated point of access for all calls and referrals. The service had introduced a telephone triage midwife whose responsibility was to accept all calls and referrals and direct them to the most appropriate pathway. This enabled women to access the most appropriate team or treatment and was an improvement since our last inspection.

Women attending the service were reviewed in triage. We saw that triage was RAG (Red, Amber and Green) rated depending on their woman's needs and risks. Women identified as being red rated required an immediate midwife and medical review. Those rated as amber required a midwife review within 15-30 minutes and doctor review within one hour and green rated required a midwife assessment within 15-30 minutes and medical review within two hours. Staff completed a book with details of referrals; however, we were told that some women who called directly to the delivery suite may not be recorded and there was no audit of triage times or attendances. This meant that activity and service demands could not be accurately calculated.

Staff had access to timely support from medical staff. Midwives told us that attendance and responsiveness had improved since our last inspection. The quality improvement plan report for March 2021 detailed bleep response times for consultants. This confirmed that bleeps were responded to within two minutes of their receipt.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. We saw that women were also offered joint appointments. One mother with a history of depression and anxiety attended the department for an urgent appointment. We saw that she was spoken to sympathetically and considerately. Staff ensured that the mental health team were included in the planning of her care and treatment.

Women's and babies' clinical observations were recorded using national tools such as the modified early obstetric warning scores (MEOWS). Calculations as to scores were correctly recorded and we saw action was taken in response to any concerns.

Staff knew about and dealt with any specific risk issues. Handovers included key information about women and their risks. Staff shared key information to keep women safe when handing over their care to others. Handovers between teams and shifts were methodical and descriptive of the mother's situation. Handovers did not follow a specific format, however, were clear and concise. Staff felt that they had sufficient information to inform their care planning. Shift changes and handovers included all necessary key information to keep women and babies safe.

Staff completed daily conversations with the Luton and Dunstable Hospital site team to discuss work pressures. If necessary, teams would allocate work to the other site to ensure that workload was manageable and prevent any unnecessary risks.

Maternity (inpatient services)

There was a clear escalation policy and action cards for staff to follow either in an emergency or when activity or acuity increased.

Elective lists were completed Monday to Friday (half days) using a designated consultant, registrar, midwife and anaesthetist. Elective lists were completed by the same theatre team covering non elective activity therefore limiting the ability to open a second theatre in the event of an emergency. The service had a process whereby a theatre team attended from main theatres in the event of an emergency. The service reported no incidents where a theatre team had been unavailable to support

The service did not have a second dedicated theatre, although one delivery room was convertible. We saw that there was no dedicated second theatre team for the service. At night the on call consultant was required to attend and the general theatre team would cover any activity. Staff reported that the second theatre had been required once in the past year.

We saw that the World Health Organisation (WHO) five steps to safer surgery checklists were not always recorded. Four women's records showed that the WHO checklist had been used, three were incomplete with sections missing, one was fully complete. The remaining records reviewed showed that a WHO was not required. We observed the WHO checklist being completed during inspection and identified that pre and post huddle sections were missing. This was not in line with service data which showed that 100% of WHO audits were compliant when they were reviewed. The service had audited between 44 and 158 cases weekly and all showed that all sections were completed in line with guidance. Following inspection, the trust confirmed that category one sections (those completed as an emergency), may not contain all details, due to the emergency situation and need for a verbal check for speed.

Full term babies who required additional support following delivery could be transferred to the level one special care units on site. Staff could access level three special care services at Luton and Dunstable Hospital if necessary, for premature (under 28 weeks), small babies (under 1 kg weight), or those requiring respiratory support. Additional special care centres could be accessed if necessary.

All clinical areas were secure with access permitted by a staff member. Visitors to all departments were required to inform staff of who they were and were then directed to the relevant area. You could not tailgate access, and staff challenged people they did not recognise.

There was a sepsis box held in treatment rooms for quick access if a woman was admitted with suspected sepsis. We saw that contents were in date. The service was in the process of being added to the trust wide sepsis audit.

Staff used the Birth-rate plus system for recording activity, acuity and staffing, however we saw that this was not always completed in a timely manner due to staffing and increased activity. This meant that the information was not always timely or accurate in reflecting pressures.

The service completed venous thromboembolism audits as part of the trust wide key performance indicator. Data showed that compliance was over 96.38% for all women attending the department from February to May 2021.

Midwifery staffing

The service did not have enough midwifery staff; however, we did not see any evidence of this impacting negatively on women's safety. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Maternity (inpatient services)

The number of midwives and maternity care assistants did not match the planned numbers. During inspection, we saw that due to training, sickness and shielding, staffing was below the establishment. The delivery suite should have had seven midwives on duty and there were four. There should have been three midwives on duty in Orchard ward and there were two. The services were busy, and staff felt pressured. Staff who were not scheduled to work clinically were pulled from their normal work, for example the neonate feeding specialist, director of midwifery and head of midwifery all completed clinical tasks to support the team.

