Northampton General Hospital NHS Trust

Northampton General Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Northampton General Hospital

Requires Improvement 

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

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

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

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

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

Northampton General Hospital is the main site for maternity services for the trust. It comprises of a central birth suite which was midwife lead, a labour ward with maternity theatres and a close observation unit. Post and antenatal wards, day assessment unit, and maternity triage.

A higher proportion of mothers (16%) were in the second most deprived decile at booking compared to the national average. There were 75% white women, with 12% Asian or Asian British and 6% Black or Black British women. There was also an increasing community presence of an Afghanistan community.

Maternity services delivered 4,019 babies between January and December 2021.

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

How we carried out the inspection

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

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 Northampton General Hospital.

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

- Not all midwives and medical staff had completed level 3 safeguarding training or training in infection prevention and control.
- Staff did not consistently complete checks of specialist equipment and there were some out of date and missing items on emergency trolleys.
- Staff did not always fully and accurately completed records in relation to antenatal appointment and birthing plans.
- The service did not always have enough staff to care for women and keep them safe or to support their choices in birthing options.
- Infection, prevention and control was not always followed to reduce the risk of infections, from the environment and the use of PPE.

However:

- The service had enough staff to care for women and keep them safe. Staff had undertaken mandatory training in some key areas and skills. They worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well.
- The service managed safety incidents well and learned lessons from them.
- Staff understood the service's vision and values, and work was in progress to support the culture of the unit to promote these.

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement

Mandatory training

The service provided mandatory training in key skills to all staff, but not all staff were up to date with mandatory training.

The service had a maternity services training strategy it was version controlled and in date. It had an up to date training needs analysis which outlined the specific maternity training requirements for each staff group and the frequency of the training.

A weeklong learning programme had been developed which encompassed different days of training. This covered refresher training, new requirements or training as a result of incidents. The training feedback from was positive, staff felt the protected time enabled them to focus on the training. This programme was still being rolled out to all staff, which meant we found gaps in some areas.

The trust target for mandatory training was 85%.

Nursing and midwifery staff had not always kept up to date with their mandatory training. We saw overall compliance with mandatory training was 79.7%, which was below the trust target. Infection prevention and practice training compliance was 43.5% for midwifery staff and fire safety training was 74.5%. However, compliance rates were above 85% for the mandatory training modules, covering safeguarding for children, equality and diversity, Governance and record keeping and moving and handling.

Medical staff had not always kept up to date with their mandatory training. Medical staff overall compliance with training targets was 69.7%, which did not meet the trust target. Medical staff compliance was below target for safeguarding adults' level 1 (72%), equality and diversity (78%), fire safety training (56%), infection prevention and practice (44.9%), manual handling (66.7%) and health and safety (72%).

The service had identified 45 staff to be trained in Advanced New-born Life Support and 97% of these had completed the initial course with 73% completing the annual update.

Midwifery staff completed basic life support training and 81.9% of midwifery staff had completed this. Only 77.5% of medical staff had completed adult basic life support training. This meant the trust could not be assured the staff on all shifts were suitably trained and up to date.

Staff completed regular skills and drills training. These relate to onsite training sessions on topics which may have been identified from incidents or as a refresher. Information provided by the service showed 85% of staff had completed a maternity specific multidisciplinary training day. However, we found gaps in relation to Birthing pool evacuation.

The service offered women the use of three birthing pools in the Barratts Birthing centre and a birthing pool on the Sturridge labour ward. We asked the trust to provide training data for birthing pool evacuation. After the inspection the service told us pool evacuation training was a module in the point of care simulations which had been suspended during the COVID-19 pandemic and again in April 2022. The service told us they had introduced a pool evacuation training video in the PROMPT (PRactical Obstetric Multi-Professional Training), training day and plan to reinstate simulations in 2023. The figures shared with us reflect 78% of midwives and 81% of maternity support workers have participated in these training sessions. However, face to face training had not been completed since the beginning of the pandemic. Therefore, the trust could not be assured staff were competent in the event of sudden deterioration of women in the birthing pool who required evacuation.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff were offered training on how to recognise and report abuse and they knew how to apply it. However not all staff have completed it.

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The service offered level 3 online safeguarding children training to staff. We looked at the content and saw it included expected areas including child sexual exploitation and female genital mutilation (FGW). Arrangements were in place for women with, or at risk of, FGM. Any identified issues were referred to an obstetric consultant and the safeguarding team.

The face to face training included scenario-based training, from incidents or new items which could relate to the service. The service provided a schedule throughout 2023 to cover level 3 safeguarding training sessions with a range of topics and external speakers.

