University Hospitals Bristol and Weston NHS Foundation Trust

Weston General Hospital

Inspection report

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Ratings

Overall rating for this location	Insufficient evidence to rate
Are services safe?	**Insufficient evidence to rate**
Are services well-led?	**Insufficient evidence to rate**

Our findings

Overall summary of services at Weston General Hospital

Insufficient evidence to rate

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 Weston General Hospital.

We inspected the maternity service at Ashcombe Birth Centre at Weston 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.

Ashcombe Birth Centre at Weston General Hospital provides maternity services to the population of Weston Super Mare, Clevedon and the surrounding areas in North Somerset.

Maternity services include scanning rooms, outpatient clinics and a midwifery led birthing centre Ashcombe Birth Centre. Between November 2022 and November 2023, 9 babies were born at Ashcombe Birth Centre at Weston General Hospital.

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.

Weston General Hospital is not currently rated.

Our rating of good for maternity services did not change the hospital rating overall.

We also inspected 1 other maternity service run by University Hospitals Bristol and Weston NHS Foundation Trust. Our report is here:

- UHBW Bristol Main Site – St Michael's Hospital - https://www.cqc.org.uk/location/RA7C1

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited the outpatient clinics, day assessment unit and birthing rooms.

We spoke with 2 midwives, 2 midwifery support workers and 3 admin staff.

We reviewed 2 patient care records.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

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

Good

We had not previously rated this service. We rated it as good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect women and birthing people from abuse, and managed safety well.
- The service controlled infection risk well. The environment was suitable, and the service had enough equipment to keep women and birthing people safe.
- The service had enough midwifery staff, planned and actual staffing numbers were equal to each other.
- Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- There was limited evidence of learning from incidents.
- There was no vision and strategy specific to the service.

Is the service safe?

Good

We had not previously rated this service. We rated safe as good.

Mandatory training

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

Midwifery staff received and kept up to date with their mandatory training. 88% per cent of staff had completed all 12 core skills mandatory training courses against a trust target of 90% and 91% of staff had completed all 19 remaining mandatory training modules against a trust target of 90%.

Medical staff received and mostly kept up to date with their mandatory training. 77% per cent of staff had completed all 12 core skills mandatory training courses against a trust target of 90% and 76% of staff had completed all 19 remaining mandatory training modules against a trust target of 90%.

Maternity

The service made sure that staff received multi-professional simulated obstetric emergency training. The practice development team regularly reviewed the contents of obstetric emergency training to include learning from incidents at the trust.

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

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

Safeguarding

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

Midwifery staff received training specific for their role on how to recognise and report abuse. Training records showed that 70% of midwives had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could name safeguarding leads.

Cleanliness, infection control and hygiene

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

The birth centre, including toilets, showers and clinical areas was visibly clean and well cared for. There were suitable furnishings, which were clean and well-maintained. A weekly cleaning schedule was displayed, and we could see the checks on this had been completed.

Staff followed infection control principles. They had bare arms below the elbow and hair was tied back. Staff wore uniforms and used personal protective equipment (PPE) as required. Hand washing and drying facilities were visible and there was access to hand sanitizer.

We did not observe staff needing to clean equipment after patient contact but saw labels were attached to equipment to show when it was last cleaned.

Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas.

However, staff at Ashcombe Birth Centre did not have access to clear guidance on how to clean birthing pools after use. Following the inspection, the service provided a copy of the clinical standard operating procedure for cleaning of water birth pools recently been updated in December 2023.

Maternity

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.

The design of the environment followed national guidance.

The unit was previously a hospital ward and had been redesigned as far as reasonably practical to fit the various areas of the service in. There was a reception desk and different waiting areas, depending on if attending for a scan, to see a midwife or the obstetrician. An obstetrician is a doctor who specialises in care during pregnancy, labour and after birth. A referral to an obstetrician is made if there are concerns about your pregnancy – for example, you had a previous complication in pregnancy or have a long-term illness. One labour room was in use at the time of our visit, with a second room adjoining, which could be turned into a labour room if needed.

Areas where women and birthing people would have an examination were protected by privacy curtains. Couches in these areas were clean and well maintained. All areas could be closed off by doors, which helped further with privacy. There was a shower cubicle in the Day Assessment Unit. This was clean and suitable for use.