Midwife staffing was reported as being a chronic problem for over one year. During inspection we saw and were told that staffing was often challenging across all areas. Staff prioritised the delivery suite to maintain women and baby's safety for delivery, and post-natal areas were regularly short staffed. We were told there were frequently three or four midwives on duty in the delivery suite against an establishment of seven midwives (including the coordinator). The day assessment unit (DAU) staff reported that there was often staffing issues which meant that a midwife off Orchard ward would cover the activity, as well as working clinically on the ward.

The number of vacancies had been exacerbated by the need for staff to shield or report sick due to COVID-19. To mitigate risks, service leads had made the decision to pull specialist from their roles part time to cover capacity. However, this left some gaps in specialist services. Specialist midwives and ward managers were regularly working clinically meaning that specialist support services such as tongue tie and neonate feeding services were working on reduced capacity. Staff told us that they regularly missed breaks and there were multiple comments referring to the inability to complete training or take annual leave.

Service data showed that registered staff cover was between 78.4 to 83% of the establishment for day shifts and 86 to 99% at night for March to May 2021. Data also showed that midwifery care assistant fill rates were 88 to 137% during day shifts and 93 to 130% at night for the same period. This demonstrated that the services were using additional midwifery care assistants to assist with the qualified midwife deficit to ensure safety.

Midwives told us that the coordinator role on the delivery suite was also responsible for completing the initial triage of women attending the triage area. Coordinators expressed concerns that this meant that they were not always available for completing 'fresh eyes' or assisting colleagues. Concerns had been escalated to the matrons.

Staffing levels impacted on women's experiences. We were told that some women did not have timely access to specialist support, staff were sometimes insensitive in their communication (in post-natal areas) and women did not always feel that they had sufficient time to ask questions.

The service had high vacancy rates; however, a large number of midwives had been recruited. Vacancies were reported as 18.59 whole time equivalent (WTE) in total. That included -1.66 WTE Band 7, 10.72 WTE Band 6, 5.13 WTE Band 5 and 4.4 WTE Band 3 staff. There had been a large recruitment drive with the successful recruitment of 18 midwives who were due to commence in September. The staff recruitment was welcomed by the current midwives; however, they were also anxious about the additional workload to fully support their transition from student to midwife roles. The current vacancy for midwives was reported as 22 vacancies.

Service leads reviewed the number and grade of midwives and midwifery care assistants needed for each shift in accordance with national guidance. Following the last staffing review (2019) there had been a shift in midwife: midwifery care assistant ratio from 90:10 to 85:15 (midwife: midwifery care assistant percentage). From March 2021, the trust had reverted back to 90:10 recognising the importance of a higher registered staff skill mix. Leads reported a plan to recruit registered nurses for the post-natal ward, with an aim to recruit sufficient numbers to provide one nurse on every shift. They would then be supported to complete midwifery training if they wished.

Ward managers could adjust staffing levels daily according to the needs of women, although there was no guarantee that staff would be available. The service leads had introduced an acuity tool to assist with the identification of staffing needs, however, we saw that on the day of inspection, this was not completed as staff had not had the time due to activity.

Service leads explained that they had considered the transfer of staff across the two hospital sites, however the decision had been made to manage the staffing deficit at Bedford Hospital by using specialist staff and reallocating work where possible. It was felt that by moving staff, from the Luton and Dunstable site would destabilise staffing in two areas. With the deficit largely at Bedford, the emphasis could be on that service. Service leads also reported working with the wider east of England team for workforce planning.

The service had variable sickness rates. Service data showed that midwife sickness was reported as 5 to 8.23% for February to April 2021. The trust board report for December 2020 reports the sickness rate at Bedford Hospital as 4.74% in comparison to 3.51% at Luton Hospital.

We saw that there was a steady number of agency staff used within the service, with 550 to 648 hours per month from March to May 2021. Managers used bank and agency staff, where possible that were familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

We saw that the service audited women's experiences with regards to one to one staffing during delivery. We reviewed ten audits which confirmed that women had received one to one care during their delivery. Service data showed that 98 to 99.4% of women received one to one care during delivery in February to April 2021.

Staff were able to gain support from the midwifery matrons and contact details for the on call matron was displayed in clinical areas. There was a named matron covering the units from 8am to 4pm, and then overnight.

All staff we spoke with, told us that they felt that service leads were doing everything they could to ensure safe staffing.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience, although we did not see any evidence of this impacting negatively on women and baby's safety. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Data provided by the service showed that there were nine whole time equivalent consultants in post against a funded establishment for eight following recent recruitment. Staff reported that medical staffing was satisfactory, although locum staff were used to maintain numbers. The quality improvement plan for March 2021 detailed that there were eight consultants, seven registrars and one midgrade doctors in post, with a vacancy for one consultant and two middle grade doctors.

Although the service reported that there were some gaps in the medical staffing numbers, they generally felt that there were sufficient numbers to meet demands of the service. Doctors reported any gaps in rotas were usually picked up by locum staff. The medical staff matched the planned number. Midwifery staff reported that doctors were easily accessible and responsive to calls. They completed regular ward rounds.