Level 3 safeguarding children training was provided to staff in line with national intercollegiate (2019) guidelines. However, not all nursing and midwifery staff received specific training for their role on how to recognise and report abuse. Only 45.8% of eligible midwifery staff had completed safeguarding adults' level 3 training. However, 88.1% had completed safeguarding children level 3 training.

Not all medical staff received training for their role on how to recognise and report abuse. Medical staff did not complete level 3 safeguarding adults training and compliance with level 3 children's training was 58.7%.

This meant the trust could not be assured the staff on all shifts were suitably trained and up to date with safeguarding requirements.

After the inspection the trust told us following discussions with the Integrated Care Board (ICB) their aim was to meet their target of 85% training in Adult Safeguarding Level 3 by 1st April 2023 and were on trajectory to achieve this. We will review this on our next inspection to ensure compliance has been met.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were designated safeguarding midwives, however, staff told us there was a lack of defined roles and responsibilities. This meant there was a reliance on the safeguarding midwives to deal with all safeguarding referrals which meant they lacked the capacity to address them all. This meant there was a risk some safeguarding concerns could be missed due to capacity or lack of knowledge.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service met with social services monthly to discuss unborn babies, review cases and share concerns.

The safeguarding team and the specialist team for ethnic minorities (BAME-black, Asian and minority ethnic, specialist team) worked together to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

There was a new baby abduction policy. Staff received a copy and were required to sign off they had read and understood the policy. A near miss of a baby abduction in May 2022, investigated August 2022, prompted the renewed policy. Since the introduction of the new policy, there had been no simulations to ensure staff understanding of the policy or that it was embedded into daily practice. This meant the trust could not be assured that the staff know how to respond in the event of the risks around baby abduction.

We raised concerns about baby abduction with the senior management team. The service sent us a letter dated 22 December 2022, confirming the immediate actions they had taken. A baby abduction drill was undertaken on 16th December 2022. The drill concluded that the staff demonstrated good knowledge of immediate actions required following an abduction as well as ongoing actions. However, this drill did not include external stakeholders, staff articulated who they would call. The service plans to complete a full multi-agency drill in February 2023.

Maternity

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Measures were not always in place for equipment and control measures to protect women, themselves and others from infection. Ward areas were not always clean, and some furnishings were not well-maintained.

Cleaning records were not up-to-date and demonstrated some areas were not cleaned regularly.

We reviewed the cleaning audits for the last 3 months for Robert Watson and the Labour ward. The average of these audits was 98% and 97% respectively, however, during our inspection we found areas which were not clean and equipment which had not been maintained or repaired.

We identified a shower on the Robert Watson ward contained mould and other areas had dust and dirt not removed from general cleaning. Fridge temperatures checks were not consistently done, and this meant items stored in them could be at risk of not being effective or safe to use. We found pool equipment was stored under the sink, in the labour birthing pool room, this placed the items at a higher risk of infection. We found damaged chairs on both wards which would impact the effectiveness of cleaning.

The service could not be assured staff cleaned equipment after contact with women. When women were discharged from Robert Watson ward there was no system to inform the cleaning staff the area required cleaning. On a busy ward this placed a risk of areas not being cleaned between women using the same space.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). For example, we saw blood and urine samples handled without gloves. Babies having their nappies changes by the midwife, not wearing a disposable apron and gloves. This meant there was a higher risk of transference in relation to infections.

We raised concerns about infection, prevention and control at the end of the inspection to the leadership team. After the onsite inspection the service sent us a letter dated 7 December 2022, confirming the immediate actions they had taken. An environmental cleanliness audit on Labour ward and Robert Watson was completed on the 1st December 2022. The service took actions to address the areas found and a daily hand hygiene and PPE audit are now in place. Fridge temperature checks were put in place and being monitored. In addition, we were told the mould in the shower had been removed.

Environment and equipment

Equipment used in emergency situations was not always checked, however, the design, maintenance and use of facilities, premises kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Although staff carried out daily safety checks on specialist equipment, we found the required items within the trolleys did not always correlate with the checklist.

On Robert Watson ward the obstetric emergency trolley and the eclampsia emergency tray, had missing items against the checklist, in addition it also contained items not on the list. These inconsistencies could have had an impact on women's care as staff relied on the items within the trolleys in an emergency or daily use.

The resuscitaire on Robert Watson and transitional care both had missing items, reflecting the items had not been cross-referenced with the checklists provided. We also identified a large number of items available but not listed on the checklist, which impacted on the storage of essential items which were required in line with policy.