There were 2 separate areas for scanning, the early pregnancy scan or antenatal clinic scans.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment was organised, well maintained and had been checked routinely. Whilst most checks were carried out on other emergency equipment grab boxes, including, the eclampsia and cord prolapse kits, we found there was undated flow charts and proformas and some paperwork with the boxes was not needed or was out of date. Boxes were dusty and were not easy to get into, as they had scissors attached to a string of plastic tags, which were not easy to cut through. We bought this matter to the attention of the lead midwife, who undertook to address them.

The service had enough suitable equipment to help them to safely care for women and babies. Equipment such as sonicaids, scanners and pulse-oximeters had been safety checked and labels were attached to indicate the next service date. There were wall-mounted resuscitaires in the labour rooms, one of which we checked. The wall-mounted resuscitaires did not have clear guidance for staff on the correct air/oxygen mix to use in an emergency. We raised concerns to the birth centre lead following the inspection that not all staff may be familiar with this type of resuscitaire.

We checked a range of single use disposable items of equipment, which were kept in the securely accessed storeroom. These were in date and easily identifiable by the storage arrangements.

Staff disposed of clinical waste safely in the right bins, which were easily identifiable.

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

Assessing and responding to risk

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

Staff risk assessed women and birthing people continually antenatally and there were clear criteria for use of the midwifery-led birth centre. The service also had clear criteria for use of the birth pool.

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. Staff ensured women and birthing people met the criteria for use of the birth centre.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Women and birthing people who chose to birth outside of guidance from consultants and midwives attended a birth options clinic with an obstetrician to discuss risks and options available to create a suitable birth plan together.

The service had processes to transfer to the main hospital site if needed. If an obstetric review was needed for someone birthing at Ashcombe birth centre midwives made decisions to transfer with support from the labour ward lead midwife and labour ward coordinator at the UHBW main site.

Midwifery Staffing

The service had issues with recruitment and retention and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

The Cherry Tree continuity of carer midwives were based at Ashcombe Birth Centre.

The birth centre lead could adjust staffing levels daily according to the needs of women and birthing people.

Midwifery staffing levels across the maternity service were improving. As of November 2023, there were 18.9 WTE midwifery vacancies with a projected vacancy rate of 9.9 WTE once new starters commenced.

Staff had access to the practice education facilitators who were based at the main hospital site in Bristol.

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used an electronic records system. We reviewed 2 paper records of women and birthing people who had given birth at Ashcombe Birth Centre and found records were clear and complete.

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

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

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

Maternity

Staff stored and managed all medicines and prescribing documents safely. The storage of medicines was within 2 separate cupboards, each requiring two different keys to access. We checked items therein stored and found they were in date and in their original packaging. Staff followed a patient group direction for the use of aspiring and glucose.

A range of take-home medicines, including anti-sickness and pain relief was available. The community pharmacist monitored stock and sign out through a log.

Oxygen cylinders were in date and most Entonox cylinders were in date, although 2 used by community midwives were almost empty. Staff had access to spare oxygen cylinders that were available to use in line with trust guidance There was no medicine contained within the eclampsia box, which would mean having to find the key holder of the medicine cupboard to gather necessary medicines together. Syntometrine medicine, which is used in the active management of the third stage of labour (delivery of the placenta) and to treat excess blood loss following birth, was labelled with the date it was removed from the fridge and the date it was to be disposed of.

Fridge temperatures had been regularly checked.

Controlled medicines were managed by a different team (gynaecology), and therefore were not checked for this inspection.

There was a trained midwife who could place contraceptive implants. The diabetic midwife was a non-medical prescriber. Patient group directions were available for paracetamol and diclofenac. Patient group directions (PGDs) are written instructions to help supply or administer medicines to patients, usually in planned circumstances. If an iron infusion was required, this would only be administered if the consultant was present.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Incidents

There was limited evidence of reporting and learning from incidents at the Ashcombe Birth Centre

We reviewed 4 incidents reported in the 12 months before inspection and found them to be reported correctly.

The Birth Centre lead was reviewing an incident where a woman had been transferred to the accident and emergency department from the birth centre without an appropriate handover. The birth centre lead planned to improve the standard operating procedure for transfer from the birth centre and improve communication with the emergency department.

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.

No serious incidents had occurred at the Ashcombe Birth Centre in the past year.

Maternity

Is the service well-led?

Good

We rated well-led as good.

Leadership

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

Maternity services at Ashcombe Birth Centre were managed as part of the Women and Children's Division of University Hospitals Bristol and Weston.

Ashcombe Birth Centre was managed by a band 7 lead midwife who was supported by the community matron for the trust. The community matron reported to the Deputy Director of Midwifery and the Director of Midwifery for the trust.