Service leads were planning to increase the number of consultants to ten by the end of 2021, to increase cover for the labour ward and in response to changes to ward rounds following the Ockenden review. The priority was to ensure 24 hour coverage of the labour ward as consultant cover was currently 74.5 hours. A staggered approach was planned to ensure the service had the opportunity to develop and embed practice.

The service had reducing rates of bank and locum staff. Managers could access locums when they needed additional medical staff. Service leads reported that they had successfully recruited some locum staff to substantive posts and that this had made a significant impact on service cover. Managers made sure locums had a full induction to the service before they started work. Where possible, locums familiar with the service were used.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends. Consultant cover followed a 'hot week' process, whereby one consultant was responsible for the week's activity. We saw that one consultant covered clinical areas Monday to Thursday with another responsible for Friday to Sunday. Cover consisted of one consultant covering obstetrics and gynaecology 8am to 8.30pm Monday to Friday and 8am to 12.30pm and 6pm to 8pm on Saturdays and Sundays. Out of hours cover was also provided by one consultant with additional virtual ward rounds if necessary. In addition to the nominated consultant, there was provision to call upon a second consultant, to support increased activity.

Ward rounds were completed daily at 8am and 5pm with an additional virtual safety huddle. The 8am medical handover was led by the night registrar and attended by the obstetric senior house officer (SHO), registrar, consultant, anaesthetist, neonate team and the midwife in charge. This was completed away from the clinical area to ensure conversations could not be overheard and detailed women who were in attendance/ planned and any associated risks. We saw that there was appropriate escalation of all issues including any social concerns and communication challenges. The gynaecology handover was also completed at this meeting. The handover did not follow a formal handover tool such as SBAR (Situation, Background, Assessment and Background), however it was methodical and clear.

Handovers also included key information or messages and the 'message of the week'. We saw that the message of the week prompted staff to ensure unit cleanliness was maintained.

Medical staff appraisals had been completed by 88% of medical staff this was equivalent to seven out of eight consultants. The outstanding appraisal was in plan. The appraisal rate for all trainee doctors was 100%.

Medical staff reported 'great team working' and that there had been improvements in the medical rota. Consultants were approachable and supportive of junior staff and their colleagues. Trainee doctors reported that consultants were supportive, approachable and were always willing to assist, for example attend the unit overnight for complex cases.

Doctors told us that midwife gaps impacted on their ability to do their job, stating that they had to complete tasks that midwives would normally complete, which impacted on waiting times and care timelines.

Records

Staff kept records of women's care and treatment. Records were stored securely and easily available to all staff providing care. However, records were often loose papers with no structure.

Women's notes were comprehensive, and all staff could access them easily. However, we saw that records largely consisted of loose papers in no specific order. We reviewed nine women's records in full and saw that they were inconsistently completed and lacked some information, as detailed in the assessing risks section.

When women transferred to a new team, there were no delays in staff accessing their records. Records were transferred with the woman when they were transferred to different areas.

We were told that the trust was moving towards an electronic patient record archive. Although staff were unable to confirm the timeline for the project. It was also unclear if staff fully understood what the records would look like in the future as staff told us they were transitioning to electronic records, however service leads explained that the electronic record referred to storage only, and that a full electronic record was part of a system wide project plan.

Records were stored securely. We saw that all records were held at the nurses' station in locked trolleys. Observation charts (such as national early warning scores) were maintained at the bedside to enable access and recording.

Staff had access to computers in all departments. We saw that these were locked when not in use to prevent unauthorised access.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service used an electronic prescribing process which was monitored by the pharmacy department and had associated risk assessments which needed to be completed prior to enabling certain actions. For example, venous thromboembolism assessments needed to be completed prior to prescribing medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We saw that medicines were held securely and could not be accessed by unauthorised persons. Pharmacy staff completed regular checks and ensured that there was sufficient stock.

Controlled drugs (CDs) were stored securely and checked a minimum of daily. Controlled drugs are those defined by the Misuse of Drugs Act 1971 as subject to strict legal controls and legislation due to risks of being misused. All CDs administrations were confirmed by two members of staff in line with national guidance.

Staff followed current national practice to check women had the correct medicines. We saw that staff checked women's' identities prior to administering medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. We saw that safety alerts were shared with staff at handovers and were included in the communication folders.

Medicines management was audited monthly. Audit data showed that the number of omitted medicines, of omitted critical medicines and allergy status was reviewed to ensure women were receiving medicines in line with prescriptions. Data for March to May 2021, showed that there were minimal omissions of any type on Acorn suite. On the delivery suite, there were 8.52 to 20.3% omitted medicines and 7 to 13time critical medicine omissions for the same period. Orchard ward data showed a higher omission rate for both types of medicines, with 16.38 to 22% omissions of medicines and 12 to 17 omitted time critical medicines. The caveat to this is that some women may be recorded in more than one area, due to them moving between departments according to their progress. In contrast, the area where allergies were not recorded most frequently was the delivery suite, with two to nine omitted allergy or sensitivities recorded.