We raised concerns about the checking of emergency equipment during the inspection to the leadership team.After the onsite inspection the service sent us a letter dated 7 December 2022, confirming the immediate actions they had taken. The service confirmed the trolley checklist on Robert Watson, had been brought in line with the rest of the maternity unit. Information about the changes were shared with staff as part of the 'Take Five communication tool' during handovers.

Most equipment we reviewed was in date for servicing. For example, all equipment we reviewed had been serviced within the last year and displayed labels to confirm this.

The service had suitable facilities to meet the needs of women's families. The Barratts midwifery-led unit women had access to birthing pools, birth balls and stools to support movement in labour. However, it was identified these facilities were not always accessible due to staffing levels.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff did not always identify and quickly acted upon women at risk of deterioration

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately.

The triage system used was based on an evidence-based triage system. This system was developed to better assess and treat pregnant women who attend hospital with pregnancy related complications or concerns. The service had set the timeframe to be seen by a midwife as 15 minutes recommended by the evidence triage system tool.

The service had a maternity assessment centre where women could telephone the department to obtain advice. The triage telephone was located in the antenatal clinic. This was a conscious decision to have the telephone removed from the physical triage, which reduced the bias on any actions agreed in response to the caller's needs.

On 17 October 2022, the triage unit was moved to be within the same geographical footprint of the labour unit. When women arrive in triage, the service's standard was to be seen by a midwife within 15 minutes. The midwife completed some initial screening of blood pressure, pulse, and temperature. The women were then RAG rated (red amber green), which provided timescales and priority when women should be seen, depending on the urgency of their concern or symptoms.

An audit had been completed in May 2022 prior to the triage move. The audit identified that 100% arrival time was recorded, however the time seen by the midwife was recorded on 94% of occasions, and the doctor 73%. This meant the times women waited was not always recorded to ensure they were seen within the required timeframes. All women had an initial assessment including palpation and auscultation of the fetal heart on arrival. The audit showed for palpation was 88% and auscultation of the fetal heart 94%. The outcome of the audit noted, incomplete documentation of time seen by a doctor and the full initial assessment to include palpation and auscultation.

Maternity

On the day of the inspection we reviewed the recording of the times women had arrived, been seen by a midwife and the times seen by the doctor. The records between 7.00pm and midnight showed women waited an average of 30 minutes before being seen by a midwife. Average waiting for a doctor was an hour. Between the hours of 8.00am and midday, the times to see a midwife varied from 20 minutes to an hour. The recording of the time seen by the doctors was inconsistently recorded.

The service was about to launch the full implementation of the Birmingham symptom specific obstetric triage system (BSOTS) method of triage assessment and was developing training for staff in using the system. However, no audit had been completed following the relocation of the triage unit. This meant there was a risk the measures were not in place to support the staffing requirement to meet the planned timeframes. The delay of women being seen in triage, could have had an impact of the care they receive to support their care and the care of the baby.

The service told us they planned to put in place a new audit for the triage system, to consider the embedding of system and any waiting times, however, we were not given a timeframe for this.

The new-born and infant physical examination (NIPE) screens babies for specific conditions, ideally within 72 hours of birth. The service audited the completion of NIPE examinations and in quarter 2 achieved 95% compliance. Those who had not received a NIPE their details were examined and any possible action to reduce a reoccurrence was considered.

The service used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating.

The outcome of a serious incident in 2021 identified concerns over whether the MEOWS scores had been measured and acted upon appropriately. An audit was completed in May 2022, which reflected the actions taken to prompt the use of MEOWS, this included training, shared outcomes of the audit and support for future workstreams.

A further audit was completed in June 2022 and noted MEOWS were now being used routinely for all maternity inpatient patients. Further actions from this audit identified the need to align all relevant guidelines and paperwork to ensure clarity in the escalation process. We found this area of routinely recording MEOWS had improved and continued to be monitored.

The governance team reflected on this work and the improvements which continued to be made in this area. This ensured safety measures were in place and enabled escalation processes to be instigated to address the risk.

Staff knew about and dealt with any specific risk issues. Cardiotocography (CTG) was used during pregnancy to monitor fetal heart rate and uterine contractions. The service told us all staff were required to complete a competency test before they were recorded as passing the training. Overall compliance with CTG training and competency test was 94%.

The service had access to centralised CTG monitoring system at the nurse's station to support reviews. In addition to this 'fresh eyes' were completed by midwives to maintain an object overview of any CTG readings.

The service provided training in intermittent auscultation (IA). This was the technique of listening to and counting the fetal heart rate for 1 minute following a contraction during active labour for low risk women. Overall compliance with IA training was 62% but the service provided information that showed they had plans to improve compliance from December 2022, however no date of planned completion was identified.