Vision and Strategy

There was no specific vision or strategy for Ashcombe Birth Centre at Weston General Hospital.

Maternity services across the trust had a clear vision and strategy. They had developed the vision and strategy in consultation with staff at all levels. The service had a 'strategy on a page' document for maternity services at St Michael's Hospital as part of the trust 2020 to 20245 strategy. Strategic aims included but were not limited to investing in staff wellbeing, delivering integrated maternity services and embedding a culture of research.

Culture

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

Staff we spoke with were consistently positive about working at the service and the trust.

The service had received no complaints in relation to Ashcombe Birth Centre in the past year.

Staff were able to raise concerns. For example, community midwives had raised concerns with the community matron about the on-call rota and challenges taking compensatory rest. In response managers were auditng on-call shifts and whether community staff were able to take compensatory rest in a timely way.

Governance

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

Maternity

Managers did not formally audit transfers out of the freestanding midwifery led birth centre to the main hospital site. We requested transfer audits for the past year and the service provided details of the 2 transfers that had occurred in the past year out of 10 births. This is a transfer rate of 20%. Of these transfers 2, both were postnatally. The community matron reviewed all births and transfers from the birth centre as well as home birth activity. The trust told us there were not enough births at the birth centre to complete a formal audit.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Staff had access to policies through the trust intranet.

Staff told us a multidisciplinary meeting took place on alternate months. This allowed the wider and local team to discuss any issues, discuss good practice and agree what needed to be added to the action log. They felt this enabled greater ownership of the actions required. A separate meeting was held for the Ashcombe unit every month.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The community matron completed a yearly risk assessment for Ashcombe Birth Centre. The risk assessment was last updated in November 2023. Top risks in relation to the management of the birth centre were the risk that an intrapartum or neonatal emergency may occur without access to emergency support from the hospital, lone working and midwives attending births not always being familiar with the birth centre. These risks were mitigated by training band 6 and 7 nurses in the emergency department in neonatal resuscitation, staff completing conflict resolution as part of mandatory training and ensuring all new community midwives were given a tour of the birth centre.

The maternity dashboard did not include the number of births at Ashcombe Birth Centre. While the data from births at Ashcombe Birth Centre was included in the overall maternity dashboard, the service did not monitor clinical outcomes (such as post-partum haemorrhage and perineal tears) at the birth centre specifically. The service was unable to compare clinical outcomes between the Ashcombe Birth Centre and UHBW main site to ensure there was no unwarranted variation.

Information Management

The service collected reliable data and analysed it.

The service used an electronic records system.

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.

Engagement

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

Maternity

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to improve maternity services. The service held a monthly Patient Experience Group to gather feedback from service users and the MNVP was invited to and attended these meetings. However, the trust mainly used the MNVP to gather the views of local service users and they had minimal involvement in governance and co-production of maternity services.

We reviewed the minutes of the last three Patient Experience Group meetings and found feedback from service users and complaints was discussed. Actions from these meetings were monitored through an action plan that was reviewed at each meeting.

For the 2022 CQC Maternity survey the trust scored the 'same for 43 questions, 'better' and 'somewhat better than expected' for 6 questions and 'worse than expected' for 1 question. Maternity leaders had worked to improve results to the survey through joint working with the MNVP.

Leaders understood the needs of the local population. Managers worked to ensure local women and birthing people had access to the same range of antenatal clinics at the Weston hospital site as the Bristol site to minimise the cost and inconvenience of having to travel to Bristol.

Learning, continuous improvement and innovation

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

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

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. At the time of inspection, the service was involved in several research trials including: the Fern Study (Intervention or Expectant Management for Early Onset Selective Fetal Growth Restriction in Monochorionic Twin Pregnancy) and Stitch 2 (Emergency Cervical Cerclage to Prevent Miscarriage and Preterm Birth: A Randomised Controlled Trial).

The diversity and inclusion practice education facilitator midwife had produced 'what's in a name' pronunciation stickers with people's names spelt out phonetically to ensure staff correctly pronounced people's names. The stickers were launched in November 2022.

Ther service had created a series of induction of labour animations to support women and birthing people to understand this process better and support informed decision making.

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.

Maternity

Action the trust SHOULD take to improve:

- The service should ensure all staff are aware of the birth pool cleaning process.
- The service should ensure staff are aware of the correct air/oxygen mix to use for neonatal resuscitation.
- The service should ensure transfers from the freestanding midwifery led unit to the main hospital are audited.