Maternity (inpatient services)

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 patients honest information and suitable support

Staff knew what incidents to report and how to report them. The service used an electronic reporting tool which was accessible in all areas.

We were told that there was a positive reporting culture in the service, although some staff reported that they did not always report 'difficult shifts' or concerns regarding individuals' practices. These were reported directly to service leads instead. Staff told us they reported all transfers to special care units and all pre-term deliveries.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. We saw the Maternity Risk Report for March 2021 and saw that 98 maternity related incidents had been reported in the previous month. The most prevalent incident reported was maternity complications (20), staffing (12), admission, discharge and transfer (12), diagnostic (8), patient documentation (7) and unexpected admissions (7). The remaining 32 were one off incidents. We reviewed the incidents reported and found that they were clearly articulated activity within the department. For example, there was evidence that staffing shortages, clinical incidents, changes to service such as diverts to other organisations were reported. Investigations detailed actions taken immediately and outcomes.

There was a risk team dedicated to reviewing incidents within the service. They completed daily reviews of incidents and discussed them in detail with the service leads weekly. It was during these meetings that incidents were graded, and decisions were made in relation to investigations. We were told that the most frequent reported incidents referred to staffing. On occasions where there were multiple incidents reported in relation to one topic/ incident, the team completed a data cleanse to prevent double reporting.

Staff reported serious incidents clearly and in line with trust policy. We saw that details of serious incidents were also shared as part of the Maternity Risk Report. There had been no never events in the twelve months preceding the inspection.

Managers told us they shared learning about incidents, serious incidents and never events with their staff and across the trust. The maternity risk report for March 2021 detailed eight incidents that had occurred in February 2021 which were used for learning. The report detailed the type of incident and what had been learnt and what could be improved. Staff were encouraged to read the risk report as part of the handover.

Staff understood the duty of candour (DoC). They were open and transparent and gave women and families a full explanation if and when things went wrong. Any incident was reviewed to identify the need for DoC, and we saw that this was recorded within the incident detail. We were given examples of where DoC had been applied and staff told us women and their families were always involved with investigations and outcomes.

Staff received feedback from investigation of incidents, both internal and external to the service. Information was shared at team meetings and via the risk reports.

Maternity (inpatient services)

Staff told us that there were no formal support systems in place following incidents, however, knew how to access support if necessary. Managers told us they debriefed and supported staff after any serious incident and we were given examples. Leads also told us that if necessary external support could be used for debriefing particularly difficult cases. We were given examples of how staff had been involved with incidents that had been referred to the Healthcare Safety Investigation Branch (HSIB).

Staff met to discuss the any feedback and look at how they could improve women's' care. We were told that the service had commenced listening events to enable staff to share their thoughts and ideas about improvements that could be made.

Is the service effective?

Inspected but not rated

We did not rate effective at this inspection. Our previous rating of requires improvement remains:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We saw that policies were reviewed regularly, and the service leads monitored whether they were in date and reflected best practice. The maternity risk report for March 2021 detailed that there were 119 policies and procedures for the service. 105 of these were reported as being in date, with the remaining 14 out of date but in progress of being reviewed or awaiting approval. The service trajectory was for all policies and guidelines to be in date by the end of May 2021.

We saw that the baby abduction policy was in draft awaiting approval. The draft policy was held in the communications folder for staff to read in preparation for an abduction drill. We saw that the service had introduced action cards in relation to the baby abduction policy. These clearly identified actions for each staff group to complete in the event of an incident.

Patient Outcomes

Staff monitored the effectiveness of care and treatment. They used findings to make improvements and mostly achieved good outcomes for women.

The service used a maternity dashboard to monitor performance against key indicators and national targets. We saw activity such as the number of home births, multiple births, percentage of women receiving one to one care, caesarean section rates, elective and emergency percentages and numbers of women with different tears was compared to peers and national averages to inform performance. A red, green and amber (RAG) rating system used to highlight areas where performance was not in line with planned. We saw that the dashboard was displayed in clinical areas.

The service recorded the number of unexpected term admissions to the special care unit. Data showed that there were between six and 13 admissions from December 2020 to May 2021. This was equivalent to 2.71 to 6.4% of the births within the service. All admissions to the special care_units were incident reported.

The service completed regular audits to monitor performance and there were associated action plan for each.

The service audited compliance in completion of the modified early obstetric warning scores (MEOWS) records, across all clinical areas. Data shows that compliance for completion and accuracy within the day assessment unit had improved to 100% from March to May 2021, whilst compliance varied between 60 to 95% in the delivery suite and triage area. There were clear actions recorded as part of the audit on how to improve this, which included working with staff and discussing at meetings.

Service data showed that the times for women's triage was audited. Women were generally seen by a midwife within 30 minutes of arriving in the department as per plan, however times for being seen by a doctor were not always in line with plan. For example, doctors saw women identified as requiring a review by a doctor within 15 minutes in time within one week out of 24. There were 15 weeks where this target was not met at all, with the remaining eight weeks showing either as not applicable or 16 to 33% compliance. The same audit showed that all women attending triage were seen by a doctor within two hours of arrival.