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Staff in maternity theatres used the World Health Organisation (WHO) Surgical Safety Checklist which was a tool aimed at decreasing errors and adverse events in theatres and to improve communication and teamwork. We reviewed the WHO surgical safety checklist and found them to be completed correctly.

Staff completed risk assessments for each woman antenatally, on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring at the point of booking. We reviewed the recording of carbon monoxide monitoring and found completion in the last 3 months as follows: August 68%, September 80% and October 68%. Smoking can have an impact on the growth of the baby and these figures are below the required levels as indicted under the Saving Babies lives agenda. To support this area, the service had initiated an action plan and had recruited a band 4 Maternity Tobacco Dependency Advisor to support promotion and training in this area.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of deteriorating mental health during pregnancy. Staff screened women for depression using the 'Whooley questions.' The questions are a screening tool which was designed to try and identify symptoms that may be present in depression. There was a referral process to ensure support was accessible for women who identified with possible mental health needs.

Women who chose to birth outside of guidance were provided with support and face to face meetings with theprofessional midwifery advocate (PMA). This enabled them to discuss risks and choices and complete birth plans together.

We observed the handovers in each of the wards. The details shared included all necessary key information to keep women and babies safe. Staff used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. We saw woman's language or communication needs were discussed to ensure they were able to share important information or to obtain any related consent.

There was a pharmacist present during handover on labour ward, this was to support any drug requirements or discuss current issues. This addition to the handovers was as a result of work completed on medicines datix issues.

A communication folder was used to ensure the sharing of information or any required actions for that shift. The unit used a method called, 'take 5' this was a system to reflect any new paperwork requirements or initiatives.

At the time of our inspection the Maternity Voices Partnership (MVP) raised concern around delays in the induction of labour, which was in the process of being audited and reviewed to identify next steps. Other ongoing developments were around the promotion to use the Barratts birthing centre and accessible home births.

Midwifery Staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

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

Maternity

Managers calculated and reviewed the number of midwives, maternity support workers and registered general nurses, needed for each shift in accordance with national guidance. There was a planned ongoing recruitment approach. One of the tools used to consider staffing levels was red flags.

A red flag event was a warning sign that something may be wrong with midwifery staffing, based on the National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. The service told us the system for reporting red flags changed from LMNS Red Flag data to Birthrate Plus Acuity.

During November there had been 10 red flag events. There had been 10 incidents reported for cancelled Elective Caesarean sections in the 6 months prior to our inspection. The service told us they were unable to capture the data for red flags due to the labour ward coordinator not being supernumerary which was not in in line with best practice. It was anticipated the service would be collating future red flags via the Birthrate Plus Acuity App, which had been introduced in November 2022. We did not have access to data to show how this had impacted the service since its introduction. This meant the service could not be assured of all the possible staffing issues which may have occurred and not been recorded during this period of transition.

The service last completed a staffing and acuity review in December 2021 for midwifery staff. This stated a requirement of 197.44 (WTE) band 3 to 8 across maternity services to meet the planned needs of women. The service told us they did not, at the time of our inspection, report planned versus actual data. The service was waiting the updated version of Birthrate plus to review their staffing.

The service shared with us the Northampton General Hospital and another NHS trust Joint Safe Staffing Report for July and August 2022, which was a joint report looking at the overarching workforce for NGH and another NHS trust. The report reflected an increase in the overall vacancy rate to 14%. Recruitment was ongoing but continued to be a challenge. The staffing vacancies were covered by bank staff. We reviewed the data which showed fill rates were not always accurate. During October 2022 the obstetric staffing requirement was only 46.87% filled. Within antenatal only 77% were filled. This meant these areas had reduced staffing to provide the required level of care.

Sickness in July 2022 was reported at 10% due to multiple factors, one being the omicron variant of COVID 19; this had since reduced to 5.5%. Midwifery vacancy rate was at 27.18 whole time equivalent (WTE), recruitment to these posts was anticipated to be achieved through student midwifes and 9international midwives.

We saw the last midwifery staffing paper sent to trust Board was on 30th March 2022; however, the director of nursing had reported to the Joint People Committee on a regular basis with regard to staffing. Due to the changes in management in maternity, a revised paper was due to be submitted to the board in January 2023, in line with the Maternity Incentive scheme requirements.

The service had recruited a maternity recruitment and retention midwife who will support the workforce strategy, look at returning midwives, new recruits along with exit interviews to understand the maternity workforce situation.

The service had a home birthing team along with a community team. However, in the last 6 months the home birthing team had been disbanded due to staff vacancies. The opportunities for women to birth at home had either not been accessible or restricted. The service had recently set up a volunteer pool of midwives who wished to be part of the home birthing arrangements, to enable them to expand their offer to women.