The service completed a full review of women's notes as part of the fresh eyes audit. This identified performance against 19 standards including missed or delays in the fresh eyes' observations, delays in escalation and transfers. Data showed that overall compliance was 48 to 58% for January to May 2021.

The service had previously audited carbon monoxide monitoring as part of the clinical negligence scheme for trusts (CNST) standards. This standard had been paused during COVID-19 and staff were required to ask women about their smoking status and of necessary signpost them to the smoking cessation team. Data shows that from June 2020 to May 2021 4.8 to 9.3% of women conformed that they smoked at their initial booking.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs. However, women were not always able to access specialist support in a timely way.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw that women were able to serve their own meals and had access to snacks between mealtimes. Advice was available for women who required specialist meals or adjustments. We saw one member of staff explaining which meals were Halal. However, we were given examples where women using the service were not informed of how to access the dining room for meals and other of women who were not able to mobilise, either missing meals or had meals brought to the bed space and left out of reach.

Staff fully and accurately completed women's fluid and nutrition charts where needed. We reviewed nine women's records and saw that they detailed nutritional intake.

Staff used a nationally recognised screening tool to monitor women at risk of malnutrition. Risk assessments were completed on admission and updated as and when the woman's condition changed.

Specialist support from staff such as dietitians and speech and language therapists were available for women who needed it. Staff were able to access support, although this was largely completed as outpatient services.

We were told that there was specialist support for baby feeding, for those women and babies which were having difficulties or needed additional support. However, the impact of staffing had meant that specialist support had been reduced. The maternity voice partnership (MVP) told us that they regularly had feedback from women who felt that support and advice had not been given in a timely manner due to the inability to access it. We were given examples, where women had not been able to access the infant feeding specialist whilst in hospital, which had meant that the community team picked up the concerns once discharged home.

Competent staff

The service made sure staff were competent for their roles. However, compliance with all competency based training and appraisal rates was not in line with trust targets.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge as able. Managers reported that finding the balance between ensuring staffing levels were maintained and promoting development was difficult. Staff we spoke to told us they used to be able to access additional training, however, this had reduced over the last year due to staffing levels and the inability to release staff for training. We were also given examples of where training had been cancelled due to activity and told that some staff completed training at home.

Training compliance was tracked by the practice development midwife (PDMs) who produced a report of compliance twice a month. The reports were used by the managers to prompt staff to complete training, and if the training expired staff were sent a letter requesting that they update training as soon as possible.

The service had two PDMs and a consultant midwife who leads education across both sites. This team supported staff learning and development. They also worked clinically due to staffing levels.

The service held weekly 'protected cardiotocography (CTG) meetings,' although staff reported these did not always happen due to staffing and capacity issues. Doctors told us they escalated the inability to complete training to the lead consultant for training. We saw that 79% of midwives and 93% of obstetric staff had completed CTG training. This was an improvement since our last inspection.

Since our last inspection, in November 2020, the service had introduced a CTG competency booklet which had been completed by 50% of midwives and 100% of obstetricians.

Practical Obstetric Multi-Professional Training (PROMPT) was provided through 11 sessions per year. The study half day consisted of CTG training, human factors training, emergency scenarios and neonatal resuscitation sessions. Compliance was reported as variable with 84% for Midwives, 56% anaesthetists, and bank midwives (67%) were below the trust target of 90% in June 2021. Midwifery care assistants (MCAs) (91%) and Obstetricians (94%) compliance met the trust target.

Compliance with the gestation related optimal weight (GROW) training was below the 90% target for all staff groups. Data showed that 53% midwives and 63.2% doctors had completed the training which was not in line with recommendations from Saving Babies Lives 2019. However, this was an improvement since our last inspection.

Data provided showed that 79.39% of midwives had completed new-born screening training. This was in line with the services quality improvement programme trajectory.

Managers gave all new staff a full induction tailored to their role before they started work. The PDMs worked alongside new staff to ensure competence and help with any development needs. Staff reported that the PDMs were excellent and helped with all staff development.

Staff compliance with appraisals was below the trust target of 90%. Data provided showed that 48% of midwives and midwifery care assistants and 88% of medical staff had completed an appraisal.

Managers identified poor staff performance promptly and supported staff to improve. Any concerns with skills or practice were shared with the practice development midwives (PDMs) who were reported as being very proactive and supportive of the team. PDMs took action to address any concerns offering additional training or development plans.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The service had introduced a social media secure page for communicating key information with the team following feedback from the team. This was reported as working well and had improved staffs' knowledge of "what was going on".

We were told that the PDMs were working with peers across both hospital sites to "revamp" the preceptorship programme in time for the intake of staff in September 2021.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. We saw that the service had a minimum of two ward rounds per day. These were conducted by the consultant on call and included the midwifery team. We observed that the meetings were inclusive and detailed plans and actions required. Staff were respectful of each other and listened to opinions. Doctors and midwives reported effective team working and collaboration to provide care.

Although handovers and ward rounds did not follow a structured tool, such as the SBAR (Situation, Background, Assessment and Recommendation), we saw that information was clear and detailed enough to enable staff to know what was happening.

Staff worked across health care disciplines and with other agencies when required to care for women. We saw that additional support was gained from specialists if necessary.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. Although we did not see this during inspection, we saw detailed communication across teams regarding a woman with a mental health concern.

The service used a white board to record women's details and what was care/ treatment was required. The boards were updated regularly and used to inform discussions at MDT meetings and handovers.

Maternity (inpatient services)

Is the service responsive?

Inspected but not rated

We did not rate responsive at this inspection.

Access and flow

The service was accessible seven days per week. Women were referred to the service either through their GP or through the community midwives. Women could also self-refer using the trusts website.

Women were able to access telephone triage services from 7am to 8pm Monday to Friday. The operational triage (which was available 24 hours daily) consisted of one room on the delivery suite, where women received an initial assessment to identify the correct pathway. Triage was supported by the delivery suite coordinator in the absence of a dedicated triage midwife or when acuity was high, which placed additional pressures on the service. The coordinator was expected to review the woman on arrival and make an assessment of the treatment needed. The midwife would then be referred to the correct pathway.

The environment was not suitable for the effective management of admissions. We saw that triage was in constant use and that the lack of additional clinical space meant that women were not able to be seen if a doctor was available, if treatment or triage was already taking place. Triage was also dependent on the ability for the coordinating midwife to attend.

We saw that the service consistently delivered between 212 and 242 babies each month. The number of deliveries were displayed on the delivery suite as part of the maternity dashboard. Dashboard data also included multiple births and types of delivery.

Midwives reported that they would divert women to other sites if the staffing and activity caused concerns regarding women's and baby's risks. There was an escalation process in place for making the decision to divert care and we saw that there had been two reported incidents in the three months preceding the inspection, in response to acuity, staffing or capacity concerns.

The service collected feedback through the friends and family test. The maternity dashboard for March 2021 showed that 100% of women completing the audit said that they were extremely likely to recommend the service. We saw multiple cards and letters from women detailing their gratitude to the team for their support during their pregnancy. The service was achieving its target of 4.97% home births and reported achieving 5%. This was despite the reduction in community midwives in response to inpatient staffing levels. There were plans in place to improve home births once staffing levels had improved.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. Although, there were some delays in changes made to the service in response to feedback.

Maternity (inpatient services)

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The service displayed contact details for the patient advise and liaison team (PALS). Staff told us that concerns were acted upon quickly and that they would escalate to the coordinator, matron or service leads if necessary.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw communication across the team with themes and details of any specific complaints in the communication folder. The quality improvement plan for March 2021 detailed the number of complaints received and details of the areas of concern. We saw that the any concerns escalated to the PALS team were highlighted in the communication folder. There had been three concerns reported for maternity services which included concerns about treatment/ advise, concerns regarding a member of the public's behaviour and a negative comment about a women's experience on Orchard ward.

We were not assured that women's feedback about the service was always acted upon. The maternity voice partnership (MVPs) told us that they regularly feedback women's experiences to service leads. Common feedback from service users related to concerns with poor orientation to Orchard ward, for example, women were not always told where or how to access food and refreshments and there had been concerns relating to the insensitive attitude of some staff. Women using the service felt that their negative experiences were 'probably as a result of staffing.'

Is the service well-led?

Inspected but not rated

We did not rate well led at this inspection. Our previous rating of inadequate remains:

Leadership

Leaders had the skills and abilities to run the service, although the leadership team were relatively new and had not had sufficient time to embed changes. However, service leads understood and managed the priorities and issues the service faced. They were visible and approachable in the service.

Maternity services were part of the women and children's division. Since the hospital merged to become the Bedfordshire Hospitals NHS Foundation Trust, there had been changes to the local leadership. There was a director of midwifery, clinical director and senior general manager who had oversight of the service across the trust. The leadership team was new, with the clinical director being in post for one year and the head of midwifery and director of midwifery joining the team within the last three months.

The leadership structure was replicated by a head of midwifery, deputy clinical director and general manager at each hospital site. The clinical director had been in post for around one year and some posts had been recruited into over the last three months, consequently the team had not had sufficient time to mature.

Service leads told us they worked collectively across the trust and were visible on both sites. The team formally met weekly to discuss performance; however, it was clear from discussions with leads that they communicated on a daily basis about the service.

Maternity (inpatient services)

Service leads attended regular meetings with the trust board and senior leadership team (SLT). We were told that these meetings were focused on performance and the team were regularly held to account for performance. There was a nominated non- executive director lead for maternity services.

The leadership teams were supported by local matrons and ward managers. During inspection, the matrons were working clinically. Midwives had mixed opinions of the matrons and their ways of working. Some staff felt supported, however others felt that matrons acted as a barrier to change and found them overly critical, suggesting that they would prefer to approach senior leaders instead.