Maternity

The service had a range of specialist midwives to support different areas. We spoke with the bereavement midwife who shared with us the support networks on offer for women who have lost a baby. At the time of our inspection the service was 8.00am to 5.00pm Monday to Friday, this was not in line with the Ockendon (2022) recommendations, however, recruitment was underway to increase the bereavement support to 7 days.

We saw that initially there were 4 teams to provide continuity of care. However, during COVID 19 and the staffing pressure these teams were disbanded with the exception of the team who support women with cultural needs. This team had established positive links with the different communities especially the Afghan community.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. 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 babies safe.

Medical workforce Consultant obstetricians last year split into obstetrics and Gynaecology This was a clinically led decision to move to this model. Senior consultants reflected this as a strong approach to having the right people who are really engaged with the maternity agenda., Consultants were on site between 8.00am and 22.00pm, 7 days per week, there was a twilight shift and on call arrangements. There was a buddy system in place to provide cover and support for annual leave.

There was a consultant statement of purpose in respect of the roles and responsibilities from the Royal College of Obstetricians and Gynaecologists (RCOG), which was to be followed by the middle grade doctors should they need to escalate a siltation which required a consultant to attend. There had been some tensions with regard to the escalation process with junior doctors and consultants on Delivery Suite, however this had been identified and improvements had been made.

There had been some instability in the senior midwifery side, due to sickness at matron level, which had impacted on the doctor midwife relationship. However, following the senior midwife appointments staff told us they had noted some improvements.

The service had no consultant vacancies. The service told us they had a plan in place to increase consultant staffing from 10 to 12. The service used locum medical staffing when required to fill rota gaps; this supported the out of hours rota gaps that had been a long-standing staffing concern in the service.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always clear up to date. or easily available to all staff providing care.

Women's notes were not always comprehensive, the service had two recording systems which made it difficult to navigate having all the information easily accessible.

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We reviewed 7 records across labour and post-natal. These records showed details which should have been completed during antenatal appointments were either missing or completed by the women. These included the birth plan of the midwife or consultant. Carbon testing was not completed consistently and some records in relation to fetal movements at 25 weeks had not been completed.

When using paper records the patient sticker was not always attached, this was not in line with trust policy and meant should a page be separated from the file it would be difficult to know who the record belonged to.

The multiple systems did not talk to one another. As one was paper the other an electronic system call. For example, we reviewed a record which required a woman to receive an anaesthetic review, however we saw the checklist had not been completed on either system, this meant the trust could not be assured the review had been completed.

The service had identified this as a risk through the maternity service data set. There was a digital strategy support by the LMNS in moving to fully electronic records and the project had already engaged staff in the requirements and introduction. However, there was no specified time frame for this or any measures in place to consider how to provide consistency of record keeping, until the digital system is implemented.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines well.

Staff completed general medicine records accurately and kept them up to date. However, we reviewed the medicines records for the controlled drugs (CD) on Labour ward and found recording errors. For example, Pethidine had only been signed by one midwife, which was not in line with trust policy.

We saw the controlled drug book had not been checked for 5 days; however, this had been picked up by the trust audit and reported as an incident. We saw 6 epidural medicines had been administered with no administration time recorded or the required sign off, which had not been identified in the audit. This meant the service could not be assured the required checks were consistently completed for controlled drugs.

Staff did not complete maternity specific medicines management training. The service told us this was being developed and would be in place by the end of January 2023. However, all new midwives starting work in the service were required to complete a medicines management session during their orientation.

The service told us they had been working with staff to raise awareness of medicine errors and how to address these. A quality improvement project had been launched, using a maternity assessment admission check list in September 2022 to raise awareness, which in turn showed an increase in incident reporting which helped identify training needs. However, we saw there was no significant decrease with the incident reporting around medicines, which meant the changes and improvements had not been embedded to consistently reduce ongoing errors.

Incidents

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

Maternity

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.

There was a daily review of the incidents reported to consider the level of harm and the appropriate person to review and action. This ensured any trends or areas of increased risk were managed swiftly. Various quality projects were initiated from the datix reviews. For example, the work on medicines.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if, and when, things went wrong. Governance reports included details of the involvement of women and birthing people in investigations and monitoring of how duty of candour had been completed.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. Clinical governance meetings were held quarterly and looked at all the data and any outcomes from incidents. For example, the use of MEOWS and the SBAR tool for monitoring women and ensuring detailed handovers. Following training and posters to remind staff, this area had improved.

Staff were given the opportunity to develop areas of learning following incidents. The trust recognised leaders within their sphere of expertise in midwifery and maternity and invested in a fellowship programme to support the development of leadership and clinical practice. The ward sister was given protected time to develop a project, which looked at the streaming of women above 20 weeks, who present at the ED (emergency department). The project looked at how midwifery could teach practitioners in ED the risks to look for and guided actions. The outcomes of the project were to set up a delivery room in ED and provide training in the use of MEOWS and the SBAR tools. This had created better outcomes for the women, as needs where being identified swiftly and the correct support obtained. The learning from this project had been shared across the trust and will be publicised in a journal as improved practice.

There was evidence that changes had been made following guidance and consistent auditing.

The national guidance when supporting women with Postpartum haemorrhage (PPH), was changed from syntometrine to oxytocin.

The service made this change, but through audit noticed an increase in major obstetric haemorrhages (MoH). The service returned to using syntometrine for all women except those that have contraindications for syntometrine.

Managers investigated incidents thoroughly. We reviewed 2 serious incident investigation reports and found a detailed chronology was completed with care and service delivery problems considered and learning identified. Women and their families were involved in these investigations and meeting minutes showed where families had declined a Healthcare Safety Investigation Branch (HSIB) investigation of an incident that affected them. The weekly serious incident group meeting fed up to the quality and safety committee and to the trust board. Managers monitored incidents that were open over 60 days and we saw action plans in place to address these to a conclusion.

Is the service well-led?

Requires Improvement 

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

Maternity

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

The service was led by an associate director of nursing, deputy director of midwifery and a head of midwifery. The triumvirate was supported by divisional managers and in addition to clinical governance. There was a clear line of reporting into the executive directors and board. There was a governance group in place and regular directorate governance meetings were held. Relevant information was escalated to the trust quality and safety committee.

There was a new leadership structure in place within maternity. We heard how the new structure would work, which included clear lines of reporting, dedicated non-clinical time to attend regular meetings and clear roles and responsibilities.

Leaders told us they felt supported and had direct access to the board level executive and non-executive director safety champions, as well as regular bi-monthly meetings where risks and issues were escalated.

The service leaders had links with the Maternity Voices Partnership (MVP) and during the inspection we spoke with the MVP chair. The trust leaders, safety champions and the MVP had developed a good relationship and had developed resources to support black, Asian and minority ethnic groups and language needs. Offering a virtual library and support groups.

The director of midwifery met with the board maternity safety champion every month. The maternity board safety champion was well-sighted on issues relating to the quality and safety of the service and a strong advocate for the service at board level.

Vision and Strategy

The service did not have a specific vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was an overarching strategy for the Northampton General Hospital trust, however, there was not a maternity specific vision and strategy.

There was a workforce strategy which was looking at a range of areas to increase staff flexibility across the unit. This included on call arrangements, flexibility around contracts and rotational working to develop and enhance skills. This would be supported by the data from the birth rate plus data to ensure acuity can support the needs of women using the service.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

Maternity

Women, relatives and carers knew how to complain or raise concerns and information was clearly displayed in visitor areas. The service received 7 complaints in the 3 months prior to our inspection. We reviewed all 7 complaints, three of which referred to the care provided, 1 referenced the lack of options on home birthing and another referred to staffing levels. All the complaints had been investigated and responses provided in line with the services policy.

The service had been on a cultural journey, recognising 12 months previously action needed to be taken to address the culture within the hospital and especially the maternity unit. In February 2022, the service engaged the support of a speak up guardian and the chief executive officer (CEO) also held some connect and share sessions to provide staff with an open forum to discuss their concerns. One area which had been identified was around the rotas and differing contracts, which had been picked up under the workforce strategy.

Within maternity staff raised issues with us of a culture of feeling bullied by senior staff. Senior leaders were open about these issues and the impact these situations had on the workforce. Staff we spoke with felt although there had been the opportunities to speak up in open forum, actions from these meetings had not been addressed and many staff still felt their concerns had not be listen to or addressed. Senior managers reflected with us, how they were still on the cultural journey and further work was required to address the concerns by staff.

The workforce team had undertaken work to ensure midwives who had been recruited from abroad were supported with their transition to their new place of work and culture. The service provided pastoral support to identify cultural nuances and themes from these sessions had led to the development of post OSCE (objective standard clinical examination) international nurse transition (POINT). The idea of the programme was to support international nurses during transition to the trust by providing a robust induction programme. The programme aimed to develop their confidence and autonomy, break down any fear of hierarchy to make international nurses feel included and welcome.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities. However, they had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a meeting structure in place which meant senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues. There were also clear links to the Local Maternity and Neonatal System (LMNS) and the integrated care board. Prior to October 2022 the Governance department consisted of a Deputy Director of Governance leading the Governance Department with a Head of Governance and teams beneath them. One of these teams focussed on Clinical Governance (incident investigations) and liaised and supported maternity with incident investigations. This was an informal arrangement and was never included on an organogram due to ongoing discussions around processes. Both the trust clinical governance team and maternity governance team were experiencing significant staffing challenges which had prevented investigations from moving forward, however processes were being realigned to ensure both teams worked collaboratively, and this was reflected in the December 2022 organogram.

Clinical governance meetings were held quarterly. We looked at meeting minutes for the last 3 meetings; they covered topics including safety concerns, incidents, training, feedback, risks, issues, and learning.

We reviewed minutes of the last 3months, from a range of governance and managerial meetings. All had standard agenda's, follow up actions and covered risk, workforce, performance, relevant dashboards estates and external visits.

In relation to supporting women with home births, it was noted some women made a choice to birth outside of guidance. A free birth guideline had been developed and was going through the trust ratification process. All women who required support with decision making on birthing options had an opportunity to, 'meet the matron' run by the PMA (Professional Midwifery Advocate) team. This team provided support with birthing plans and post-natal support to parents who had been unhappy with their experience.

In the 12 months prior to our inspection, the Barratts birthing unit had officially closed two days in September 2022. However, access to using the unit was based on staffing. The service told us they planned daily staffing for the Barratts unit however, these roles were not ringfenced. Therefore, when labour became busy staff could already be allocated to the care of a labouring woman. This meant opportunities to utilise the birthing unit were restricted. Safety aspects were considered which meant it was not always safe for two midwives to be in the unit in isolation, this had led to the unit not being used for its delivery purpose. Recently the unit had been used to support women in early labour or preparation for a caesarean. The management told us they plan to promote the use of the unit to women of low risk, along with a more robust staffing plan.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. However, systems and processes to identify trends were not always in place for all aspects of the service. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

We reviewed the service's maternity quality dashboard. The dashboard provided target figures to achieve some indicators such as midwife to birth ratio and term admissions. We saw these were consistently monitored and actions were taken to reduce the risks.

The dashboard reported on clinical outcomes such as mode of delivery and trauma during delivery. A separate dashboard reflected time from knife to skin different grades relating to caesarean sections. The total elective rate for caesarean sections was 51.4% in Q1, 15.4%. in Q2 and the emergency rate was 25.4% in Q1 and 24.2% in Q2. The trust average for C sections was 39%, the National average was 35%, therefore the trust was above this average, no rational was provided to support the increase.

The service had a risk register in place. We reviewed the risk register and saw risks were identified by a red, amber green (RAG) rated system. We found the risk register had clear updates, and evidence of risk scores reducing, and all risks were progressing within the risk reduction target timelines set by the service.

One red rated risk related to continuity of care as required by NHSE (National Health Service England). Initially there were 4 teams, however these were suspended during COVID 19. With only 1 team maintained; this team supported ethnic groups. The managers planned to review this risk and consider how this requirement could be met in the coming months.

Managers and staff used outcomes from events to drive improvements. The trust had received 2 final reports from the Healthcare Safety Investigation Branch (HSIB) in the 6 months prior to our inspection. There were some general recommendations, and the service had identified these areas and implemented actions. For example, the use of MEOWS. The service was aware they were behind with their serious incident investigations, with their oldest being open for over 1 year. They had accessed support from the LMNS and recruited a consultant to help progress these investigations. A report was shared with the trust board each quarter, which included details of the deaths reviewed and the consequent action plans. Action plans were reviewed to ensure action was taken and embedded.

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The service participated in relevant national clinical audits, submitting data to the regional maternity dashboard. This meant the service could benchmark against other services in the region and contribute to system wide improvements. The service worked with other trusts in the region to review incidents and share learning.

Outcomes for women were positive, consistent and met expectations, such as national standards. Leaders benchmarked the service against the most recent 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE-UK) report and the recommendations discussed at the quality assurance committee meeting.

The service completed a range of audits in relation to Saving Babies lives care bundle V2. These were completed by the fetal surveillance midwife. We reviewed this data, however noted that it had not been completed for the 2 months prior to our inspection. The service told us this was due to a change in staff roles and recognised this needed to recommence as part of the auditing process, however, there was no specified timescale for this.

We reviewed the trust response to a saving babies lives survey which collected information on the progress of trusts to full implementation of the saving babies lives care bundle in October 2022. We noted that the reduced fetal movement survey had not consistently been completed, with completion during August at 88%, September 98% and October 75%. This along with carbon monoxide testing data not consistently being recorded could impact on early identified risk and consideration of appropriate actions.

Managers and staff carried out a programme of repeated audits to check improvement over time. The service had an audit programme in place, recently the audit list had been reviewed and the service had a forward plan to agree future priorities with the management team. However, some systems and processes were not, at the time of our inspection, in place to identify issues or trends in care delivery. For example, the number of women who would had chosen the birthing centre or home birth however had these denied. The audit of triage ahead of the evidence-based triage system implementation, to ensure all the required measures were in place.

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 had a range of dashboards and action logs which were used to monitor data on a local and national level. We saw these were used in a range of senior meetings to review and consider actions ahead of reporting any requested changes or risks to the trust board.

Maternity and Neonatal Safety Champions Meeting were held monthly. We reviewed the last 3 meetings and found that improvements were discussed in response to feedback, incidents, or complaints. The service used an action log, to monitor and review aspects of the meeting.

In relation to fetal growth restriction, it was noted the detection rates were low at 34%, a project was in place to review and address this area. The monitoring of reduced fetal movement had improved to 95%. Intrapartum fresh eyes monitoring was consistently at 95%

The service provided data on their recording to the national MBRACE survey. Details were addressed within governance meetings to ensure timelines were met and any investigations and learning followed up.

Maternity

Engagement

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

Maternity voices partnership (MVP) engagement meetings were scheduled quarterly, however additional meetings and drop-in sessions are arranged to address any immediate issue.

The MVP had established service user coffee mornings and the use of a virtual library. MVP meetings were arranged at different locations and times to provide the opportunity for different groups to attend.

We reviewed minutes from meetings and reviewed the actions plans which we identified were either completed or in progress. The MVP chair felt the trust were responsive and actions were driven by feedback from service users. For example, the promotion of home births was responded to with email communication being disseminated to staff to promote this option of delivery.

The service held a wide range of engagement meetings with the different grades of staff. Some of these were held face to face and others through emails, briefings and letters. We also saw engagement, which was service specific, these involved working groups for induction of labour, digital strategy or pieces of work that required action.

The service produced a newsletter for staff in September 2022, which reflected the changes to maternity and the opportunity to discuss any issues. The newsletter was launched along with a meeting held face to face and accessible via teams. The meetings and newsletter reflected the key priorities in maternity and to provided staff with updates and information about the National, Regional or Trust agenda.

The newsletter reflected changes to triage, workforce development, new staff, career opportunities and thanks to staff members. The service plans to hold these events every quarter to ensure engagement and the sharing of information.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services, however levels of completed training was below the trust's targets. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The meet the matron clinic had been recognised as a celebration point in the Ockenden (2022) report. We saw the PMA team met with over 600 women and or partners to support them with outside of guidance birthing plan, options available and post-natal issues.

The continuity of care team who supported people with cultural needs had established a relationship with the local Afghan community. To support them when requiring an interpreter, they had taught the women to say the word, 'interpreter' when they contacted the triage telephone support line. This meant the caller would know immediately the person required the support of language line, before they could explain their reason for the call.

Maternity

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure the premises used by the service provider is safe to use for their intended purpose and are used in a safe way. 12 (2) (d)
- The trust must ensure the reduction of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;12 (2) (h)
- The trust must follow appropriate guidance in the proper and safe management of medicines; 12 (2)(g)
- The trust must ensure the security of the unit is reviewed in line with national guidance. Regulation 12
- The trust must ensure staff complete mandatory, safeguarding and maternity specific training in line with the Trust's own target. Regulation 12(1)(2).
- The trust must ensure staff complete regular skills and drills training, especially in relation to birthing pool evacuation. Regulation 12(1)(2) (c)

Action the trust SHOULD take to improve:

- The trust should ensure there are the required staff to implement a robust system in maternity triage to include escalation process, monitoring and documentation.
- The trust should ensure the required staffing to enable women to have a choice of birthing options which include the Barratts birthing unit and home birthing.
- The trust should ensure the culture of the service continues to be addressed to ensure staff are listen to and measures put in place to improve the wellbeing of staff.
- The trust should ensure systems were in place to ensure audits were consistently reviewed and actions taken to address any identified concerns.

Our inspection team

During our inspection of maternity services at Northampton General Hospital we spoke with 24 staff including leaders, midwives and administration staff.

We visited all areas of the unit including central delivery suite, the Barratts birth unit, maternity triage, day assessment, and Robert Watson postnatal ward. We reviewed the environment, 7 records and equipment checks whilst on site. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors, along with two specialist advisors with expertise in midwifery.

The inspection was overseen by Carolyn Jenkinson Head of Hospital Inspection as part of the national maternity services inspection programme.

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

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