Maternity care assistants (MCAs) told us that they would go directly to the matron with any concerns as they did not have any "real supervisors" and felt that more support was required. Matrons were reported as trying to identify solutions to any concerns raised by the MCAs.

All staff spoke positively about the service leads and had confidence in their abilities to manage and develop the service.

Staff told us that service leads would visit the clinical areas and could be accessed if necessary. Some staff reported that changes to the leadership had been a positive action and that they felt more confident that action would be taken to improve the service. However, some staff reported that leads were often busy and that they could not always access them.

During inspection, service leads were knowledgeable of the risks, performance and development needs of the service. There was a cohesive plan to address concerns and a shared understanding of individuals roles and responsibilities in ensuring the service developed.

Vision and Strategy

The service had a vision for what it wanted to achieve which had been developed in conjunction with stakeholders. The vision was focused on sustainability of services and aligned to the wider health economy.

The service vision had been produced in conjunction with the staff, patients and the wider health economy and was aligned to the trust vision.

Service leads were clear about their aims and recognised that there was significant work that needed to be done. They told us that they wanted to embed new ways of working before taking on additional challenges, so were implementing changes initially based on safety.

The service had aligned the vision and strategy to the Local Maternity and Neonatal Service (LMNS) and leads spoke about collaborative working with the LMNS and other stakeholders to develop services.

Culture

Staff did not always feel supported and valued. Some staff reported that they did not raise concerns as a result of challenges by some leaders. However, staff were focused on the needs of patients receiving care.

All staff we met during our inspection were welcoming, friendly and helpful. They demonstrated effective working across the wider team and were supportive of each other. However, it was clear that staffing levels impacted negatively on staff morale. Midwifery staff were frustrated by staffing levels and some were visibly upset by their experiences. We were told

that staff did not always feel listened to when they escalated concerns about staffing levels and were often unsure on the number of staff that would be available to work particularly on Orchard ward. Staff recognised that higher risk areas, such as the delivery suite, needed appropriate staffing but felt this regularly left other areas vulnerable. Staff told us that they had attended listening events but did not feel that the information they shared was taken into account.

Service leads told us that they were aware of the issues that were being raised by staff and were attempting to address them, however, recognised that there was no quick solution. There were support processes in place which included pastoral support.

Staff told us they used the freedom to speak up guardian (FTSuG) to raise concerns about the service. The FTSuG, supported staff in raising concerns and feeding back to senior leads any themes from conversations. Staff valued this role.

Some midwives reported that concerns were not always escalated due to ineffective relationships with matrons. We were told that on occasions when concerns had been escalated, staff had taken concerns 'personally' or as a criticism, which had deterred individuals to continue to raise concerns.

Stakeholders felt that staff were under pressure, and that burnout was evident, resulting in apathy. Some felt that staff were not as engaged as they had been prior to lockdown. Women's feedback to the maternity voice partnership included details of staff not acting when asked for pain relief, or not being as supportive with concerns.

Service leads told us that the consultant group were very supportive and had taken on additional lead roles as part of the service and their own development. For example, there were consultant leads for labour, termination of pregnancy and antenatal. The leads were expected to review pathways as part of the lead role.

The service had introduced 'Greatix,' which was a forum to share good practice or to celebrate achievements.

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.

The service utilised multiple meetings to share learning and monitor performance. Meeting structure was replicated across the service and trust at all levels. For example, the maternity safety and governance meeting fed into the clinical service line and then trust wide safety and governance meetings.

Meetings were chaired by the most appropriate person, with clinical leads or executive leads attending as necessary. We saw a selection of meeting minutes and found them to be detailed and clear. Meetings were well attended with full multidisciplinary attendance, and actions were highlighted and reviewed at each meeting. Meetings operated across both sites and fed into the trust executive board. Service leads confirmed that they met with the board regularly to discuss performance.

We reviewed minutes from a selection of meetings for February to May 2021 and saw that they were well attended and there was clear discussion around cases and any learning highlighted.

Staff received weekly reports and newsletters about the service. Key information was shared through meetings, minutes, social media and newsletters. Staff told us they felt informed.

Partnership working was evident, with regular meetings and collaboration with the wider maternity services, such as the Local Maternity and Neonatal Service (LMNS) and the maternity voice partnership (MVPs).

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.

Service leads were fully aware of the risks across the service and had plans in place to address them. Risks and performance were being managed in line with service improvement plans and informed decisions regarding pathways and developments. This was an improvement from our last inspection. The main area of concern was staffing, and mitigation was in place to address this. Additional risks were largely linked to the improvement of pathways and work to be completed in response to the merger to ensure consistency across the hospital sites.

The service had employed a maternity risk matron who was responsible for the oversight of risk across the service and to assist with the development of systems of working. Their main role was to focus on the development and maintenance of the risk register, incident reporting and investigations. The role required weekly meetings with service leads and the wider trust risk team.

There was a detailed risk register in place which detailed mitigation taken to address concerns and identified regular reviews. Risks had named leads for reviewing or implementing changes. Timelines for reviews were clearly recorded.

There was a maternity dashboard which was used to display performance. This was currently RAG (Red, Amber and Green) rated, however, we were told that the clinical service line was working towards using statistical process control (SPC) charts to more accurately show changes in performance. The governance team had been plotting performance against statistics and peers over the three months preceding the inspection in preparation for the transfer. The maternity dashboard was reviewed at LMNS level to identify benchmarking across the area.

The service had a robust quality improvement plan which addressed areas for development such as pathways of care and staff culture. The team were being supported by the operational development team to address some of the areas.

The service was reporting into the Clinical Negligence Scheme for Trusts (CNST) and leads told us that the service would be compliant with five areas, which was lower than expected. There were plans in place to improve compliance.

Service leads were using birth-rate plus to help with the management of acuity and workload. Staff were expected to submit data into the tool to enable the identification of pressure, however, staff reported that they did not always have time to complete this due to reduced staffing.

Engagement

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

Maternity (inpatient services)

The service endeavoured to capture staff engagement and feelings through regular surveys and listening events. Staff completed the NHS staff survey and service leads were in the process of breaking down this information into sites, having received trust wide results. We were told that the staff survey results were very mixed.

The service also complete staff surveys in line with the MatNeo (Maternity and Neonate- National Patient Safety Improvement Programme). In addition to qualified staff opinions, student midwives were also asked to provide feedback, which was reported as being very positive. However, midwives told us they did not always receive feedback relating to information collected.

The service reported regular staff listening events, however acknowledged that these had been placed on hold, due to COVID-19. There were plans to reinstate the events now social distancing rules had eased.

We spoke with the maternity voice partnership (MVPs) who told us that they engaged with the service regularly and worked collaboratively with the local maternity system to develop services. Projects were being driven externally to the service and had been impacted by the COVID- 19 outbreak. MVPs felt frustrated by the lack of pace in changes to the service and told us that they frequently had to chase to get responses or traction.

Service leads told us that the MVPs supported the trust, providing information about women's experiences and assisting with their response to the Ockenden report. We were given examples of additional contributions, such as ward visits, assisting with COVID-19 testing for visitors and participation in recruitment. The head of midwifery and MVP met every two weeks with the Local Maternity and Neonatal Service (LMNS).

Service leads told us that the MVPs were engaging with religious and minority groups to increase the service profile and improve understanding of and feedback about services available. MVPs confirmed that they had been working with the Local Maternity and Neonatal Service (LMNS) to drive engagement with minority groups, such as travellers, Black, Asian and Minority Ethnic (BAME) groups, however, this work had halted due to the inability to meet women in person.

Staff attended the LMNS meetings which were held monthly, however, we were told that this was not usually one individual, which meant that there was not a designated person to escalate to or drive change. We were told that the LMNS was proactive and had task and finish groups in place to meet project needs, however the service at Bedford had not driven changes as much as the other hospitals within the group.

There were a number of safety champions within the staff group. These staff members would meet with the board safety champion to share information and any concerns or feedback.

Staff reported that COVID-19 had helped to improve collaborative working across the two hospital sites, with staff prioritising work on pathways for Black, Asian and Minority Ethnic (BAME) women who were at an escalated risk due to the pandemic.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Service leads were committed to developing the service and were working towards a trust wide integrated team with pathways aligned across both hospital sites. Due to the merger of the trusts, hospital sites had slightly different pathways.

Maternity (inpatient services)

Stakeholders told us that the service did not drive changes and there was a reliance on the wider system to develop new ways of working. We were given examples of where the service had become focused on individual scenarios or incidents instead of the pathways of care.

Although there had been some improvements since our November 2020 inspection, there continued to be concerns around staffing and culture which had been flagged as areas for improvement since our 2018 inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations:

- The trust must ensure that compliance with all mandatory training, safeguarding and any additional role specific training is in line with the trust target. (Regulation 18 (2) (a)).
- The trust must ensure that all staff maintain effective infection control and prevention practices. (Regulation 12 (2) (h)).
- The trust must ensure that all risk assessments and women records are completed accurately and reflect risks based on full assessments. (Regulation 12 (2) (i)).
- The trust must ensure that there are adequate numbers of staff to meet the demands of the service, including, midwives, medical staff and supernumerary coordinators. (Regulation 18 (1))
- The trust must ensure that there is a dedicated triage team for the management of women attending the service. (Regulation 18 (1)).

SHOULDS

- The trust should ensure that all clinical areas are fully suitable to the service needs.
- The trust should ensure that women have access to specialist nutritional support in a timely way.
- The trust should ensure that women are orientated to the service to enable timely access.
- The trust should ensure that all activity is audited, including referrals and triage calls and attendances.
- The trust should ensure that all equipment and safety alarm checks are completed regularly, and action taken as necessary.
- The trust should ensure that all equipment cleaning is recorded in line with local policies and procedures.
- The trust should ensure that there are adequate facilities and processes in place for staff to escalate concerns.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and two specialist advisors who had experience in maternity services. The inspection team was overseen by Phillipa Styles, Head of Hospital Inspection.

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
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing