Liverpool Women's NHS Foundation Trust

Inspection report

Liverpool Womens Hospital
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

Liverpool Women's NHS Foundation Trust is a specialist trust that specialises in the health of women, babies, and their families. It is one of only two specialist trusts in the UK and the largest women's hospital in Europe. As a tertiary centre the hospital provides care for a significant proportion of patients with high levels of complexity and clinical risk, as well as serving a local population with significant deprivation. The hospital teams deliver around 8,000 babies and perform some 10,000 gynaecological procedures each year.

The trust is situated in an area where 44% of the population live in the lowest quintile for deprivation in England. 26% children (0-15 years) live in poverty. The region performs significantly worse for premature cancer, cardiovascular disease (CVD) and respiratory deaths. 46% of women booking with Liverpool Womens Hospital are from the 1st decile on the deprivation index, compared to a national average of 13%

The maternity team cares for women and their babies from conception to birth supported by the neonatal team who provide around the clock care for premature and new-born babies needing specialist care.

The trust's fertility team helps families to improve the chance of conceiving babies. Community midwifery teams were based in areas of deprivation.

In gynaecology, the trust undertakes care of women with the many varied conditions associated with the female reproductive system and is a centre for gynaecology oncology. The genetics team supports families with the diagnosis and counselling of genetic conditions. The trust also carries out gynaecology operations including surgical termination of pregnancy.

The new Community Diagnostic Centre (CDC) at the hospital includes a mobile CT scanner. At the Crown Street site, the CDC has a new colposcopy suite, CT, and MRI imaging facilities.

We carried out an unannounced inspection of the gynaecology services provided by this trust.

Our findings

A focused inspection of maternity services was also carried out as part of the CQC national maternity inspection programme which looked only at the safe and well led questions. We also inspected the well-led key question for the trust overall.

We did not inspect neonatal services, end of life care or outpatients, using our ratings principles the ratings for these services have been aggregated from the inspection in 2019.

Our rating of services went down. We rated them as requires improvement because:

We rated safe and well led as requires improvement. We rated caring, effective and responsive as good. We rated one of the trust's services as requires improvement and one as good.

Overall, the trust leadership team had knowledge of the main priorities and challenges faced by the service for the future but did not always understand and manage the immediate priorities and issues the service faced.

Although there were governance processes, throughout the service and with partner organisations, these processes were not always managed effectively.

Not all staff felt respected, supported, and valued. However, they remained focused on the needs of patients receiving care. Some staff had raised concerns several times regarding safety and staffing directly to senior leaders however they saw no quick action or improvement.

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues with effective actions to reduce their impact.

The trust collected and analysed data however it did not always act on it in a timely way. Not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were not always consistently submitted to external organisations as required.

However:

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service had an open culture where patients, their families and staff could raise concerns without fear**.** Although in maternity services some women and birthing people gave negative feedback about their experience of care.

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 trust promoted equality and diversity in daily work and provided opportunities for career development. The equality, diversity, and inclusion networks had been refreshed. The PRIDE (LBGTQ+) Network was more recently established and was developing.

The trust had plans to cope with unexpected events.

Our findings

The information systems were integrated and secure.

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

How we carried out the inspection

During our inspection of maternity services, we spoke with staff including midwives, student midwives and doctors, maternity support workers, midwifery matrons, junior doctors, middle grade obstetricians, consultant obstetricians, as well as administration and clerical staff and senior managers. We spoke to 9 women. In gynaecology we spoke with 4 women and 41 members of staff we also looked at 15 patient records.

We conducted focus group meetings with staff prior to the inspection and during the core service inspection.

The inspection was overseen by Karen Knapton the interim deputy director and included an inspection manager, inspectors, and specialist advisers. An executive reviewer supported our inspection of well-led for the trust overall. Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

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

Outstanding practice

We found the following outstanding practice:

Trust wide

- There was innovative work regarding anti-racism. The equality diversity manager held monthly reflective practice with executive directors. The trust was in the top 10 performing trusts nationally in 4 of the WRES indicators and top performing in 2 of these indicators.
- The trust had developed a staff pantry in response to local economic hardship providing food and sanitary products for staff, volunteers, and students, this was sustained by staff donations through salaries and support from local partner organisations.
- The trust was hosting and supporting the C-GULL – Children Growing up in Liverpool research programme. The programme focused on improving the health and wellbeing of children and their families within the Liverpool City Region. It will trace the lives of over 10,000 local families to understand more about what influences the health and wellbeing of children and their families living in the region.
- The Non-English-Speaking Team (NEST) provided care for those women, birthing people and families booked at Liverpool Women's Hospital who did not speak English. The trust hosted an antenatal clinic using translation services with midwifery and consultant support, and home visits could be arranged. Information was provided in the woman's own language so they could make the right choice for them and their baby.

Our findings

- Supported interns, working in partnership with schools and the trust hotel services provider students with neuro diverse and physical disabilities have been provided with work experience opportunities in the trust in preparation for them looking for jobs.

Core Service

Maternity

- The service used charitable funds to fund several initiatives to meet the basic needs of women and birthing people who were vulnerable. For example, they accessed funding for SIM cards for women and birthing people who were digitally excluded. They issued food vouchers to women in need.

Gynaecology

- The service provided robotic assisted surgery for women needing different types of urogynaecology operations. The gynaecology department had been the first specialised women's health unit in the country to offer this treatment.

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 8 legal requirements. This action related to 1 of the trust services.

Trust wide

- The trust must ensure it operates effective systems and processes to assess, monitor and improve the quality of services and mitigate the risks to women, birthing people, and babies. Regulation 17 (1)(2)(a)(b)

Core service

Maternity

Following our inspection, we issued a warning notice requiring the trust to make significant improvements.

- The trust must assess and do all that is reasonably practicable to mitigate risks to the health and safety of women, birthing people, and babies. Regulation 12 (1)(2)(a)(b)

This includes but is not limited to:

- Timely and effective triage of women and birthing people
- Assessing, documenting, and responding to ongoing risks to the safety of women, birthing people, and babies at all stages of pregnancy in line with national guidance

Our findings

- The trust must ensure they deploy sufficient, suitably qualified midwifery staff cross all areas of the service. Regulation 18 (1)
- The trust must ensure staff are up to date with mandatory training. Regulation 12 (1)(2)(c)
- The trust must ensure there are sufficient numbers of suitably qualified, competent medical staff to deliver the service and reduce delays in medical review in maternity triage.. Regulation 18 (1)
- The trust must ensure it operates effective systems and processes to assess, monitor and improve the quality of services and mitigate the risks to women, birthing people, and babies. Regulation 17 (1)(2)(a)(b)

This includes but is not limited to:

- The reporting and management of patient safety incidents
- Receiving and acting on feedback from women, birthing people, families, and staff
- Operating robust governance processes
- Taking action to improve perinatal mortality rates
- Taking timely and effective action to address risks and improve performance
- Operating a robust risk register, with effective mitigation and controls and updated action plans
- Collecting reliable data to analyse and improve performance
- Operating effective audit processes

Gynaecology

- The trust must ensure people can access the service when they need it, particularly for cancer pathways and scan services in line with national guidance and implement this as appropriate. Regulation 12 (1)

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure it continues the roll out of the Oliver McGowan Mandatory Training on Learning Disability and Autism.
- The trust should ensure it continues to implement its action plan to identify any gaps in its Equality Delivery System 2022 (EDS2) with defined lines of reporting.

Core service

Maternity

- The trust should ensure staff complete relevant safeguarding checks and logs when a woman or birthing person is admitted to the service. They should ensure staff have access to appropriate support when dealing with safeguarding concerns. Regulation 13

Our findings

- The trust should ensure all staff adhere to best practise in infection prevention and control, including 'bare below elbows' guidance. Regulation 12
- The trust should ensure all equipment is in date and suitable for purpose. Regulation 15
- The trust should ensure staff answer call bells quickly to prevent risk of harm to women and birthing people. Regulation 12
- The trust should ensure all staff receive an annual appraisal to ensure staff are supported and able to develop. Regulation 12
- The trust should ensure staff follow systems and processes to safely prescribe, administer, record and store medicines. Regulation 12
- The service should ensure staff are supported to raise concerns through the trust Freedom to Speak Up Guardian and action is taken on concerns raised by staff.

Gynaecology and Termination of Pregnancy

- The trust should ensure that there is sufficient medical cover available for the Bedford Unit and gynaecology emergency departments. Regulation 18
- The trust should ensure medical staff complete their required mandatory training and have regular appraisals. Regulation 18
- The trust should ensure that staff have clear prescribing regimes to follow when oxygen is prescribed Regulation 12
- The trust should ensure that they review the current Service Level Agreement to ensure medicines for the termination of pregnancy are delivered to the right patient and in a timely manner. Regulation 12
- The trust should review arrangements in the gynaecology day case admissions area to ensure women's privacy and dignity is maintained. Regulation 10

Is this organisation well-led?

Leadership

Overall, the trust leadership team had knowledge of the main priorities and challenges faced by the service for the future but did not always understand and manage the immediate priorities and issues the service faced.

There was a unitary board of directors with no director vacancies. There was a blend of experienced and more recently appointed executives. The chief executive joined the trust in 2008 and had a background in human resources and organisational development. Historically there had been a high turnover of chief nurses who had left for various reasons. The current chief nurse had been in post since December 2022 following a secondment into the trust during 2021 and then as the interim chief nurse following the retirement of their predecessor. They had also been the chief nurse at this trust 7 years ago and in an acute trust.

The medical director (MD) had been in post for 2.5 years and prior to that had been the Medical director of the North West Genomics Laboratory Hub. They retained a clinical portfolio for one PA (programmed activity)/week.

The trust had a finance structure similar to that you would find in a small to medium sized hospital.

Our findings

There has been significant change with the senior members of the finance function over the last year. The deputy director post was filled on an interim basis with an appropriately experienced individual. Overall, staff turnover in the last twelve months was high (25%) but the trust indicated that it had been successful in filling finance vacancies.

All executive directors had responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities included the maintenance of the corporate risk register and the promotion of risk management to staff within their areas of accountability. Executive directors had responsibility for monitoring their own systems to ensure they were effective, for accountability, critical challenge, and oversight of risk.

Working relationships between executive directors was described as very good. The chair and CEO had a positive working relationship and were clear about their roles and accountabilities.

There was a 3-division structure in place since 2019 (family health, gynaecology, and clinical support services). Operational management teams had been strengthened since 2020.

The director of midwifery and a new head of midwifery came into post in mid-2022. The director of midwifery sits in the corporate nurse leadership structure reporting to the chief nurse. The head of midwifery role sits in the family health division and reported operationally to the divisional manager with a dotted professional reporting line to the director of midwifery. The head of midwifery was physically located alongside the management team for family health.

During interviews it was not clear about the separation of responsibilities between these two roles. There did not appear to be clear objectives, lines of accountability or effective joint working between the director of midwifery and head of midwifery. The director of midwifery was removed from the oversight of operational delivery and risk, and we did not feel they could fulfil their role as relevant information did not seem to be shared. It was unclear how the director of midwifery was providing assurance to the Board for example on risk profiles and strategic implementation of priorities at a local level. There did not appear to be any clear objectives for this post.

The director of midwifery informally attended the Trust Board and sat on the Quality Committee and reported on strategic maternity matters.

The trust informed us the chief nurse had identified the potential loss of clarity on the delineation between the two roles and had set priorities in August 2022 for the next 6 months. There was a further review in March 2023 to reflect on the previous 6 months and agree focus for each role moving forward. A presentation was given to the Board in February 2023 showing the impact of the director of midwifery role in its first six months.

Although the leadership team had the knowledge of the main priorities and challenges facing the services, during some interviews leaders could not clearly or consistently articulate business details. For example, in some interviews it was not clear if all leaders had strong oversight relating to their immediate priorities, risks and challenges, such as understanding about vacancy rates, staffing figures and when Birthrate plus staffing tool was last reviewed. Key performance indicators could not always be articulated against national benchmarks and where the trust performed against them.

The recruitment and induction of non-executive directors was positive. The chair had been in post since 2016. The five new non-executive directors (NED) had been appointed since 2019. There was a varied mix of skills and experience

across the NEDs and a considered approach to the skill set requirements when new directors were recruited. Non-executive directors reported that relationships with the chair were supportive and there was sufficient challenge and influence to drive improvements. They were clear about their roles and responsibilities and played a large role in chairing committees.

The chair indicated that there was succession planning in place for NEDs with a performance development review of each NED annually and a skills matrix for the Board matched to the strategic objectives for example improved increased diversity and local community representation as well as IT skills.

Formal yearly reviews of each director's performance took place focussing on individual delivery and development needs.

There were regular executive meetings which focussed on different issues ensuring accountability for specific pieces of work. There were also weekly informal executive team meetings which the CEO did not attend, this was seen as a safe space for directors to support each other to deliver the strategic objectives.

Workforce Race Equality data for March 2022 showed board member and non-executive director data for racially minoritized staff had increased to 3 individuals which was a positive progression from previous years where there was only 1 individual from a racially minoritized background in a non-executive director role.

There was time set aside for board development. The Leadership and Talent Management Strategic Framework was developed to meet Theme 4 of the trust's Putting People First Strategy, investing in people and leaders. Senior leadership forums which included clinical and non-clinical leaders and the executive team were run 4 times a year. In 2022/2023 the sessions focussed on strategy development, fair and just culture, diversity and inclusion, compassionate culture. The trust used external experts to run sessions such as EDI. There were systems for succession planning and talent management with a focus on developing the skill set of middle management and clinical leaders. The trust had several aspiring leadership programmes.

Leaders (both Executive and Non-Executive) engaged in wider system developments and the recent Liverpool Clinical Services Review.

There was a well-established council of governors. We found that engagement of governors with the trust's priorities was good. The governors were clear about their role and systems were in place for them to hold the non-executive directors to account. Governors reported they were involved in several workstreams such as helping with decisions on the ICB, Future Generations and the Ockenden report. Governors spoke positively about the training they had received. Governors felt there could be more opportunities for involvement in patient safety walk-rounds.

Pharmacy Leadership

The pharmacy staff team continued to feed into all the relevant committees. A review of the committees by the new clinical director of pharmacy had led to pharmacy representation at the risk committee. The pharmacy department had two junior pharmacist whole time equivalent roles to fill, and the team said they sometimes struggled to recruit due to the speciality of the trust. The pharmacy team were in communication with Health Education England who were aiming to get junior pharmacists to rotate around the Liverpool Hospitals.

The trust did not have a seven-day service to reconcile patients' medicines who were admitted over the weekend. At weekends, the pharmacy staff focus was limited to discharges.

Our findings

Fit and proper persons

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This includes checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We reviewed staff files for members of the board of directors. We found documents such as annual fit and proper persons self-declaration, disclosure and barring service, insolvency and registration checks were compliant with Regulation 5.

Vision and Strategy

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

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The trust engaged through social media and existing groups including Patient Advice and Liaison Service who carried out walking the floor and speaking with patients. The trust launched its five-year strategy in 2021.

There was a vision, values and focus on people, safety of services and patient experience. There were several enabling strategies which supported the overall strategy.

Each division had an operational and implementation plan which linked to the trust strategy. Staff were aware of and knowledgeable about the trust's core values and spoke readily of how these related to the work in their services.

Executive and non-executive directors were engaged in wider system developments and the Liverpool Clinical Services Review. Partnership working with the wider system had been increasingly necessary due to the isolated site issues.

The leadership team were clear the sustainability of services was a key priority. The Future Generations Strategy identified the need for services to be co-located with an acute trust to provide a full range of services and specialties for patients. Further clarity was required as to the affordability of the proposed co-location model and contingency models of care, and how these would be funded over time.

The trust had increased its partnership working with several clinical networks and local trusts in Liverpool to strengthen its approach to a changing environment. Executives had engaged with the wider system including NHSE, the Integrated Care Board (ICB) and at PLACE regarding the Case for Change for the Future Generations strategy. Progress in developing partnerships and associated governance was reported on a quarterly basis through the trust's assurance framework.

There was a 5 year Clinical and Quality Strategy which set out quality improvement themes and clinical priorities. The strategy was developed with input from staff, patients, and governors. Clinical priorities included changes to the care model, developing partnerships, aspirations for the workforce and achieving accreditation. The strategy was monitored by the Quality Committee. A refresh of the strategy was planned for 2023/2024.

Our findings

The trust had a Supporting Patients with Additional Needs Strategy. It set out a three-year strategic plan detailing how the trust would respond to the profile of its local population and work with patients, carers, staff, and partners to deliver high quality, person-centred care for people with additional needs and their carers/families.

The strategy was focused on promoting the rights of those with additional needs that met the definition of having a disability as described in the Equality Act 2010. These included but was not restricted to those with a learning disability, autism, dementia, mental illness and or a physical disability.

Culture

Not all staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. Equality, diversity, and inclusion networks had been refreshed. The service had an open culture where patients, their families and staff could raise concerns without fear. Although in maternity services some women and birthing people gave negative feedback about their experience of care

Not all staff felt respected, supported, and valued. However, they remained focused on the needs of patients receiving care. Some staff in maternity had raised concerns several times regarding safety and staffing directly to senior leaders however they saw no quick action or improvement.

Staff were positive about their departments and the local leadership teams; they were able to speak to local leaders about difficult issues when things went wrong. The 2022 staff survey results showed the trust scored average when benchmarked with other specialist trusts for raising concerns with some improvement when compared to the 2021 survey.

The trust had a fair and just culture programme since 2018/2019. There were 10 senior leaders accredited in fair and just culture methods. After the inspection the trust reported that at the time of the inspection, 55% of all managers and leaders had undertaken and passed the training. The 2022 staff survey showed most staff felt managers demonstrated and encouraged a fair and just culture.

Non-Executive Directors felt positive about the culture of the organisation and were supported to go out into the hospital to speak with people. Visits to services and support functions had now started following the lifting of restrictions of COVID-19.

Governors whilst positive about the organisation, reported a delay in being allowed to resume site visits until they had been risk assessed but were unsure when this would be arranged.

Staff gave mixed responses about the engagement and visibility from the senior leadership team. However, many staff described a positive allegiance to Liverpool Women’s and to the provision of high-quality care for patients.

Data from the most recent workforce race equality standards report showed positive performance with some exceptions. The likelihood of being appointed from interview if an applicant was of racially minoritized background had worsened from 52.70% to 46.15% in 2022. Also, the number of disabled staff experiencing bullying, harassment or abuse in the workplace had worsened to 26.5% from 21.3% in 2021 compared to 16.5% for non-disabled colleagues. However more disabled staff said they would report bullying, harassment, or abuse. The trust had implemented a plan to identify the cause and implement corrective action where necessary.

Our findings

The trust outlined several areas of progress on EDI initiatives as well as further plans. This indicated the trust's confidence in progressing diversity and inclusion and how this would inform future development of the inclusion strategy.

The Equality Delivery System 2022 (EDS2) reports showed the trust had undertaken EDS2 grading and assessment. The report identified several inequalities and gaps in data however there was no action plan as to how the issues identified were going to addressed and where this was going to be reported. At the time of inspection this was a draft document and had not been finalised for submission. Since the inspection the trust confirmed the document was completed in accordance with relevant timescales for EDS reporting and provided details of actions.

The trust provided a copy of the 'Reasons to be Proud' which highlighted several positive initiatives around diversity and inclusion. Although it was too early to measure if these initiatives had any impact on the inequalities and culture of the organisation.

The trust had an equality, diversity, and inclusion (EDI) network with a broad range of representation. The networks had been refreshed. The PRIDE (LBGTQ+) Network was more recently established and was developing. Members from the different networks spoke with enthusiasm and positivity about their work and the support offered by the trust. They shared examples of joint working to challenge inequalities and discrimination.

There were formal mechanisms and regular dialogue with staff side representatives and the executive team. Staff reported positive relationships and support for trade union activities. Work was ongoing to review the process for accompanying staff during disciplinary processes, at present staff were unable to choose the person they wanted to accompany them. Post inspection the trust reported that in practice they allowed other companions on occasion as appropriate.

There was a Freedom to Speak Up, Raising Concerns and Whistleblowing Policy. The trust had 2 Freedom to Speak-Up (FTSU) guardians (clinical and non-clinical) who were available across evenings, nights, and weekends. The Chief People Officer was the executive lead and FTSU guardians had access to the CEO. The guardians reported into the Putting People First Committee (PPF) on a bi-annual basis and annually to the Board.

Feedback and trends from FTSU fed into the trust integrated governance reports. The trust had a desktop icon where, with one click, staff could access all information relating to the Speak Up service and could submit an online concern directly to the Guardians. A FTSU temperature check survey was completed every 6 months this showed improvement in the visibility and availability of the service.

The November 2022, Freedom to Speak Up report to the PPFC showed the guardian service received a total of 31 concerns, which was an increase of 5 from the equivalent periods in 2021/22 when 26 concerns were received.

During Q1 and Q2 there were 3 themes in relation to the concerns raised. The majority related to HR issues about interaction with staff and their managers/supervisors. Concerns around the fairness of internal promotion or development opportunities and concerns raised by maternity staff relating to the pressures specifically in the Maternity Assessment Unit. Although the trust was aware of these issues staff said they had raised concerns several times regarding safety and staffing directly to senior leaders and through FTSU leads however they saw no action or improvement. These concerns were also identified during the maternity core services inspection, we wrote to the trust asking them to take immediate action.

Our findings

The guardian reported there were difficulties in finding an environment in the trust which staff felt was confidential enough to meet and raise their concern. Some meetings had been held at external venues.

We met with the guardian for safer working during the inspection. This role was introduced nationally to protect patients and doctors by making sure doctors were not working unsafe hours. The guardian was allocated 0.5 of a PA in their job plan for the role, this was manageable with the number of exception reports and size of the trust. Themes from exception reports were mainly around gaps in the medical staffing rota. There were monthly junior doctors' forums and attendance had improved in the last 6 months. All the junior doctors were invited to the meetings which gave them an opportunity to discuss their concerns. A quarterly report was presented to the Board.

The GMC survey feedback report 2022 showed there was an improvement in educational and clinical supervision. Overall satisfaction and adequate experience for trainees had dropped but was above the national average of 76%, this was being monitored.

In the NHS Staff Survey 2022 the trust scored 6.5 for stressors at work against a national average of 6.6. The trust recognised that staff wellbeing was an important factor to consider especially following the pandemic and were well sighted on the support and impact on staff following a major incident in November 2021.

The 2022 staff survey results indicated an area for focus was staff morale in the finance department. Steps had begun to engage staff in these issues and interviewees reported a positive working culture within the department and the wider trust.

The trust had a new psychology led support service developed in response to the increasing levels of absence relating to stress, anxiety, and depression and 2 wellbeing coaches had been recruited to work with managers. This was a proactive way to promote wellbeing within the trust.

The pharmacy staff team had regular appraisals within the department with a current 90% of staff having had an appraisal within this financial year. Weekly meetings were embedded within the team to enable communication and education of incidents. The department was aware of high and low incident reporters within the trust and had continued to use various communication types to steer improvement in reporting and learning. Staff at ward level were aware of the pharmacy team and spoke positively about the impact they had.

Governance

There were governance processes, throughout the service and with partner organisations. However, these processes were not always effective. 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 trust had structures, systems, and processes in place to support the delivery of its strategy including board committees, divisional committees, and team meetings. There was an established set of board committees and arrangements for reporting to the board. The company secretary had good oversight of the board assurance framework and was responsible for organising the board papers and committees.

The board assurance framework identified risks to the implementation of the trust's strategy and was linked to relevant corporate risks. The framework was supplemented by a corporate risk register which captured significant risks and reported to the Board. Relevant sections of the board assurance framework were allocated to each of the board committees for review with a focus on gaps and remedial action.

Our findings

The chief executive chaired the Corporate Risk Committee which coordinated all categories of risk management. The committee met at least six times a year to review all significant corporate risks and consider whether any risks needed to be escalated to a relevant committee, sub-committee, or group.

The committee was responsible for ensuring that any lessons learned arising from the corporate risk register were communicated across the trust. Following the changes to the organisational structure, the membership of the Corporate Risk Committee was amended to ensure representation from the three clinical divisions. The Corporate Risk Committee reported to the Quality Committee of the Board of Directors.

However, we found issues on inspection that were escalated through audit and governance processes that had not been fully addressed. For example, the Family Health Divisional Safety Champions – Q2 22-23 Report stated the service could meet safe minimum staffing requirements for existing continuity of carer provision. During our inspection we found the service did not always have sufficient staff deployed to keep women, birthing people and babies safe. These concerns were escalated to the trust, and they suspended continuity of carer to improve staffing levels on MAU and the midwifery led unit.

The trust had developed a Risk Appetite Statement for 2022/23 that outlined the level of risk the trust was willing to take to achieve its objectives. The risk appetite formed part of the Board Assurance Framework and was used to inform discussions around strategic risk.

During the core service inspection staff said they understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. During our inspection, we found there was a risk-based approach to setting the annual internal audit plan and systems to track the implementation of internal audit recommendations. The most recent head of internal audit opinion was one of substantial assurance that there was a good system of internal control to meet the trust's objectives and that controls were generally being applied consistently.

Performance against the corporate objectives 2022/23 was reviewed every 6 months by the Board. The objectives were aligned to the trust's strategic aims. The December 2022 report showed 8 objectives were on track, 7 risks had been identified but were on track and 2 were off track. These related to improvement in staff engagement, however at the time of this review the Annual Staff Survey had not been published.

The Audit Committee was chaired by a non-executive director and the trust chair was in attendance. The non-executive directors were experienced in their fields and clear about their roles and what they expected from the executive. This committee was responsible for providing assurance to the Board on the trust's system of internal control through independent review of corporate governance and risk management arrangements. However, it was unclear if this was supported by other executives attending audit committee.

The Audit Committee reviewed its effectiveness with input from the trust's internal and external auditors.

The NHS financial sustainability checklist had been self-assessed and reviewed by internal audit. The areas identified for improvement were budget and cost improvement programme (CIP) monitoring, which were scored weaker than other domains. In 2022/23 29 of 54 identified CIP schemes had either not started or were, not delivering the planned financial benefits, which further indicated a need to strengthen the process and governance of CIP identification and delivery.

Our findings

The areas identified for improvement were budget and CIP monitoring, which were scored weaker than other areas.

An unusually high reliance was placed upon the “deputies’ group” to discharge several important corporate responsibilities including CIP development, financial recovery and business case review. Given the financial challenges faced by the trust, these areas are likely to benefit from more direct Executive involvement.

Review of committee minutes indicated that all the key financial governance areas were covered, but more emphasis could be given to the actions agreed to address the financial challenges faced by the trust.

Both the Finance and Audit Committees had conducted internal annual effectiveness reviews with the Audit Committee undertaking an effectiveness review with the internal auditor during 2021/22. Given the change in NEDs since 2020 it would be appropriate to refresh the audit committee effectiveness self-assessment for 2023/24.

There was a corporate governance team headed by the associate director of quality who had been in post 18 months and reported directly to the chief nurse. The team comprised of four additional staff and one vacancy to support the governance function. A quality improvement and compliance manager had recently been appointed to strengthen these areas.

There was a formal governance and reporting structure for the implementation of the Ockenden recommendations. Monitoring and tracking of progress were provided to the Quality Committee and Board. A maternity transformation board was in place which met monthly and received progress reports from 5 workstreams to achieve Ockenden compliance.

Management of risk, issues, and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues with effective actions to reduce their impact. They had plans to cope with unexpected events.

There was a Risk Management Strategy which was in date and set out the trust approach to risk management in the divisions and corporately.

There was a collective awareness and understanding of risk and issues associated with being an isolated hospital site due to the lack of some critical services, particularly the risks associated with transferring women to an intensive care unit and the lack of a 24-hour blood transfusion service.

However, the executive leaders did not always manage priorities and issues effectively. The Quality Committee report to board in April 2022 identified ‘continued issues with telephone triage process in MAU [Maternity assessment unit]’. The committee requested the executive team consider the issues as a matter of priority and identify timescales to report back to the next committee’. However, we identified concerns regarding telephone triage processes still existed during this inspection. The Chair of the Risk and Quality Committee told us that concerns came up regarding 30-minute triage times through the Maternity Transformation Board. The trust carried out a review in December 2022. CQC findings were in line with what came back to committee the week of the inspection.

Our findings

Post inspection the trust reported following a service-led review, the decision was made to temporarily suspend the Continuity of Carer service from 8 May for a period of 6 months. An alternative model, providing a degree of continuity antenatally and postnatally, was now in place enabling an enhanced level of support to women from vulnerable or marginalised cohorts.

Similarly, a risk was added to the register for MAU on 26 November 2019. The risk register identified gaps in controls and ineffective controls, and we found the same issues identified during our inspection. There was risk relating to insufficient resource to support blood transfusion which had been on the risk register since 23 November 2018 with no controls entered. Minutes of the Corporate Risk Committee 18 January 2023 identified and escalated to 'service leads to bring all overdue risks, risks actions and risks without actions in date by 20 January 2023'.

There was a lack of clarity throughout the inspection period of the status for "continuity of carer". The Board presentation to CQC on 21 February 2023 and confirmed by the chief nurse during interview, described four teams being in place. The response from the trust in a letter dated 27 January 2023 to a regulatory notice said that this model had been stood down to release 30 WTE midwives. These staff would be based on the midwifery led unit to ensure that women were not redirected to maternity assessment unit.

Serious incidents were discussed at a weekly harm meeting and were submitted to the ICB with a rationale from the chair of the meeting for escalation to SI. This rationale was captured within the 72-hour review report. This meeting was chaired by the medical director, chief nurse or nominated deputies. The rationale was also captured for incidents that had been determined not to meet the SI threshold.

However, during several interviews with directors the oversight and management of incidents and risks and the compliance against the trust's key performance indicators was not always consistent. There appeared to be a lack of detail and effective grip regarding this area.

Analysis of NRLS relating to gynaecology prior to the inspection showed between March 2022 and November 2022 there was a mean average of 220 days between the incidents being reported and closed and then uploaded to the NRLS. Three severe harm incidents took 12 months to report. All three incidents classed as 'severe harm' were reported in 2022 and took place in 2021. Two of these incidents had a reporting delay of over 12 months and were also raised under STEIS. The remaining severe NRLS relates to an incident in August 2021 where no beds were available on the gynaecology ward and had a reporting delay of 7 months.

Analysis of the NHS national reporting system for incidents showed irregular patterns of incident reporting with difficulty in determining when incidents occurred. For example, we saw an incident reported to the national reporting learning system (NRLS) in October 2022 which took place in January 2022. Following our inspection, the service provided information that showed this was reported to the national serious incident reporting system in February 2022, when it was recognised as a never event.

In February 2023 an overview was provided, of the open incidents waiting review and closure across the trust. There was a total of 474 open incidents within the web holding system; 173 were in the division of family health, of which 51 related to delivery suite and 153 were in gynaecology, 97 of which related to the emergency department.

This was identified on the service risk register, particularly around timeliness of incident reviews.

Our findings

Information added to incidents indicated they did not need reporting as the information 'was captured elsewhere'. An explanation was that this was only added once the incident had been reviewed and closed and related to an agreement to no longer report 52 week breaches as incidents. Post inspection the trust reported the breach information was available on other systems and was only incident reportable if following a harm review, harm had been determined to have occurred because of the breach. This narrative was currently under review.

Staff also said they did not always receive feedback when reporting incidents.

During our inspection, we found a high threshold for the grading of patient safety incidents. Therefore, we were not assured all incidents were allocated the correct level of harm and investigated accordingly. For example, during the maternity inspection an incident was reported as no harm where issues were identified with documentation and delay in transfer and diagnosis and the woman experienced a post-partum haemorrhage of 2.6 litres and manual removal of the placenta in theatre.

Learning from serious incidents was an area that required strengthening and was a continued area of focus for 2022/23.

The NHS Staff Survey 2022 showed the trust had above average scores for questions on reporting errors, near misses and incidents per patient/bed days compared to similar trusts.

Each division had a risk register, any organisational risks scoring 15 and above were reported to the corporate risk register. Staff had access to the risk register and were able to escalate concerns as needed.

The trust had brought in what it described an "earned autonomy" structure and process to manage divisional performance over the last 2 years. We were told that no division were yet at a point where they have the earned autonomy, and this was work in progress.

At the maternity inspection staffing levels did not always match the planned numbers. Staff in the maternity assessment unit gave multiple examples of situations where high acuity and low staffing made the unit feel unsafe. During our well led interviews there appeared to be confusion when Birthrate Plus had been completed externally and internally. The chief nurse reported Birthrate Plus had been applied but not in the last 12 months. We questioned whether the ratio of midwife: birth of 1:28 was sufficient due to the high risk and acuity of patients. The chief nurse told us the trust used a variety of national safe staffing tools and the trust was doing a review of staffing with input from the director of midwifery and head of midwifery.

We asked about assurance and compliance with Sepsis 6. The chief nurse identified there was variable compliance particularly in maternity and acknowledged further work was needed in this area. We were informed compliance was 50% in maternity with the trust was working towards 90%. Post inspection the trust provided evidence of an audit from January to March 2023 which showed 70% achievement of antibiotics in the golden hour and 70% of all the sepsis 6 bundle. The trust had appointed a sepsis lead who was working on delivering the trust target reduction in gram-negative sepsis.

Gynaecology and elective recovery remained significantly challenging. Whilst performance for cancer waiting times for patients seen within two weeks of an urgent GP referral were within the highest 25% of trusts nationally, the waiting times for treatment within 31 days following a decision to treat was among the lowest 25% nationally.

The trust used national products such as Model Hospital and 'Getting it Right First Time (GIRFT)' data to support the trust's elective recovery programme,

Our findings

The trust had a standard operating procedure Patient Access – Admissions Process for Recording P-Number Category – Clinical Validation Programme. This was to ensure patients on lengthy waiting lists were dated in clinical priority. Updates were provided to the Board on the elective recovery plan through divisional performance reviews and other controls and systems.

We spoke with medical staff in gynaecology who said patients being seen in the clinic for the week during our inspection had been referred from October 2021. There were 1-3 urgent clinic slots for gynaecology emergencies per week. These were on Monday and Friday afternoons. If there was an urgent case main lists could be interrupted. Referrals were triaged by the consultant nurse. We were told, the main reason for the long waiting times was a lack of theatre time. There were waiting list initiative clinics most weekends. Delays in treatment was on the Board Assurance Framework.

The trust reported they would deliver deficit outturn for the financial year 2022/2023. Executives were working with system partners and were investing in safety associated with an isolated site which was increasing costs. The trust had a recovery action plan in place, however it was not always meeting its cost improvement programme.

The chief nurse was the executive director for safeguarding adults and children. There was a clear accountability structure for safeguarding from operational level to the Trust board. The trust Safeguarding Sub-committee and Safeguarding Operational Group provided the Board of Directors, Clinical Commissioning Group, and external safeguarding boards with assurance to respond effectively and demonstrate accountability, for all aspects of safeguarding children, young people, and adults. An annual safeguarding report was presented to the Board. The Board had received training in safeguarding.

The team reported good external overview with partners including collaborative working with system partners such as the police, other safeguarding teams in the local maternity network and the local authority multi agency service hub.

There were 2 safeguarding leads who were managing the service in the absence of the manager. There was no named nurse for the unborn child as this role was covered by the manager who was absent from work. The team said 90% of their work activity was for safeguarding unborn babies. Interim arrangement was being reviewed by the chief nurse.

The trust had a service level agreement for infection prevention and control (IPC) with a local acute trust. The director of infection prevention and control (DIPC) was a microbiologist and reported to the chief nurse who chaired the IPC committee. The committee reported to the quality committee, which then reported to the Board. There was confidence that concerns were acted on and the team was well supported.

There was no overarching strategy for IPC but there was a workplan which involved stakeholder input.

Audits showed from the 2021 to 2022 report there was a 100% compliance rate for infection prevention and control audits and 87% compliance for clinical practice ward audits. New standards introduced for audits were expected to be 95% compliant by the end of 2023. There had been no reported serious incident infection outbreaks in the last 12 months.

There was an estates manager and a team to ensure the site was safe. There was a clear reporting process to the chief operating officer who was accountable for the estates function. The team had contributed to the trust estates strategy for the Crown Street site, but the longer-term vision was to be co-located.

There was effective oversight of risks to the estate. The main risks were upkeep of old pipework and water quality, together with fire safety.

Our findings

There was a continued challenge around the estate regarding space at the hospital site due to increasing demands as part of the elective recovery programme and general increase in patient attendances. Portacabins had been installed as a temporary measure to cope with some of those demands with much depending on a new location or co-location move in the future.

The patient led assessments of the care environment (PLACE) results had improved compared to 2019. The report was not publicly available at the time of inspection.

Information Management

The trust collected and analysed data however it did not always act on it in a timely way. Not all 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 not always consistently submitted to external organisations as required.

The service collected and analysed data, but it did not always act on it in a timely way. For example, the performance reports to the Board from October 2022 identified ongoing challenges with waiting times and the number of open serious incidents as very concerning and needed to be investigated and acted on. The same concerns were continuing to flag in the March 2023 performance report.

Not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. During the inspection of maternity services, we were provided with the dashboard summary report sent to the Northwest Coast Clinical Network. This showed key performance indicators and performance over time for some metrics.

However, performance data was only displayed for April to November 2022. There was no ‘live’ dashboard which gave up-to-date performance data and managers could not see other locations for internal benchmarking and comparison.

The chief information officer was responsible for digital information technology, cyber security, the implementation of patient electronic records, information governance and projects.

There were multiple disconnected IT systems which had evolved over time. This was recognised by the trust and was incorporated into the Digital Generations Strategy 2020-2024 which aimed to deliver 4 key themes, digital identity, fundamentals, excellence, and innovation.

Digital solutions were co-designed with staff and stakeholder engagement. There were 3 clinical chief information officers in the digital leadership team, which ensured a patient focussed approach.

The trust was fully compliant with Maternity Service Data Set (MSDS).

There was a digital journey plan for 2022/2023 with key milestones to ensure the trust had the digital capabilities including the planned implementation of electronic patient records in July 2023. There were contingency plans to ensure systems worked effectively during the transition phase including 24/7 IT support and digital coaches to assist staff with training and any concerns.

IT risks were recorded on the corporate risk register and the board assurance framework.

Our findings

There were systems for information governance and processes for reporting breaches to the Information Commissioner's Office. The trust achieved 'standard exceeded' for the Data Security Protection Toolkit 202/2021.

Data or notifications were not always consistently submitted to external organisations as required. We found that incidents were not always reported to the NHS National Reporting Systems in a timely way and the Care Quality Commission had not routinely received notifications of serious incidents and never events once these were known to the trust. The chief nurse acknowledged there had been a backlog of incidents in the system spanning over 12 months however this position had improved.

Interviewees emphasised different reasons to explain the trust's underlying financial deficit including the maternity tariff, site safety, regulatory requirements and business cases such as the community diagnostic centre which indicated a potential lack of clarity about the component drivers of the trust deficit.

Engagement

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

Engagement

There had been a refresh of the Patient Experience & Engagement Strategy and work was ongoing. The trust ambition was to ensure every patient would have an outstanding experience.

The Board recognised the importance of partner organisations to support them in providing safe and effective care. Engagement with the integrated care system and integrated care partnership had increased particularly around the sustainability of an isolated site.

Executives worked within the wider health and care systems to improve outcomes for women. The chief executive was a board member of Liverpool Heath Partners, Joint Senior Responsible Officer (SRO) for Women's and Children's Partnership Board and SRO for the Local Maternity System.

The chief operating officer and medical director chaired the Cheshire and Merseyside Gold Command for maternity services each week. Executives were engaged with various forums hosted by the ICB for example the Cheshire and Merseyside medical directors' meeting.

The Patient Involvement and Experience Sub-Committee reviewed the progress against the Women's, Babies and Families Experience Strategy. This was undertaken in June of each year and any concerns were escalated to the Quality Committee.

The trust had a patient experience matron to build relationships with local community leaders and act on feedback about trust services. The matron also formed part of the ward accreditation scheme to monitor progress on patient experience. The Maternity Voice Partnership and other service user groups were requested to be integral to the assessment team for any future accreditations.

Our findings

The patient experience team could demonstrate positive outcomes for patients particularly hard to reach groups. For example, there was targeted engagement by community midwives including a direct link to a midwife on confirmation of pregnancy using a QR code link. Additionally, changes had been made to menus and dining experiences with involvement from the deaf community.

The trust measured the effectiveness of care, for people with additional needs. Feedback was gained using an enhanced 'Easy Read' Friends and Families test to provide a patient and/or carer perspective. This was undertaken prior to discharge or by telephone following discharge.

The National Maternity Survey 2022 showed the trust scored higher than the England average for women being involved in decisions about their care during labour and birth. Thinking about antenatal care, and being involved in decisions, the trust scored the same as other trusts.

Staff Engagement

The Communication, Marketing and Engagement Strategy 2021-24 set out 7 ambitions which were aligned to the trust's vision, strategy, and objectives. The strategy had been developed with staff engagement in April 2021. The performance against this strategy for April to September 2022-23 showed out of 31 strategy promises, 9 were complete, 19 were in progress and 3 were overdue. The trust had a plan to meet these priorities during the next 6 months.

The People Strategy summarised several activities where the trust celebrated and engaged with wider groups of staff and stakeholders.

There was a quarterly staff engagement report providing updates on survey responses and progress with actions to the Putting People First Committee. Twice annual Big Conversations took place with a focus on ensuring the loop of feedback to staff and actions were being progressed. Board and senior managers were involved in the Big Conversations.

Staff said engagement had improved since the last inspection and most staff said there was active communication with staff, both within the divisions and trust wide.

The trust had a 60% response rate in the 2022 staff survey against a national average response rate of 46%.

Despite the trust having several initiatives in place to improve staff engagement we were not clear

about the incongruence between the engagement and culture work in the trust and what was coming through in the 2022 staff survey results. Maternity had raised concerns regarding the safety and staffing pressures in the Maternity Assessment Unit several times and felt they had not been listened to.

The trust engagement score jointly with one other trust was most improved in the country. The national staff engagement score is 7. The trust's staff engagement Score is 7.1. The trust sits within the group of 13 acute specialist trusts and had the lowest score in this cohort. Staff recommending the trust as a place to work was 61% compared to 56% in 2021. There was improvement for five out of nine People Promise elements and themes over 2021. The Maternity We have a Voice that Counts score increased from 5.7 to 6.1 in year.

Learning, continuous improvement and innovation

Our findings

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

Each quarter the Patient Involvement and Experience sub-committee received a report detailing the themes from complaints and PALS concerns. The subcommittee made recommendations to address any themes and monitored progress until these were completed. The Chair's report from the sub-committee was received at the Quality Committee which reported into the Board. Complaints were a standing agenda item on the division's safety and governance meetings.

Currently a lessons learnt report was generated for the ICB as part of the quarterly integrated governance report.

The report for quarter 3 2022/2023 showed there were 17 complaints opened a decrease of 6 from the previous quarter. Complaint outcomes showed 12 were partially upheld, 4 not upheld and 3 were withdrawn. The main themes were around communication, patient care and clinical treatment.

The trust had received 28 compliments in quarter 3 which was a decrease of 4 from the previous quarter.

The trust had a managing incidents and serious incidents policy in place with clear reporting roles and responsibilities. A flow chart was included to support staff in how to manage and report an incident. The policy was renewed in June 2022.

All heads of divisions had responsibility for reporting, grading, and reviewing incidents with daily oversight meetings to review them undertaken by the risk and governance team.

We were told there had been a weekly process to performance manage the divisions to ensure they were reviewing their incidents in a timely way in terms of having sufficient resource, oversight, and robust triage to make sure incidents pertaining to moderate harm or above and potential serious incidents were reviewed, escalated, and investigated appropriately. However, during the well led interviews we found inconsistencies in narratives in how the process was managed.

This performance management process had since been stood down. However, the monitoring of the web holding file remained ongoing and was reported into the Safety and Effectiveness Sub-committee meeting monthly by the risk and safety manager.

There was external oversight from partners such as the local maternity partnership and neonatal system and the ICB.

The Mortality and Learning from Deaths review was part of the regular monitoring schedule of the trust. This was in line with recommendations by the National Guidance on Learning from Deaths and the CQC. It showed the work taking place operationally and was overseen by the Safety and Effectiveness Sub-Committee and Quality Committee who reported to the Board. The information also included evidence required by the Maternity Incentive Scheme standards.

We reviewed a sample of 20 stillbirths. In all cases the neonatal perinatal mortality tool was used. All cases were assessed and fully completed. Action plans were noted with timescales and a responsible person. Questions posed by parents appeared to be fully answered in most cases. A summary and conclusion were noted in all cases. We were told that the data for neonatal deaths did not show an increased risk specifically by race or deprivation; the % of still births was the same as the booking population.

Our findings

A Quality Improvement Framework had been developed with staff trained in QI methodology. Examples of QI projects included theatre utilisation programme and maintaining a preterm admission temperature in an era of deferred cord clamping and delivery room cuddles.

A refreshed Research Development & Innovation Strategy was presented to the Board in early 2023. Participation in research was encouraged.

The trust was hosting and supporting the C-GULL – Children Growing up in Liverpool research programme. The programme focused on improving the health and wellbeing of children and their families within the Liverpool City Region. C-GULL was a flagship birth cohort nested within a civic data linkage programme. It will trace the lives of over 10,000 local families to understand more about what influences the health and wellbeing of children and their families living in the region.

The trust was in the 2021 – 2022 Becoming an Inclusive Companies Top 50 (34th) organisation for benchmarking, expertise, challenge.

The Great Place to Work Group was multidisciplinary involving staff from all areas, professions and bands which focused on the development of actions to drive an improved level of staff engagement and wellbeing.

The trust had support in place for staff who had experienced baby loss at any stage of pregnancy.

There was a menopause club which was set up with support from specialists and 1:1 monopod brief consultation.

Support was available for staff and partners undergoing fertility treatment.

Estates have evaluated schemes implemented to ensure they were effective and provided a positive return on investment such as the new neonatal unit, the new surgical robotic surgical service and they told us they would be evaluating the new diagnostic scanning schemes.

A half year report had been reported to board for the one-year green plan. Recommendations were made to look at the trust's carbon footprint and set targets. The trust had partnered with a larger trust to support them with this, and practical solutions had already been implemented such as introducing skips for recycling. However, this was in the early stages with some evidence of small-scale innovations.

Site security had received a significant upgrade following the major incident in 2021 to increase on site safety and security. Security was outsourced and renewed yearly. Following this major incident last year there was still some learning which required review by estates.

Volunteers made up 10% of the workforce, there were 21 different roles which freed up 1500 hours of staff time. The trust has secured funding from Health Education England to develop a volunteer to careers programme for maternity services.

The perinatal and non-perinatal leads were working with the local mental health trust to develop and strengthen the service level agreement for non-perinatal mental health support. This was included in the 2023/2024 business planning. The trust had employed a psychologist in last 9-12 months for patients and staff.

Our findings

There was innovative work regarding anti-racism. The equality diversity manger held monthly reflective practice with executive directors. The trust was in the top 10 performing trusts nationally in 4 of the WRES indicators and top performing in 2 of these indicators.

The Non-English-Speaking Team (NEST) provided care for those women and families booked at Liverpool Women's Hospital who did not speak English. The trust hosted an antenatal clinic using translation services with midwifery and consultant support, and home visits could be arranged. Information was provided in the woman's own language so they could make the right choices for them and their baby.

The trust had developed a staff pantry providing food and sanitary products for staff, volunteers, and students, this was sustained by staff donations through salaries and support from local partner organisations.

The trust's finance department was currently at Financial Skills Development level 2 and was looking to maintain at this level rather than progress to level 3 currently, due to the recent staff turnover.

The pharmacy department learned from external reviews by the Healthcare Safety Investigation Branch (HSIB) External reports and had taken steps in improving Venous Thromboembolism assessments.

A pilot on the maternity ward for near point dispensing for discharges to improve patient flow had resulted in obtaining funding for a pharmacist and pharmacy technician to continue this. The trust had made links with a local Children's Hospital to staff 22 neonatal beds. Pharmacy staff had been funded for these new beds; however, staff had not been employed yet. It was unclear whether there would be enough time to fill the posts given the difficulty of filling the two current posts.

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↓ Jun 2023	Good ➔➔ Jun 2023	Good ➔➔ Jun 2023	Good ➔➔ Jun 2023	Requires Improvement ➔➔ Jun 2023	Requires Improvement ↓ Jun 2023

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Liverpool Women's Hospital	Requires Improvement ↓ Jun 2023	Good → ← Jun 2023	Good → ← Jun 2023	Good → ← Jun 2023	Good ↑ Jun 2023	Good → ← Jun 2023
Liverpool Women's at Aintree	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015
Overall trust	Requires Improvement ↓ Jun 2023	Good → ← Jun 2023	Good → ← Jun 2023	Good → ← Jun 2023	Requires Improvement → ← Jun 2023	Requires Improvement ↓ Jun 2023

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

Rating for Liverpool Women's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015
Neonatal services	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020
Outpatients and diagnostic imaging	Good May 2015	Not rated	Good May 2015	Good May 2015	Good May 2015	Good May 2015
Termination of pregnancy	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015
Gynaecology	Good ↑ Jun 2023	Good ↑ Jun 2023	Good → ← Jun 2023	Requires Improvement → ← Jun 2023	Good ↑ Jun 2023	Good ↑ Jun 2023
Maternity	Inadequate ↓↓ Jun 2023	Good Apr 2020	Good Apr 2020	Outstanding Apr 2020	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023
Overall	Requires Improvement ↓ Jun 2023	Good → ← Jun 2023	Good → ← Jun 2023	Good → ← Jun 2023	Good ↑ Jun 2023	Good → ← Jun 2023

Rating for Liverpool Women's at Aintree

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015

Liverpool Women's Hospital

Crown Street
Liverpool
L8 7SS
Tel: 01517089988
www.cqc.org.uk/location/REMAX/contact

Description of this hospital

We inspected gynaecology services at Liverpool Women's Hospital as part of the comprehensive inspection of Liverpool Women's NHS Foundation Trust. We also carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions, as part of our national maternity services inspection programme.

Gynaecology

The Liverpool Women's NHS Foundation Trust gynaecology division, is a tertiary referral centre for gynaecology, performing approximately 10,000 procedures per year. The division primarily runs the services from the main hospital site at Crown Street, but also has sites at Aintree. The division has a number of services within it, fertility medicine, inpatient gynaecology and day case, colposcopy and hysteroscopy, ambulatory care, a gynaecology emergency department, a termination of pregnancy unit, a two bedded high dependency unit and gynaecology oncology.

The Bedford Unit provides termination of pregnancy services including early medical abortion (up to 16 weeks plus 6 days gestation) and surgical abortion (up to 12 weeks plus 6 days gestation).

We carried out an unannounced comprehensive inspection of gynaecology and termination of pregnancy using a risk-based methodology and a combined core service framework. Two inspectors and a specialist advisor were on site for two days, with offsite support from an inspection manager, head of inspection and data analysts.

We had the opportunity to speak with 4 patients using the service and looked at patient feedback shared with the commission prior to inspection. We also spoke with 41 different members of staff working across the service.

We reviewed service 15 combined electronic and paper patients' records.

See main report for overall summary and findings.

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

- The service had enough nursing staff to care for patients and keep them safe. Nursing staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They mostly managed medicines well. The service learned lessons from safety incidents. Staff collected safety information and used it to improve the service.

Our findings

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually. The Bedford Unit had been awarded an internal Gold rating on 14 October 2022 for 'Be Brilliant Accreditation System'(BBAS) for KPI compliance.

However

- Completion rates in some mandatory training for medical staff were low, and key learning regarding the Oliver McGowan Mandatory Training on Learning Disability and Autism was still being planned. Although electronic records showed equipment had been checked, some equipment did not display test servicing dates. Some medicines delivered by post for termination of pregnancy had been incorrectly delivered, however this related to one incident relating an external delivery company. Medical staff were not always available in a timely way to complete patient reviews in some parts of the service. The service used systems for managing patient safety incidents, although historically there had been some delays in reporting serious incidents, but this had improved.
- We requested but did not receive data for completed appraisals for medical staff.
- Women's privacy and dignity was not always maintained when attending for day case admissions.
- Key services were not always available seven days a week. People could not always access the service when they needed it and often had to wait too long for treatment, particularly for cancer pathways and scan services.

Maternity

We inspected the maternity service at Liverpool Women's 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.

Our findings

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.

Liverpool Women's Hospital is the main site for maternity services for the trust. It comprises of a delivery suite with maternity theatres, induction of labour beds and some enhanced recovery rooms. There is a 52 bed post and antenatal ward called Mat Base, which also contains transitional care beds. The service has a maternity assessment unit (triage) and early pregnancy assessment unit (which is part of the gynaecology emergency department). The service also has fetal medicine and maternal medicine units which provide services to women and birthing people from across the Merseyside, Cheshire and Northwest region. Ante and postnatal clinics are also provided at this location and there is an alongside midwifery led birth unit.

The local maternity population come from higher levels of deprivation than the national average with 47% in the most deprived decile compared to 13% nationally. Fewer mothers were Asian or Asian British or Black or Black British compared to the national averages.

During our inspection we spoke with staff including midwives, student midwives and doctors, maternity support workers, midwifery matrons, junior doctors, middle grade obstetricians, consultant obstetricians, as well as administration and clerical staff and senior managers. We also spoke to 9 women, birthing people and families.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so.

Our rating of this service went down. We rated it as requires improvement because:

- Not all staff had training in key skills.
- Some staff did not always adhere to infection prevention and control best practice. Cleaning records were up-to-date but they did not always demonstrate that all areas were cleaned regularly.
- Staff did not consistently assess risks to woman and birthing people nor act on them. Frequent staff shortages increased risks to women and birthing people across the maternity service.
- Women and birthing people could not always access the service when they needed it nor receive treatment within agreed timeframes and national targets.
- The service did not always have enough maternity staff to keep women safe from avoidable harm and to provide the right care and treatment. Staffing levels did not always match the planned numbers.
- Staff did not always keep good care records.
- Staff did not always use systems and processes to safely prescribe, administer, record and store medicines.
- The service did not always manage safety incidents well nor learn lessons from them.
- Staff felt did not always feel respected, supported and valued. They were not always able to focus on the needs of women and birthing people receiving care.
- Leaders did not operate effective governance systems. They did not always manage risk, issues and performance well. They did not consistently monitor the effectiveness of the service. Though staff were committed to improving services they did not always have the skills and resources to do so.

Our findings

- Managers did not always ensure staff were competent. Not all staff had received an annual appraisal.

However:

- Staff worked well together for the benefit of women and birthing people and understood how to protect women and birthing people from abuse.
- Local leaders had the skills and abilities to run the service and were visible and approachable in the service for women and birthing people and staff.
- Staff understood the service's vision and values, and how to apply them in their work. 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.

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 ↓

Is the service safe?

Inadequate ↓↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service did not make sure everyone completed mandatory training.

Staff were not up-to-date with their mandatory training. The service provided information that showed staff were required to complete mandatory training, clinical mandatory training and local mandatory training. Records showed that 77% of medical staff and 81.5% of all other staff, including midwives, had completed the required mandatory training courses. Compliance with mandatory training was lower for midwifery staff working in the maternity assessment unit at 66%. Some staff told us they found it difficult to access training due to staffing levels and training being cancelled.

Records showed 58.6% of medical staff and 65% of all other staff, including midwives, had completed clinical mandatory training. They showed 74% of midwifery staff and 68% of medical staff had completed local mandatory training. The maternity specific training needs analysis provided by the trust, did not outline the difference between the 3 types of mandatory training nor provide a target for mandatory training compliance.

Staff completed training and competency assessments for cardiotocography (CTG) as part of the K2 training package. K2 is an online learning package for fetal monitoring. CTG is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Sixty-eight per cent of midwifery staff and 75% of medical staff had completed CTG training. Compliance with CTG training was lowest for midwifery staff in the maternity ward at 61% and maternity assessment unit at 65%.

The service provided information that showed 93% of midwives, 91% of maternity support workers, 90.5% of obstetric medical staff and 97% of obstetric anaesthetic staff had attended multi professional simulated obstetric emergency training. Staff told us they attended 6 study days a year which included simulated obstetric emergency training and life support training and this time was protected.

Staff were supported to complete mandatory training by a team of 3 practice development clinical educator midwives. However, some staff reported midwives were often pulled from these specialist roles to support staff shortages in the unit.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed both level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. Seventy- seven per cent of medical staff had completed safeguarding level 3 training and 84% of midwifery staff.

We looked at the contents of the safeguarding training that staff completed; it covered the expected modules for safeguarding level 3 training. The modules were delivered face to face and were specific to the levels required for different staff. Each level built on the understanding and responsibility level associated with the staff role.

Staff could give examples of how to protect woman and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics. During handover we saw staff made adjustments to meet the needs of women and birthing people with protected characteristics such as mental health.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked woman and birthing people about domestic abuse, and we saw this recorded in records we reviewed. Where safeguarding concerns were identified staff were supported by the safeguarding team and appropriate referrals made. The safeguarding team offered safeguarding supervision to staff. However, some staff told us they did not always get enough support from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw evidence during our inspection that safeguarding concerns were discussed and escalated appropriately to the trust safeguarding team. Staff explained safeguarding procedures, how to make referrals and how to access advice. Safeguarding leads met daily to discuss all women, birthing people or babies where safeguarding concerns had been raised.

However, though patient records detailed where safeguarding concerns had been escalated in line with local procedures, staff did not always complete a safety log with relevant system checks on admission. In 6 out of 10 records we reviewed the safety log was not completed.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. All babies wore an electronic tag which set off an alarm if the baby was taken off the ward and hospital doors automatically locked when the alarm was activated. Staff carried out daily checks to ensure all babies had tags attached.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect woman and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean. However, not all staff followed 'bare below elbows' infection control measures and cleaning processes and checks were not always clear.

Maternity service areas were mostly clean and had suitable furnishings which were visibly clean and well-maintained. However, we found some pieces of equipment on delivery suite which were visibly dirty and some corridor areas were cluttered, as they were used to store equipment such as drip stands.

The trust had introduced some new cleaning standards in May 2022. We reviewed the detailed cleaning proforma which covered all aspects of the wards and equipment and who was responsible for each area.

However, during our inspection we saw though cleaning records were up-to-date they did not always demonstrate that all areas were cleaned regularly. This was because checklists did not have a detailed breakdown of what had been cleaned in each area or room. Staff on Mat Base (the post and antenatal ward) completed checklists to show an area had been cleaned and used 'I am clean' stickers on some equipment to indicate it had been cleaned and was ready for use. However, they could not show us any detailed checklists to demonstrate what had been cleaned in each area or room and how frequently this was required nor did all items of equipment have 'I am clean' stickers. Therefore, we could not be assured there was a robust system to ensure all areas and equipment were cleaned routinely.

The unit used disposable curtains around bed spaces. However, these did not all have dates to indicate when they were due to be changed.

The service generally performed well for cleanliness and audited cleaning checks every month. We looked at audits for the last 3 months and found all areas were covered in detail and any actions were noted and signed off once completed. For example, damage to walls or sink sealants were reported to the estates department and recorded once actioned.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). Staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. There was good provision of hand washing facilities and alcohol hand gel throughout the unit. However, we observed some staff wore false or gel polish nails, which is not in line with 'bare below elbows' guidance.

Leaders completed regular infection prevention and control and hand hygiene audits. Data showed audits were completed every month in all maternity areas. Between October 2022 and January 2023, matrons spot check audits showed all areas had high compliance, except maternity base (the ante and post-natal ward) which was rated amber with 86% compliance in December 2022. This had improved to 95% in January 2023. Hand hygiene audits showed good levels of compliance between October 2022 and January 2023.

Staff completed required checks in relation to water sampling and the use of the birthing pools to ensure risk of infection from water related bacteria was managed. When any area was noted to have a positive sample, staff disinfected the pool to ensure the required safety levels were met and repeated testing to ensure a negative sample was received.

We saw staff mostly cleaned equipment after contact with women and birthing people and labelled equipment to show when it was last cleaned. Managers carried out spot checks of rooms to check rooms were cleaned after use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always people safe. This was because the maternity assessment unit was not an appropriate environment for women and birthing people to give birth. However, staff managed clinical waste well.

Woman and birthing people could reach call bells but staff did not always respond quickly when called. During our inspection, we saw call bells were not answered in a timely way on Mat Base, the mixed ante and post-natal ward. We

saw midwives did not answer a call bell for 15 minutes and had to be alerted by a member of our inspection team. We received feedback from women and birthing people following our inspection who told us they waited for lengthy periods for call bells to be answered. For example, women and birthing people reported waiting between 25 minutes and 3 hours for call bells to be answered.

The design of the environment mostly followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

The service had completed self-harm and ligature risk assessments in all areas. The risk assessment identified actions to lessen the risk of women and birthing people self-harming through ligature. However, the risk assessment identified there was no ligature free safe room on the maternity assessment unit (MAU).

However, the environment in MAU was not appropriate for women and birthing people in advanced stages of labour or giving birth. We received feedback from women and birthing people who told us about negative experiences whilst in active labour in MAU. This included a negative impact on privacy and dignity.

In MAU we found first aid boxes which were past their expiry date. There was an umbilical venous catheter found with packaging opened which would pose a risk of infection if used. The ECG machine did not have a service date displayed so it was not evident of it had been properly maintained and serviced.

We found out of date blood culture bottles in the delivery suite, we escalated this to managers who removed them immediately.

Staff carried out daily safety checks of specialist equipment. Records showed equipment had undergone appropriate electrical testing. Most specialist and emergency equipment was monitored on an electronic kit check system. Staff completed daily checks online using handheld devices and records we reviewed showed equipment was mostly checked daily. However, the resuscitation trolley in MAU was not checked using this electronic system and we found gaps in daily checks of equipment. We found some gaps in checks of emergency equipment on the midwife led unit (MLU).

The service did not always have enough suitable equipment to help them to safely care for woman and birthing people and babies. This was because we were not assured staff would be able to access appropriate resuscitation equipment in all areas. The induction of labour suite did not have a resuscitaire. There was an emergency grab bag and baby changing mat on a worksurface in an examination room. This would be difficult to access if the room was in use. However, staff could access mobile resuscitaires from the delivery suite area, which the induction of labour bay was located within. We found a neonatal resuscitation mask on a resuscitiare in the delivery suite on which the sterile seal was broken. There was a sign on emergency equipment on MAU for a ‘perimortem c/s pack’ but this was not present on the equipment.

Staff regularly checked birthing pool cleanliness. There was a standard operating procedure in place in the midwifery led unit for cleaning the birthing pools which included a legionella check.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. However, some women and birthing people we spoke to told us there were not always suitable facilities for partners to stay overnight.

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 areas while waiting for removal.

Maternity

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman but did not consistently take action to remove or minimise risks. Frequent staff shortages increased risks to women and birthing people across the maternity service. This meant staff did not always identify nor quickly act upon woman and birthing people at risk of deterioration.

Women and birthing people could not always access emergency services when needed nor receive treatment within agreed timeframes and national targets. This was because the service did not operate effective and timely triage processes to protect women, birthing people and babies.

Though staff used an evidence-based, standardised risk assessment tool for maternity triage we found delays in initial triage of women presenting to the maternity assessment unit (MAU). Women and birthing people frequently waited over 30 minutes for initial triage by a midwife. We reviewed 9 sets of patient records where the woman or birthing person had attended MAU and only 2 were seen within 30 minutes, with the longest wait being 3 hours. This was not in line with trust policy of triage within 30 minutes nor national best practice guidance of 15 minutes.

The triage telephone helpline was often not staffed which meant that women and birthing people could not always access timely advice and support placing increased pressure on women attending the unit as they had been unable to obtain advice and support via the telephone triage system.

Low risk women in labour who had chosen to birth in the midwife led unit (MLU) could present directly to the MLU. However, between March and December 2022 the MLU was closed as a place of birth for 34% of the time. Women and birthing people in labour would then present to the MAU, further increasing demand and pressure within MAU. Between July and December 2022 there 21 occasions where babies were born in MAU. The service reviewed all these cases and found in 29% there had been a delay in transfer as there were no available beds on MLU or the delivery suite. Of the 21 women and birthing people the service had identified 10 were deemed to be low risk, who would meet the criteria for an MLU birth. In 5 of these cases the MLU was closed.

We found delays in women and birthing people being reviewed by a doctor following initial triage in MAU. This meant women, birthing people and babies may not have their condition assessed by an appropriate clinical member of staff in a timely way, therefore delaying treatment and exposing them to increased risk of harm.

There were delays in transferring women to delivery suite from MAU. This meant one to one care in labour could not always be provided. Records showed between July and December 2023 one to one care in labour had not been provided on 21 occasions. Though one to one care in labour was provided 99% of the time between October and December 2022, there is a risk of harm to women and birthing people where this is not provided. To mitigate this risk, the service completed a clinical review for all women and birthing people who did not receive one to one care in labour.

Staff on the midwifery led unit (MLU) could not articulate what risk assessments would be carried out when a woman or birthing person arrived at the unit in labour. This meant women arriving at the MLU in labour may not have all risks assessed, placing them at risk of harm.

Following our inspection, we notified the trust of our serious concerns around delays in triage assessment and asked them to provide an urgent action plan to show how these concerns would be addressed. The trust submitted an action plan which addressed the concerns highlighted and mitigated immediate risks to women, birthing people and babies.

Maternity

Staff did not always share key information to keep women and birthing people safe when handing over their care to others. This was because staff did not consistently use a recognised tool to handover care of women, birthing people and babies to other staff or areas. This is important as it ensures staff have all relevant information to provide safe and effective care.

We attended handover on Mat Base and this did not follow a situation, background, assessment and recommendation (SBAR) format. SBAR is a framework for communication between members of the healthcare team recommended by NHS England. We reviewed an audit of handovers in relation to SBAR. This was completed on 30 January 2023 by the digital midwives. This audit reviewed 30 records from October to December 2022 and it showed only 2 out of 30 records were completed with the appropriate clinical information.

Handovers on Mat Base between shift leaders did not include all information to keep women, birthing people and babies safe. This was because shift leaders gave limited information due to the number of women and birthing people they had to cover when handing over. We observed the handover was limited to highlighting safeguarding concerns and there were frequent interruptions to the handover. The midwife in charge did not attend the doctors ward round but this was attended by the midwife responsible for providing direct care to that woman or birthing person.

There were no safety huddles on the midwife led unit. Safety huddles on Mat Base had been started as part of improvement work with the first held the day before our inspection. A safety huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused on women, birthing people and babies most at risk, often patient harms and lessons learnt are also discussed. The midwife in charge of Mat Base did not attend the unit safety huddle to feed in any issues regarding staffing and acuity which may have an impact on the care of women and birthing people.

High risk women and birthing people staying on Mat Base were not cared for in shared bays but spread throughout the ward. This meant there was a risk it was more difficult for midwives to maintain close and frequent observation of the highest risk women and birthing people. However, the service told us staff used a dynamic risk assessment process to decide the most suitable position of women and birthing people within the ward.

However, we saw the ward round on delivery suite was effective with all relevant members of the team present including the anaesthetist.

The patient care record was on a secure electronic patient record system used by all staff involved in the care of women and birthing people. Each episode of care was recorded by health professionals and was used to share information between care givers.

Once women and birthing people had been triaged and care and treatment was provided, staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used the Modified Early Obstetric Warning Score (MEOWS) for each woman. We reviewed 10 MEOWS records and found though staff completed records of observations in the MEOWS chart, in 3 charts an overall score had not been allocated and one set of records had not been completed at all. The score on MEOWS indicates overall risk and what action should to be taken to escalated women and birthing people at higher risk.

During our inspection, we saw the CTG machine used for a woman in labour pulled observations directly to the electronic record, but these were not all accurate. For example, the pulse rate did not pull across correctly. This meant records were not easily available on the system to other professionals assessing the women during labour and may not be accurate.

However, we reviewed the quarterly audit of compliance with MEOWS completion and escalation for October to December 2023 and saw 97% compliance with staff escalating concerns appropriately to a clinician.

We saw staff used The World Health Organisation (WHO) Surgical Safety Checklist tool in theatre. The tool aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists and ensured any required actions were addressed in relation to staff training or upgrades of how data is recorded on the trusts system. We saw compliance rates for the WHO checklist for caesarean sections was between 95-98%. Other invasive procedures saw a lower compliance rate of 60% which the service had reviewed and was providing additional training to staff. The trust used the LocSSIPs (Local Safety Standard for Invasive Procedures) as a measure for these procedures and benchmark when auditing.

Staff used the ‘fresh eyes’ approach to safely and effectively carry out fetal monitoring. Leaders audited how effectively staff monitored woman and birthing people during labour having continuous cardiotocograph (CTG). The service audited CTG checks and randomly sampled 5 cases each month from June to December 2022. Over this period there had been an improvement in compliance with fresh eyes check form the previous audit with compliance rates between reflecting between 80 and 100%. compliant with the fresh eyes completion in a timely manner. Actions to address low compliance included support provided by the fetal surveillance midwife, additional training such as 'Baby Lifeline’ advanced masterclass and support from the preceptorship midwives

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

Staff completed, or arranged, psychosocial assessments and risk assessments for woman and birthing people thought to be at risk of self-harm or suicide. We saw mental health assessments were completed in all records we reviewed.

The service provided transitional care for babies who required additional care.

Midwifery Staffing

The service did not always have enough maternity staff to keep women safe from avoidable harm and to provide the right care and treatment. Staffing levels did not always match the planned numbers.

Staffing levels did not always match the planned numbers putting the safety of woman and birthing people and babies at risk. On the day of inspection, on Mat Base midwifery staffing should have been 13 midwives and 3 maternity support workers but it was 11 midwives and 2 maternity support workers. We reviewed the most recent biannual staffing report submitted to trust board and saw midwifery staff fill rates between 25.8% and 101% between January and June 2022. Maternity assessment unit midwifery staff fill rates were not reported separately, therefore we were unable to ascertain if actual staffing matched planned for this area in that period. The report identified a decline in fill rates across maternity services. The average fill rate for registered midwives in the midwifery led unit was 63.8% on days 75.8% at night.

Some staff told us staffing levels made the unit feel unsafe. Staff told us they frequently were unable to take breaks, especially overnight and they often did not have enough staff on Mat Base. We saw the impact of staffing shortages and lack of appropriate staff skill mix on patient care whilst we were on inspection. For example, we saw delays in triage of women presenting to maternity assessment unit (MAU) and staff could not always answer call bells quickly nor give timely pain relief to women and birthing people on Mat Base.

Maternity

Staff in the MAU gave multiple examples of situations where high acuity and low staffing made the unit feel unsafe. One member of staff stated, 'it's a very scary place'.The service reported several incidents where low staffing in the maternity assessment unit led to delays in triage and put women, birthing people and babies at risk of harm.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. The service told us red flag events reported to board were not yet aligned with NICE midwifery red flag events. Following our inspection, the service told us work was completed to align the trust electronic reporting system with this. The new standard operating procedure for midwifery red flags was launched in April 2023. Prior to this work, the service reported 109 maternity red flags between August and October 2022. The trust board report November 2022 stated all trust red flag events between January and June 2022 related to maternity services. The trust reported 216 clinical incidents related to staffing or staff sickness between January and June 2022.'

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in January 2022. We reviewed the report to trust board in February 2022 following the review and saw the funded establishment of midwives and maternity support workers was higher than the recommendations of the review by 24.91 whole time equivalent (WTE) midwives and 2.54 WTE maternity support workers. However, due to vacancies, sickness and turnover this level of staffing was not met.

There was a supernumerary co-ordinator/ bleep holder on duty during the day who had oversight of the staffing, acuity, and capacity.

We reviewed the online staffing report for the week beginning 23 January 2023 used by the midwifery bleep holder to assess staffing and acuity across the service on each shift. This graded staffing levels as red, amber or green based on actual staffing and acuity, with red indicating the greatest staff shortages. The report showed that of 7 early shifts 2 were rated red and 5 amber, of 7 late shifts 2 were rated red and 5 amber. Staff explained the report was a live system which was updated throughout the day if staff were redeployed between areas or if bank staff were found. Managers allocated midwives from continuity of care teams to shifts and this improved staffing, however 2 days still did not meet the required staffing being rated amber.

Managers did not always have the resources to adjust staffing levels daily according to the needs of woman and birthing people. Managers moved staff according to the number of woman and birthing people in clinical areas. Though staff received a local induction they told us this was at short notice and they were expected to work in areas unfamiliar to them. Information provided by the service showed between January and June 2022 bank and agency fill rate did not match demand in maternity services.

At the time of our inspection, the service continued to run 4 continuity of carer teams in the community. The continuity of carer model is a way of delivering maternity care so that women and birthing people receive dedicated support from the same midwifery team throughout their pregnancy. Managers told us the decision was taken to continue with these teams due to the needs of the community the teams served. Midwives from the continuity of carer teams were identified to come in and support the maternity unit in line with the trust staffing escalation policy.

However, recommendations from NHS England in September 2022 told trusts all national targets on delivering continuity of carer were suspended. They told trusts they should suspend existing provision of continuity of carer where trusts could not meet minimum safe staffing requirements.

Maternity

Following our inspection, we raised urgent concerns about safe midwifery staffing levels. The trust told us they had immediately suspended the continuity of carer model, which released 30 WTE midwives and based 2 midwives on midwifery led unit for that weekend to ensure women and birthing people were not redirected to maternity assessment unit. The trust then reassessed the impact and reinstated continuity of carer. Following further review the service suspended continuity of carer again from 8 May 2023 for a period of 6 months.

The service had high vacancy rates, turnover rates, sickness rates and high use of bank nurses. At the time of our inspection the were 30.61 WTE midwife vacancies and managers told us they had 9.84 WTE midwives due to start work. Sickness rates reported for the whole trust were higher than the trust threshold of 4.5% between January and June 2022. Following our inspection, the service provided information that showed absence levels were decreasing and were 9.25% in March 2023. The service had taken action to manage absence such as wellbeing coaches, employee support services and amendments to short term sickness absence policies.

Managers told us the turnover rate in June 2022 was 9.8%. The service had rolling recruitment for midwifery vacancies and was working with the communications team to make job adverts more attractive and holding recruitment open days.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. Most bank staff were staff who already worked within the service.

The service did not make sure staff were competent for their roles. Managers did not always appraise staff's work performance nor hold supervision meetings with them to provide support and development.

Managers did not ensure staff developed through yearly, constructive appraisals of their work. The service provided information that showed only 51% of midwifery staff had completed an annual personal development review.

Managers made sure staff received any specialist training for their role. A practice development team supported midwives. The team included 3 practice development clinical educator midwives.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep woman and birthing people and babies safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff to keep woman and birthing people and babies safe. The medical staff did not always match the planned number. The medical staffing establishment for the maternity assessment unit (MAU) was reported as one senior house officer (SHO). Staff told us there frequently was not an SHO available. During our inspection we saw the doctor assigned to MAU was moved to work on delivery suite leaving no dedicated medical cover. The service told us this followed the internal escalation process for staff absence and the doctor returned to MAU. Managers told us the service was developing the role of advanced care practitioner (ACP) to provide medical cover in MAU. However, at the time of our inspection, no members of staff were fully trained as an ACP. Following our inspection, the service confirmed 5 ACPs had completed training and had been deployed to MAU.

We asked for but the service did not provide vacancy, turnover and sickness rates for medical staff. We reviewed the maternity staffing paper provided to trust board for January to June 2022 but saw this did not provide an update on medical staffing only midwifery.

Maternity

During our inspection, we saw junior medical staff sickness absence impacting on patient flow. There were delays in discharging or moving women, birthing people and babies from delivery suite due to wait for a medical review. This meant women and birthing people waiting in maternity assessment unit for a bed in the delivery suite were also delayed in receiving timely care and treatment in the right place.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The rota for consultant obstetricians was organised in line with Royal College of Obstetrician and Gynaecologist guidelines. However, staff told us medical staff often got moved from Mat Base to MAU and this was not reflected in the service risk register.

The service did not have an intensivist doctor as they did not have an intensive care unit. The service ensured there was sufficient cover from an anaesthetist 24 hours a day, 7 days a week. There was a joint anaesthetic and obstetric doctor daily ward round of the 4 high dependency beds on delivery suite.

The service always had a consultant on call during evenings and weekends. There was resident consultant on delivery suite until midnight on weekdays. The service had plans to increase the number of consultant hours. They were also developing the role of physician associate in the service.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Ninety-three per cent of medical staff had completed an annual personal development review.

Records

Staff kept records of woman and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. However, records were not always complete.

Woman and birthing people's notes were comprehensive and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 10 electronic records and found records were clear. However, they were not always complete. For example, safeguarding logs were not completed in 6 of the records we reviewed. Observations and modified early obstetric warning scores were not fully completed in electronic records.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. Women and birthing people could access their own pregnancy records through an online app.

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

Medicines

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

Staff did not consistently follow systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission, which were on a different system to the electronic patient record. Prescription charts did not include a record of weight, height or allergies. Staff told us these were documented on a different electronic system which they would also check before prescribing or administering medicines. This meant there was a risk that staff may not check all systems or make an error as all the relevant information was not in the same place.

Staff told us the system to sign off take home medicines by the shift lead on Mat Base delayed discharge for some women.

Staff completed medicines management training as part of mandatory training. We saw 72% of midwifery staff and 62% of medical staff had completed medicines management training.

The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff did not always complete medicines records accurately. Medicines records were mostly clear and up-to-date. However, in 2 out of the 3 records we reviewed where it was required, staff had not recorded a reason for omission of medicines. The role and grade of the person prescribing was not recorded on records we reviewed.

Staff mostly 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 monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff checked controlled drug stocks daily. However. We found an error in the count of controlled drugs on Mat Base. The incorrect amount of oramorph in stock was transcribed onto a new page in the controlled drugs book. We escalated this to managers and this was immediately rectified and confirmed no controlled drug was missing.

Incidents

The service did not always manage safety incidents well. Staff did not always recognise and report incidents and near misses in a timely way. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised. However, we received feedback from women and birthing people that they were not always given honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff could describe what incidents were reportable and how to use the electronic reporting system. However, staff did not always raise concerns and report incidents and near misses in line with trust policy. For example, there were 21 occurrences of babies being born on the maternity assessment unit between July and December 2022. The service told us 11 (52%) of the 21 incidents were reported on the trust electronic incident reporting system. Some staff told us they did not report all incidents relating to staffing shortages and breaches in waiting times due to the busyness and pressure within the unit.

We reviewed incidents reported to the national reporting system in the 3 months before inspection. This showed an irregular pattern of incident reporting. We saw delays in reporting of incidents to the national system, for example one incident which took place in January 2022 was reported to the national system in October 2022. Therefore, we could not be assured incidents were reported and investigated in a timely way and it was hard to identify when incidents actually occurred.

It was unclear if 'never events' were reported in a consistent and timely way. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. For example, we saw an incident reported to the national reporting learning system (NRLS) in October

2022 which took place in January 2022. Following our inspection, the service provided information that showed this was reported to the national serious incident reporting system in February 2022, when it was recognised as a never event. This meant we could not be assured the service recognised never events in a timely way and therefore took timely action to learn from them.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. However, some incidents such as 3rd and 4th degree tears and post-partum haemorrhages were not investigated on an individual basis but grouped together to conduct a thematic review. This meant we could not be assured learning from incidents was shared in a timely way.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. The service had a system to share feedback to staff when they requested this on the online reporting system. However, some staff told us feedback from incidents reported was very limited.

Managers did not always debrief and support staff after any serious incident. Some staff told us they did not receive debriefs after serious incidents.

Managers investigated incidents thoroughly. We reviewed 3 serious incident rapid reviews and found immediate learning points were identified and shared with staff and incidents were escalated for further investigation. However, managers did not always involve women and birthing people and their families in these investigations. We received feedback from women and families who had been affected by serious incidents who told us they had not been involved in the investigation only given the investigation report when completed.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions and some incidents such as 3rd and 4th degree tears and post-partum haemorrhages were also grouped together to conduct a thematic review.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Duty of candour was carried out by each woman or birthing person's lead consultant where possible. However, in one incident we reviewed we saw duty of candour was potentially delayed due to the woman being non-English speaking.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. The fetal monitoring midwife reviewed all serious incidents to assess the use of cardiotocography within the incident and met with staff following any incident. They attended weekly 'learning through incidents' call with doctors and the weekly meeting to look at all unexpected admissions to the neonatal unit.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Maternity

Local leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles. They were visible and approachable in the service for women and birthing people and staff. However, executive leaders did not always understand and manage the priorities and issues the service faced.

Leaders had the skills and abilities to run the service. The maternity leadership team was relatively newly formed within the family health divisional and the triumvirate consisted of a head of midwifery, clinical director of obstetrics and divisional general manager. They had professional reporting lines to the chief operating officer and chief nurse. The trust had invested in the leadership team in 2022 and recruited a director of midwifery. Below these leaders were 5 midwifery matrons with respective specialisms. The maternity service was supported by midwifery leads for retention, maternity education, preceptorships, fetal surveillance, risk, MBRACCE/ CDOP, infant feeding and digital midwives.

Leaders understood the priorities and issues the service faced. Senior leaders in maternity services met monthly. We looked at meeting minutes for November 2022 and saw they covered the expected range of themes and agenda items.

Local leaders were visible and approachable in the service for woman and birthing people and staff. Staff told us maternity service leaders were visible and approachable within the unit. However, some staff told us leaders were not responsive and had been dismissive when they raised issues. There had been recent disruption to management on Mat Base which staff told us had resulted in a lack of leadership on that ward.

However, executive leaders did not always manage priorities and issues effectively. For example, we reviewed the quality committee report to board in April 2022 which identified ‘continued issues with telephone triage process in MAU. The committee requested the executive team consider the issues as a matter of priority and identify timescales to report back to next committee’. However, we identified concerns regarding telephone triage processes still existed during our inspection.

The service was supported by maternity safety champions and non-executive directors. The non-executive maternity safety champion conducted walk abouts in the maternity service to meet staff and women and birthing people. We reviewed minutes of the safety champion walk abouts for September to December 2022. These showed a clear structure which covered relevant safety areas. However, the minutes did not give sufficient detail to fully understand the matters discussed and any agreed actions.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action. There was a clear and ambitious 5-year strategy designed to raise the standards of maternity services in Liverpool. The trust's 'Maternity Transformation Programme' started in October 2021 and aimed to fulfil their strategic objectives by October 2026. Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services at The Shrewsbury and Telford Hospital NHS Trust and these were reflected in the strategy.

The strategy consisted of several improvement initiatives such as training and resourcing an enhanced maternity care pathway, improved antenatal and postnatal care pathways and an innovative service user and staff engagement system co-produced and conducted in partnership with the Maternity Voices Partnership.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The strategy was split into 6 workstreams which primarily focused on improving patient flow and accessibility; staff culture, resource and development; improving the safety and quality of maternity care; ensuring the estates at the trust were fit for purpose and safe; workforce planning; and aligning the service to the trust wide digital strategy.

Leaders had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies. Medical staff told us they were involved in the development of the trust strategy

Culture

Not all staff felt respected, supported, and valued. The service did not consistently have an open culture where women and birthing people, their families and staff could raise concerns without fear. During our inspection, we saw staff were focused on the needs of women and birthing people receiving care. However, following our inspection, some women and birthing people gave negative feedback about their experience of care.

Not all staff felt respected, supported, and valued**.** Though some staff told us maternity leaders were supportive others told us they did not feel listened to, and they did not see any evidence of change when they raised concerns. Some staff told us they had raised concerns regarding the safety of maternity services and staffing directly to senior leaders and through the trust Freedom to Speak Up Guardian, but they had seen no action or improvement. A Freedom to Speak Up Guardian works alongside the trust's senior leadership team to ensure staff have the capability to speak up effectively and are supported appropriately if they have concerns regarding patient care.

However, some staff spoke positively about the support they had received from managers and colleagues. Newly qualified midwifery staff particularly praised the support given through their preceptorship period. The trust wide NHS staff survey for 20221 showed staff morale and engagement had increaseddeclined from the previous year's scores.

The service did not always have an open culture where women and birthing people, their families and staff could raise concerns without fear. Following our inspection, we received feedback from staff telling us they felt managers did not listen to their concerns and reporting low morale with a 'blame culture' in place. The service did not always promote equality and diversity in daily work. Some staff contacted CQC following our inspection alleging they had been treated differently due to the colour of their skin.

Leaders told us they were aware of the impact of staffing issues on morale and had implemented a number of staff wellbeing measures such as wellbeing coaches and psychology support.

Woman and birthing people, relatives, and carers knew how to complain or raise concerns. The service received 7 complaints in the 3 months before the inspection. We reviewed all complaints and found that 'delay or failure to follow up (on clinical treatment)' was a common theme in 6 out of 7 complaints received in this period. We were unable to review the trust's complaint responses as this information was not supplied to the CQC.

Some women and birthing people provided feedback following our inspection that they did not feel they had been listened to during their pregnancy journey and when raising concerns.

Following our inspection, 347 women sent feedback about their maternity care at Liverpool Women's Hospital. Some women and birthing people praised staff attitude and the care received with 51 being completely positive and a further

3 containing some positive feedback. However, 293 women and birthing people raised concerns regarding their care at Liverpool Women's Hospital. Themes raised included lack of postnatal care, concerns with triage processes, basic care needs such as pain relief, food and drink not being met, poor staff attitude, the impact of low staffing levels and concerns about their care and treatment during labour.

However, during our inspection we saw staff were focused on the needs of woman and birthing people receiving care. We saw staff striving to deliver the best possible care they could in difficult circumstances. Staff described positive working relationships across the multidisciplinary team focused on the needs of women and birthing people. Staff recognised the power of caring relationships between people. Staff we spoke with clearly demonstrated a focus on dignity and respect.

The bereavement team provided responsive and compassionate care and support to women, birthing people and families. Families we spoke to praised the support received from bereavement midwives. Bereavement midwives offered [practical and emotional support to women, birthing people and families who had experience any pregnancy or baby loss. Support was not time limited and tailored to individual needs. the bereavement service provided support groups that met the needs of the whole family. For example, they had a support group specifically for dad's in partnership with a local charity. However, the bereavement service was not available 7 days a week, in line with recommendations from the last Ockenden report. Lack of 7-day bereavement support was identified as learning through the perinatal mortality review tool and a business case was being put together to increase the service.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. Senior leaders we spoke with demonstrated a good understanding of the needs of local women and communities and some of the health inequalities faced. They described initiatives with partner organisations such as Citizens Advice Bureaux to help address inequalities for women and birthing people.

Governance

Leaders did not operate effective governance processes, throughout the service. However, 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 did not always operate effective governance processes throughout the service. There was a clear governance framework for the family health division which outlined how information flowed between maternity services and the board. Leaders monitored key safety and performance metrics through a comprehensive series of governance meetings. However, we found issues on inspection that were escalated through audit and governance processes that had not been fully addressed. For example, the Family Health Divisional Safety Champions – Q2 22-23 Report stated the service could meet safe minimum staffing requirements for existing continuity of carer provision. However, on inspection we found the service did not always have sufficient staff deployed to keep women, birthing people and babies safe. We escalated this to the trust and they suspended continuity of carer to improve staffing levels on MAU and the midwifery led unit. The trust informed us that incremental changes have occurred and additional staff were put in MAU and above Birth rate plus requirements following the CQC visit.

Though staff knew how to escalate issues we were not assured processes to escalate issues to managers and leaders were robust. For example, the telephone triage line was not supported consistently, placing increased pressure on women attending the unit as they were unable to obtain advice and support via the telephone triage system. We saw red flag notifications had not always been completed to identify when the staffing fell below the agreed safety numbers or when women had not been assessed within the agreed 30 minute timeframe

The Maternity Incentive Scheme is a national programme that rewards trusts' that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. Following our inspection, the service provided information to show they had provided evidence of their compliance with all 10 safety initiatives to the Board in November 2022.

Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Clinical governance meetings were held monthly. We reviewed 2 set of minutes covering the last 3 months of meetings. In the minutes we reviewed we saw meetings followed a clear agenda and actions arising from these discussions were highlighted from one meeting to the next.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Policies and guidelines we reviewed reflected relevant national guidelines, were up-to-date and version controlled.

Management of risk, issues and performance

Leaders and teams did not consistently use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues nor identify actions to reduce their impact.

The service participated in relevant national clinical audits. However, outcomes for women and birthing people were not always in line with national standards. The trust was an outlier in the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) perinatal mortality surveillance report. The adjusted perinatal mortality rate was more than 5% higher than the comparator group average for all birth and births excluding congenital abnormalities. The service had an independent peer review of their mortality data in 2020 and May 2022. Both reviews concluded that was no clear causative factor identified for the elevated mortality rates, however areas of improvement were identified. The review made recommendations around clinical practice, workforce, governance, service provision and how mortality data was monitored at network level.

Leaders reviewed all stillbirths through the perinatal mortality review tool (PMRT) process. We reviewed the standardised quarterly perinatal board report for July to September 2022. This showed there had been a decrease in the still birth rate over the last 12 months. It also showed in 57% of antenatal case and 86% of postnatal cases care issues were identified, however they would not have made a difference to the outcome. The report identified learning and actions to be taken. The service reported 100% compliance with PMRT reporting. However, minutes of PMRT meetings were not recorded, therefore we could not assess the robustness of this process.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had an audit programme in place to check improvements over time. This included trust wide and maternity specific audits. For example, the service measured the quality of care in women undergoing elective outpatient and inpatient induction of labour and compared practice against National Institute for Health & Care Excellence (NICE) quality standards.

However, audits were not consistently used by mangers and leaders to make improvements and take timely action. The service did not provide any audit data to reflect how they have reviewed and monitored the standardised assessment tool for triage since its implementation. The audit of situation, background, assessment, recommendation (SBAR) handover tool in January 2023 found low compliance in all areas. On inspection we found SBAR was not used on Mat Base.

The trust ward accreditation scheme implemented in August 2022 identified Mat Base as the worst performing area, rated white (the lowest rating) and an action plan was developed. However, on inspection we found concerns, in areas such as handover and medicines management which the action plan was designed to address. Maternity assessment unit (MAU) had been assessed as bronze (second worst rating)and an action plan developed following this assessment. This meant we could not be assured leaders took timely and effective action to address risks and improve performance.

Leaders did not always identify and escalate relevant risks and issues nor identify actions to reduce their impact. During our inspection we saw not all incidents were reported on the online incident reporting system. For example, we were told inspection were told 31 out of 39 women and birthing people on the first day of inspection were not seen within 30 minutes in MAU. The service told us it was the responsibility of the clinical teams within MAU to report in line with trust policy. However, there were no incident reports on the electronic reporting system regarding this. This meant managers and leaders were not aware of risk issues in a timely way.

We reviewed the red flag report for November 2022. This report focused on the reporting requirements for delays in induction of labour over 4 hours. The report highlighted changes needed to the electronic reporting system needed to make this requirement easier for staff to report.

The service was represented at the weekly trust wide serious incident harm meeting. Incidents discussed at this meeting were those escalated following review by the division. The Ockenden report shared with board in May 2022 identified the importance of robust serious incident management practices as an area for improvement. However, we did not see robust systems during our inspection.

We reviewed the risk register for the service. There was a risk ratio which graded the risks from low to extreme risk. We saw there were 33 risks on the risk register. Of these 8 had control effectiveness ‘not recorded or tested’, 9 stated ‘ineffective controls’. We saw the risk of ‘insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes’ had been on the risk register since 2021 and remained extreme with no improvements noted.

A risk was added to the register for MAU on 26/11/2019. The risk register identified gaps in controls and ineffective controls and we found the same issues identified during our inspection. There was risk relating to insufficient resource to support blood transfusion which had been on the risk register since 23/11/2018 with no controls entered/ effectiveness of controls entered.

However, the service provided evidence following our inspection that the risk register was reviewed weekly and through the divisional maternity and risk and governance committee, as well as the trust risk committee.

During our inspection, we found a high threshold for the grading of patient safety incidents. Therefore, we were not assured all incidents were allocated the correct level of harm and investigated accordingly. For example, we saw an incident reported as no harm where issues were identified with documentation and delay in transfer and diagnosis and the woman experienced a post-partum haemorrhage of 2.6 litres and manual removal of the placenta in theatre.

Maternity

Information Management

The service did not always collect and analyse reliable data. Staff could not always 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 did not always collect and analyse reliable data. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

We requested the maternity performance dashboard used by senior managers. The service provided the dashboard summary report sent to the Northwest Coast Clinical Network. This showed key performance indicators and performance over time for some metrics. However, performance data was only displayed for April to November 2022. There was no 'live' dashboard which gave up-to-date performance data and managers could not see other locations for internal benchmarking and comparison. Following our inspection, the trust told us the data sent to the North West Coast Clinical Network was taken from a 'live' dashboard which was reviewed regularly by the divisional board.

We could not be assured of accuracy of data provided by the service during and following our inspection. For example, we asked for information about the number of babies born in the maternity assessment unit (MAU). The service provided information on 2 occasions, one which stated 10 babies had been born in MAU and the other which stated 12 babies had. Some staff told us records were not always completed contemporaneously. For example, for births on MAU midwives documented the 1,2 and 3rd stage of labour and notes were completed by ward midwife on transfer. This meant there was a risk the correct place of birth may not be recorded in records.

Information systems were integrated and secure**.** Data or notifications were consistently submitted to external organisations. The service submitted data to external bodies including the National Neonatal Audit Programme, MBRRACE-UK and Healthcare Safety Investigation Branch (HSIB). However, we found delays in submission of data to the national reporting and learning system (NRLS).

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 woman and birthing people.

Leaders worked with the local Maternity Voices Partnership (MVP) in decisions about patient care. MVP engagement meetings were scheduled monthly and the MVP chair met weekly with senior leaders. We looked at minutes and action plans from the most recent meetings and saw discussions and actions agreed around how the trust disseminate important information to women and birthing partners.

The MVP and service worked together to engage with women from a range of backgrounds. For example, listening events had been held at a local mosque. However, feedback from the MVP and some women showed not all women were given information and options to make informed birth choices.

Maternity

The service made available interpreting services for women, birthing people and pregnant people.Staff told us they had good access to translation services and could use a computer on wheels to have online translation during care and treatment. The service had a QR code which women and birthing people could scan to access the 'my pregnancy note' application in different languages.

Leaders understood the needs of the local population. The trust collected equality monitoring data about people using the service. The enhanced care team focused on supporting women and birthing people with complex needs such as mental health or who were victims of domestic violence. There was also a team specifically for non-English speaking women. They ensured women and birthing people who were digitally excluded could access their notes by providing SIM cards. The service provided food vouchers to women and birthing people from deprived backgrounds and used funding from the trust's charity to provide vitamin prescriptions to vulnerable women.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Local leaders encouraged innovation and participation in research. However, staff did not always have the skills and resources to implement improvements to services and these were not always timely.

Staff and local leaders were committed to making improvements to the service and passionate about improving the care offered to women, birthing people and babies. Staff gave examples of improvements made on Mat Base. However, during our inspection we saw further improvement was needed to ensure women, birthing people and babies received safe care and treatment across the maternity pathway.

Staff were committed to continually learning and improving services. Quality improvement was routinely discussed at Maternity Transformation Board meetings. We saw that quality improvement was always an item on the agenda and staff were engaged in conversation about their ideas and innovations. For example, the minutes from the January 2023 showed those in attendance discussed the staff, culture, development and research at the service.

However, we did not see evidence discussions on quality improvement led to timely and effective change. Where improvements had been identified, such as in telephone triage, action had not always been taken. The service did not react sufficiently to risk identified through internal processes such as the risk register process. We saw risks on inspection which were recognised on the risk register but insufficient action had been taken to mitigate these risks.

Local leaders encouraged innovation and participation in research. The service collaborated with local universities and external agencies to support research studies. However, staff told us midwives in specialist research roles sometimes had to provide cover due to staff shortages across the service.

Gynaecology

Good ↑

Is the service safe?

Good ↑

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However not all medical staff were compliant with mandatory training.

Not all staff received and kept up to date with their mandatory training. Medical staff compliance had fallen from 92% to 78% at December 2022. However, most staff groups had over a 95% training compliance. Gynaecology inpatients was 94.62% and gynaecology management was 89.19% giving a total of 96.11% compliance rate overall which was an improvement since the last CQC inspection. A mandatory training study day was held monthly to support staff in completing their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. All nursing staff we spoke with had completed their mandatory training with a comprehensive induction for preceptorship nurses. Administrative staff had received basic life support training level 1 via e-learning with an overall compliance percentage of 95.38%. Only three people had yet to complete it fully but had completed more than 66% of the online training. Additional clinical, nursing and midwifery staff had an overall completion rate of 93.52% for level 2 basic life support and resuscitation face to face training of 93.52%, and six staff had completed level 3 training with a further 4 working towards it.

Compliance with mandatory training for theatre staff was high, with rates indicated at 100%. Mandatory training compliance for staff in the Bedford unit was 98.2%

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff informed us this was not part of mandatory training, although most staff had completed additional training in this area also. We requested but did not receive trust data to confirm whether these subjects were included as part of mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training using a rag rated tracker. Emails showed managers requesting staff complete outstanding training ‘as a matter of urgency’ and deadlines to respond to the manager.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff understood the importance of maintaining the confidentiality of information about patients’ identity and their care and treatment.

Gynaecology

Safeguarding training figures were included in the mandatory information from the trust but were not broken down. Staff said they received training specific for their role on how to recognise and report abuse. All qualified staff and managers said they were trained to Level 3 children and adults safeguarding training. In addition, the trust safeguarding team had delivered separate training for awareness of domestic abuse and sexual harassment. Safeguarding training modules included knowledge of female genital mutilation (FGM) and Child Sexual Exploitation (CSE)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We spoke with a range of staff including housekeeping who provided clear safeguarding understanding and knowledge. All had completed their safeguarding training to a level appropriate to their role and knew how to make a safeguarding referral and who to inform if they had concerns. Information provided and staff confirmed appropriate safeguarding measures were in place when patients under the age of 18 requested a termination of pregnancy.

The trust had an under 18's Bedford Unit pathway for patients using the action line and self-referral when accessing termination of pregnancy services. The trust had a standard operating procedure for under 18s accessing the Bedford unit. Initial safeguarding assessment would be carried out for any patients under 18, which included specific care pathways for under 16 years of age. Nurses determined from the telephone triage the patient's age and competency to consent, also following the patient eligibility criteria and flowchart. Women under 18 years old would be seen for a face-to-face appointment prior to their procedure, from which any safeguarding concerns would be escalated.

Staff said they only took referrals when patients had been triaged and received appropriate counselling from an approved abortion advisory service. Any safeguarding concerns and patients under the age of 18 when getting pregnant were flagged on an electronic system.

Staff were aware of the Gillick Competency and Fraser Guidelines and took referrals from an approved abortion advisory service. (Gillick competency and Fraser guidelines refer to a legal case from the 1980s which looked at whether doctors should be able to give contraceptive advice or treatment to young people under 16-years-old without parental consent.)

Cleanliness, infection control and hygiene

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

Ward areas were clean, uncluttered and had suitable furnishings which were clean and well-maintained. A poster campaign was in place in all communal areas of the trust promoting hand hygiene.

No PLACE were carried out during the pandemic.

Cleaning audits for the months of August to September 2022 showed a five-star rating for the trust overall. A recognised healthcare cleanliness programme audit is used in NHS hospitals across the UK (and abroad) to monitor services such as cleaning, catering, waste, security and estates. It provides a benchmark against NHS National Standard of Cleanliness 2021 audits.

A monthly audit check had been completed on the gynaecology ward for the cleanliness of mattresses, the environment and hand hygiene 1 February 2023. The trust displayed a combined compliance for all its' gynaecology services including services in Aintree and Knutsford. In January 2023 audits for IPC was 93.75%

Staff used records to identify how well the service prevented infections. In 2021/22, the trust reported no cases of Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia and were compliant with the target set by the Department of Health. The trust has only reported two of these infections in the past 10 years. In the same period the trust reported no cases of Clostridium difficile (C difficile). This was a lower incidence compared to other trusts in the region or nationally.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff followed current guidance on infection prevention and control and hand gel was provided throughout the building and ward entrances. However, it was noted hand gel was not positioned outside the main theatres. Two side rooms were available to isolate patients if there was a risk of infection. Patients also said the environment was clean.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We spoke with housekeeping staff who confirmed cleaning was undertaken and recorded.

Staff worked effectively to prevent, identify and treat surgical site infections.The infection prevention and control team reviewed surgical site infections (SSI) for a two-month period twice yearly. SSI rates remained below the trust threshold of 5%, at around 2 - 3% during the period 2021 to 2022.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe although we saw there was restricted space in the gynaecology emergency department. Staff were trained to use equipment. Staff managed clinical waste well.

We observed and patients told us they could reach their call bells with staff responding quickly when called.

The design of the environment followed national guidance. However, the environment in the gynaecology emergency department (GED) was very restricted for space, especially if there was a surge in the number of patients accessing the service. This had been noted in incident reporting about capacity in the department, particularly for patients who needed to be isolated during periods when there was a surge of patients. This had also been identified by the trust and noted in our previous inspection reports. Although there had been no specific actions to respond to this to date, there was a proposed business case in development for review of care pathways to improve patient access. There were additional challenges in accessing facilities in the department due to scan services utilising treatment rooms at different times.

Staff carried out daily safety checks of specialist equipment and recorded these in electronic systems. There was a 100% compliance rate for checking the emergency trolley in gynaecology. Records also showed ward and GED air temperatures were maintained to an ambient level as were fridge temperatures. Fire hydrants we observed had been serviced. Staff completed daily checks on specialist theatre equipment, and we saw that oxygen cylinders were in date and securely stored.

During the onsite inspection we spot checked a sample of equipment for portable appliance testing and saw these had been completed. We saw that some equipment in the GED did not have date stickers to indicate when the equipment was last serviced, although this was recorded in electronic systems. Staff we spoke with confirmed the hospital's biomedical engineering department was responsive if any equipment breakdown or concerns were raised and completed routine equipment maintenance and servicing checks. Following the inspection, we requested further information to confirm the dates for latest equipment servicing The trust sent details of 93 items of equipment for which routine servicing had been carried out, with dates ranging between January 2021 and April 2023.

Stock items and other consumables were stored safely and in an orderly way. Control of Substances Hazardous to Health (COSHH) items were appropriately stored in secure cabinets.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients. Specialist equipment for bariatric patients was available when needed across the service.

Staff disposed of clinical waste safely. We observed sharps bins were not overfilled and used correctly. Waste and clinical waste bins together with coloured coded linings were in place and not over filled.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

We reviewed patient records and staff confirmed they used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. They completed risk assessments for each patient on admission and arrival, using a recognised tool, and reviewed this regularly, including after any incident. The trust had specific protocols for Gynaecology Emergencies pathway, including for conditions such as pelvic inflammatory disease (PID) and haemorrhage.

Staff knew about and dealt with any specific risk issues. Staff routinely completed sepsis screening and assessed patients for risk of Venous Thromboembolism (VTE), falls and pressure ulcers for patients where indicated. Theatre staff followed National (NatSSIPS) and Local Patient Safety Standards for Invasive Procedures (LocSSIPS) checks, discussing and recording any individual patient risks. We observed theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) surgical safety checklist and found these were fully completed and recorded in electronic systems.

Following a termination of pregnancy, women were provided with a pregnancy testing kit to complete at home two weeks after their procedure, to confirm that pregnancy had terminated. They were provided with information for what action to take if they had any concerns after discharge.

The service had an ad hoc 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). This had been identified as a gap for gynaecology patients and the trust-wide mental health lead was developing a business case to go into the 23/24 planning round.

Staff assessed and identified in patient records where women were at risk of domestic violence.

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

Staff shared key information to keep patients safe when handing over their care to others. We observed staff completing regular daily safety huddles on the wards we visited. Theatre staff had recently implemented a new handover documentation record sheet for handover between day and night staff. This included details of the out of hours team, on call team, any staff sickness, availability of high dependency unit beds, any issues with stores or instruments, and any theatre over-runs.

Gynaecology

We observed a shift handover which included all necessary key information to keep patients safe.

Nurse staffing

The service mostly had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients 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 mostly had enough nursing and support staff to keep patients safe and managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with safer staffing national guidance.

In November 2022 the gynaecology ward fill rate for day shift registered nurses (RN) was 87.50% and 83.33% for health care assistants (HCA). Shift fill rates for nights for the same period was 128.33% RN and 103% HCA. The fill rate of 128.33% RN on nights reflected senior RN cover rotating between GED and inpatient areas. The fill rate was reflective of an RN vacancy position, short-term sickness and maternity leave. The allocated rostering system allowed managers to make staff moves from other departments to maintain safe staffing along with a lower bed occupancy across the division. Where shifts could not be covered managers used bank staff where possible. The gynaecology ward was one RN down on the morning shift of 25 January when we inspected.

Staff said managers worked across the directorate to maintain safe staffing and move staff where they were needed. Staff in the service worked flexibly across wards when needed to cover any staffing shortfalls.

The high dependency unit maintained separate staffing and roster, having a core team of 7 registered nurses, including the ward manager. There were no reported staffing challenges for the unit. There had been recent recruitment of band 5 nurses in the gynaecology outpatient department and managers reported that staffing levels were good.

The Bedford suite for termination of pregnancy services had seven registered nurses and 2 healthcare assistants rostered Monday to Friday 8.30 -4.30.

Staff in the gynaecology emergency department told us the staffing shortfalls often affected patient flow and resulted in delays for women receiving treatment and care. Managers in this area noted that planning the correct staffing levels and establishment was complex due to the need for skill mix to meet the varying patient needs and surges in patient flow.

At our last inspection we found the trust did not have children's nursing or medical trained staff in post to manage young persons between the age of 16 and18 years old. Since our last inspection the trust had employed a children and young people's nurse with two additional ward link nurses.

The service had reducing vacancy rates with two RN recruited in November reducing the vacancy rate to 0.71 whole time equivalent (WTE).

Gynaecology services had reducing sickness rates over the last 12 months with staff sickness peaking in January to March 2022 at 13.2% and 12.9% respectively. The most recent figure for November 2022 was 6.9% for RNs with a target of less than 7.47% and 13.9% for HCAs with a target of 12.9%. showing a significant improvement for RN sickness rates. All were for short term sickness.

The service was improving turnover rates for HCA staff at 13.1% with a target of 13.6% but still had a high turnover for RNs of 17.2% with a target of 11.2%.

Gynaecology

Although in general there had been an improvement in staffing levels since our last inspection, there were specific areas of impact where staffing shortages could affect patient flow, notably in the gynaecology emergency department.

The termination of pregnancy service based in the Bedford unit had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with safer staffing national guidance. We reviewed staffing rosters for a three-month period and found 5 days where staffing levels were significantly impacted. The allocated rostering system allowed managers to make staff moves from other departments to maintain safe staffing. Where shifts could not be covered managers used bank staff where possible. On the day of our inspection Bedford Unit was one RN and one HCA down on 24 January.

Staff said managers worked across the directorate to maintain safe staffing and move staff where they were needed.

Medical staffing

The service did not always have enough available medical staff in all areas with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

There were 27 whole time equivalent consultant posts for the service, of which there were four clinical leads for gynaecology. One of the clinical leads specialised in urogynaecology and oncology and the other leads worked across the service for general gynaecology.

Data provided by the trust indicated the vacancies in medical staffing as 1.3 whole time equivalent (WTE) consultant post; 1 WTE specialty registrar vacancy; 5.5 WTE trust grade higher specialty trainee (St3+) and 0.12 WTE clinical assistant. Overall, the contracted workforce was 52.24 WTEs with a funded establishment of 57.35 WTE posts. The trust also provided details of areas where there was over establishment in staffing from the Deanery in lower speciality trainee roles.

Medical staffing for the Gynaecology Emergency Department (GED) was one consultant during the day, plus one registrar and two speciality trainee doctors. Staff said there were frequent treatment delays and delays in women being discharged due to waiting for review by a doctor; this was both in the GED unit and Bedford Unit.

Staff on the Bedford Unit did not have a doctor specifically rostered to ensure patients waiting for treatment and medication could be treated in a timely way. Staff described a member of staff having to leave the ward to ‘find a doctor’ without conscientious objections to signing termination of pregnancy treatments. We heard that there could be frequent lengthy waiting times for women in this situation. Whilst there could be long waiting times for doctors to complete the necessary termination of pregnancy documentation, we did not see evidence of harm to women arising as a result of staffing shortages

The service always had a consultant on call during evenings and weekends. We requested further details of the current medical staffing for the service which indicated a cumulative sickness absence rate of 3.66% for the year to March 2023; this was within the trust target of 4.5%. The turnover rate for medical staff was 6.92%, which was also within the trust target of 13%.. The service did not regularly use locum staff.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records we reviewed were fully completed, dated and signed. The service mostly used e-records in secure electronic systems, which staff could access using password protection. We saw that where paper records were in use, these were locked away securely.

The service used three separate electronic systems for different patient records. There was a main patient record for clinical records containing assessment and referral details; a separate system was used for medicines management; another system was used for test results. Staff would need to cross reference between systems, for instance if there was any flag for a patient at risk of domestic violence. The trust was in the process of moving towards a single integrated electronic patient record, due to be completed during 2023.

When patients were transferred to a new team, there was potential for delays in staff accessing their records as other external partners did not always have access to the records.

Anaesthetic records were completed in electronic anaesthetic charts as well as being duplicated in electronic medicines records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, although there had been issues with postal delivery of medicines for termination of pregnancy.

Staff followed systems and processes to prescribe and administer medicines safely and practice had improved since the last inspection. Medicines in all areas we visited were stored securely. The trust had introduced an electronic system to measure the temperature of fridges and rooms to ensure medicines were stored safely. The electronic system alerted the pharmacy department if action had not been taken by the area to rectify temperatures outside the recommended temperature. Temperature readings had resulted in air conditioning being funded for some wards to ensure medicines were stored correctly. Medicines and equipment used in an emergency were stored securely and checks were completed regularly and managed by an online system.

For termination of pregnancy women had a choice about how they would like to receive their medicines. The trust had an agreement with a pharmacy to provide medicines for termination of pregnancy through the post for women who requested this. We saw there had been a recent incident in which medication was delivered to wrong address where the package had been incorrectly labelled during delivery. Managers were reviewing their arrangements with third party providers in following up this incident.

Staff completed medicines records accurately and kept them up to date, however for 1 person we found when oxygen was prescribed there was not always clear instructions to follow for variable doses.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation compliance figures provided by the trust reported less than 40% of patients had their medicines reconciled in a timely manner. The pharmacy department had highlighted some reasons for the low figures reported. The inability of the electronic Prescribing and Medicines Administration (ePMA) system to highlight patients who required a medicines reconciliation and the lack of a seven-day service to reconcile medicines over the weekend was making it difficult to know the true medicines reconciliation figures. The new clinical director of pharmacy said a point prevalence audit would be completed to obtain a more accurate picture. The trust was also in the process of moving over to a new ePMA, which would allow the system to identify patients needing to be seen.

Gynaecology

Incidents

The service followed systems and processes for managing patient safety incidents. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

The trust had a comprehensive policy for managing incidents and serious incidents. Staff knew what incidents to report and how to report them.During inspection Band 5 nurses told us and we saw that they did not always have access to the trust incident reporting system, but knew to report to the ward manager for inputting on the system the trust incident reporting system but knew to report to the ward manager for inputting on the system. Preceptorship nurses said this was included in their induction. All Band 7 nurses received email updates regarding incidents reported across the trust, as well as the related learning and any themes identified. Staff in the gynaecology emergency department met in weekly safety and governance meetings to review and discuss incidents, together with any learning identified from these. The gynaecology outpatient department had recently reintroduced 'incident of the week' as a focus for staff learning.

The service had one never event recorded in the last 12 months. Staff in theatres described the learning that had been implemented following a previous never event where a surgical pack had been retained post operatively. The service had benchmarked practice with another specialist NHS trust, identifying a new practice of applying a coloured wristband for patents where packs had been inserted. The wristband would only be removed once the pack was removed. Managers shared learning about never events with their staff and across the trust. Managers shared learning with their staff about never events that happened elsewhere

There were 12 serious incidents reported under the gynaecology speciality in 2022. Five of these related to commissioning incidents, with the rest in the categories of treatment delays, surgical/invasive procedure incidents and diagnostic incidents. There was a mean average of 109 days from incident to report.

Four reported serious incidents related to delays in oncology, including for surgery missing the six-week window following chemotherapy.

The high dependency unit reported any incidents where patients had been transferred to other trusts for critical care and continuing support, when this was needed. During 2022 there had been three occasions where women had been transferred for higher-level specialist care.

Staff raised concerns and reported serious incidents clearly and in line with trust policy. Data reviewed showed staff had reported incidents clearly. For example, reporting of four-hour beaches when patients attended the gynaecology emergency department, (GED) a national requirement for accident and emergency departments. Of those reviewed they clearly stated the situation, staff and patient acuity, reason for the delay and what actions staff had taken to escalate. However, we also noted in the data staff were told not to report these incidents using the trust online reporting system as the information was being gathered elsewhere. We also noted in the incidents reported there was variability in the categorisation of harms, with some apparent higher-level incidents recorded as low harm. Between from 1 October 2022 to the date of inspection 99% of reported incidents were categorised as causing low or no harm to patients.

Staff understood the principles of the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Gynaecology

Staff received feedback from investigation of incidents, both internal and external to the service. In the different wards and departments that we visited, staff said they attended regular meetings to review and discuss incidents and learning outcomes. If any staff were unable to attend, they would receive email updates of the meeting discussions. Staff met to discuss the feedback and look at improvements to patient care. As a division, senior leaders had implemented a senior team meeting to discuss any incidents for focus and sharing with staff locally.

There was evidence that changes had been made as a result of feedback.

At ward and department level managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good  

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

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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, including where relevant from the National Institute for Health and Clinical Excellence (NICE), and the Royal College of Obstetricians and Gynaecologists (RCOG).

Policies we reviewed were in date and accessible to all staff, for example, sepsis management, infection prevention control and management of medicines. Policies and standard operating procedures were reviewed regularly by managers and service leaders for any relevant updates. Condition specific protocols were followed for different gynaecological conditions, with a regular audit programme completed for these. There was a strong focus on performance quality and audit outcomes in the service, which managers regularly monitored and reviewed. Results of routine audits across the gynaecology service showed high compliance for completed audits and in audit outcomes. For January 2023, medicines audits were 100%; for infection prevention and control audits 99.5%; for nursing key performance indicators (KPIs) 95.87% and for matrons' spot checks 95.87%.

Staff in the Bedford suite followed specific evidence-based protocols for termination of pregnancy. The service followed an eligibility criteria for referral, offering different medical or surgical procedures depending on the woman's stage of pregnancy. Following a recent incident, the service had implemented a new standard operating procedure and flowchart. This included routine pregnancy checking at different stages following termination of pregnancy procedures, to ensure there were no products of conception remaining. Consultants had also introduced a standard for early pregnancy scans, resulting in a reduction in the number of patients returning where a diagnosis had been unclear. There was also a pregnancy loss flowchart for staff to follow in cases of miscarriage. This included specific actions for pregnancy loss at under 12 weeks or at over 12 weeks.

Gynaecology

Since the last inspection the trust had established a role for a children and young people's specialist nurse lead. In collaboration with the service leads, the specialist nurse had implemented a new guidance document called pathways of care for under 18 years old. This was based on current best practice.

The safety governance board in theatres displayed the 'policy of the month' for staff focus. At the time of inspection this was the Trust policy for Accountable Items during surgery.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Staff were aware of the often sensitive and personal context for women receiving treatment and care in the service and were alert to the psychological and emotional needs related to this.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff provided patients with treatment for any nausea and vomiting they may have following surgery. Specialist support from staff such as dietitians was available for patients who needed it.

Patients waiting to have surgery were not left nil by mouth for long periods. Post procedure patients were offered a choice of beverages and snacks, with a full menu of dietary choices available to meet individual needs and preferences.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There was also a new young persons' pain assessment tool for those under 18 implemented in November 2022. Patients we spoke with, except for one, said they had been given pain relief when needed. One patient had to wait for a few hours for staff to come back on a night shift to ask for pain relief again.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

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

Gynaecology

Outcomes for patients were mostly positive, consistent and met expectations. Managers and staff used the results to improve patients' outcomes. The service followed a scheduled programme of audits to determine the effectiveness of care and treatment. Among these were a schedule of monthly audits, including key performance indicators specific to department areas, medicines management, infection prevention and control and hand hygiene, and matrons spot checks.

The rate of reattendance within seven days was above the national and regional averages. There had been a sharp rise in the average length of stay for elective admissions from 1.2 days in July 2022 to 2.6 days in August 2022. As of September 2022, the average length of stay (2.7 days) was higher than the national average (1.6 days) and in the worst performing quartile (highest 25%).

Prior to this average length of stay had been more similar to peer trusts. The average length of stay of emergency admissions has been similar to the peer median since September 2021. As of September 2022, the average length of stay was 3.1 days compared to a peer median of 3.3 days. The percentage of patients that reattended the department within 7 days following a previous attendance at A&E has been higher than comparators for most of the period and increasing throughout 2022. Peaking in August 2022, 13% of patients reattended compared with 9% for comparators. This had improved over the last two months to 9% in September 2022 and 8.4% in October 2022.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment and shared and made sure staff understood information from the audits. We saw in all areas information was displayed for patients and staff about audit participation and results. Improvement was checked and monitored.

Competent staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of inspection there was a 96% completion rate for staff appraisals for nursing and healthcare assistant staff. Following inspection, the trust provided data for completed appraisals for medical staff. This showed that 86.21% of medical staff in gynaecology had completed their annual appraisals, this was below a trust target of 90%. .

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff we spoke with confirmed they had one to one meetings with their managers to discuss their development.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff were available to provide support for junior doctors where this was needed. Consultants recognised that due to change in personnel following retirement of experienced clinicians, there was a need to build on the established skills within the new team and were looking at different models of care. Plans were being developed for a ward forum to support practice for all gynaecology medical staff. There were four nurse consultants and one associate nurse practitioner in the service, with two other ANPs in training.

The Bedford unit for termination of pregnancy was a nurse led unit.

Gynaecology

Specialist nurses in the gynaecology outpatient department provided a nurse led colposcopy service. There were five nurse consultants in gynaecology outpatients who could carry out ultrasound scans.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Practice education facilitators were available in all areas to support the learning and development needs of staff, including three practice education facilitators who were available specifically to support staff in theatres.

The practice education facilitators completed training needs analysis for different departments supporting managers and staff with any learning requirements. A band 4 clinical coordinator role had been introduced in the gynaecology outpatient department to support ongoing implementation of a staff competency matrix. Nursing staff in the high dependency unit completed level 2 critical care competencies through the regional critical care network. Two staff were also planning to complete a further 12-month course in critical care.

The specialist nurse for children and young people supported the trusts resuscitation team for delivering training in basic life support, with adaptations for children and young people. Link nurses were available across the service to support staff and share guidance in different aspects of practice, such as infection prevention and control, pharmacy and supporting students.

Managers made sure staff received any specialist training for their role. A range of additional training was available for staff to access, dependent on their role. Principally among this, many staff told us they had been able to access training for domestic abuse stalking and honour-based violence, as well as training for palliative care.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. This included MDTs for oncology patients receiving different treatments for cancer.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service leaders described how there had been more cross divisional working between gynaecology and maternity services to support each other but this was still in its infancy. This model had been implemented in the gynaecology and termination of pregnancy services.

The service also had links with other NHS trust providers for management of patients with higher care needs or who required more complex scan and surgical procedures. The Bedford unit worked closely with an external approved counselling and abortion service. There was collaborative working with community services in delivering a women's health education programme. The service had also worked closely with primary care services in the care and management of women with postmenopausal gynaecological conditions.

Gynaecology

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

The Bedford unit was available for termination of pregnancy services between 8:30 am and 4:30 pm Mondays to Fridays. Out of hours, women were signposted to attend the gynaecology emergency department or the nearest accident and emergency unit. The gynaecology outpatients department was available 8am to 6pm Monday- Friday. Additional clinics were being held on Saturday mornings in response to waiting list times.

There was a lack of pharmacy support to provide a seven-day service.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards and units. We also observed notice boards with health information on corridors.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. We saw consent policies and procedures were fully adhered to and patients were fully informed about the treatments and care they were having. Staff explained and ensured patients understood each care intervention being provided.

We saw staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported young people who wished to make decisions about their treatment. They carefully triaged and assessed young people following the Bedford Unit pathway for patients using the action line and self-referral when accessing termination of pregnancy services. Consent procedures were documented in line with statutory requirements of the 1967 Abortion Act and we saw during inspection that HSA 1 forms were fully completed.

Gynaecology

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, mostly respected their privacy and dignity, and took account of their individual needs.

We observed and patients told us staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them with respect and with kindness.

We saw that some women being admitted to the ward as day cases often spent lengthy periods sitting in gowns in the admissions area whilst waiting for their procedures. This had been noted at the last inspection as a privacy and dignity concern. We raised the issue again to service leaders on this inspection, who informed us of the actions taken to improve the situation.

Otherwise, patients and their carers spoke positively about the gynaecology service. We saw that staff were especially attentive to women's privacy and dignity, responding to women's needs in a sensitive and professional manner. Private treatment rooms were available in the gynaecology emergency department, gynaecology outpatients and the Bedford suite. Chaperones were available for women where this was requested.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Gynaecology

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients attending the Bedford unit for termination of pregnancy were provided with rooms which were separate from women attending for scans following a miscarriage. Staff were sensitive to the differing emotional states women may be experiencing in accessing gynaecological services and ensured patients were nursed in separate areas to accommodate this.

Specialist staff, including for bereavement support, were available for women who had experienced pregnancy loss.

Staff demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff took time to carefully and fully explain the treatments being provided, ensuring they answered any questions patients had.

Women accessing termination of pregnancy services would complete HSA4 forms which would be submitted as a statutory notification. The forms were fully discussed with women at the time of their procedure.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff directed patients to where and how they could complete friends and family test surveys, and other questionnaires.

Staff supported patients to make advanced decisions about their care.

Patients gave positive feedback about the service.We saw feedback from patients' relatives which was highly appreciative of the care provided to their loved ones in the last days of life. A 2022 report based on the adult in patient survey indicated that scores for the metric 'patients were given enough privacy when discussing condition or treatment' and ' able to take own medication when needed to' were among the most improved scores in survey results. The gynaecology service had achieved within the highest three scores nationally in the national patient survey results.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service planned and provided care in a way to meet the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Gynaecology

Managers planned and organised services to meet the needs of the local population.

Facilities and premises were appropriate for the services being delivered.

The service had an ad hoc 24-hour access to mental health liaison and specialist mental health support, for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. Among these, the gynaecology emergency department had a 'honeysuckle' notice board, displaying information and contact numbers for support organisations following a miscarriage.

Managers monitored and took action to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients and their carers spoke positively about the gynaecology service with some saying they had received excellent care. Patients living with mental health and autism reported staff had made reasonable adjustments to support them in their care and treatment.

Wards were not designed to meet the needs of patients living with dementia. This was identified on PLACE in 2021. We observed there was no environmental adjustments for patients living with dementia.

The Honeysuckle Team's specialist bereavement midwives held a monthly support group. Group sessions would take place in a calm, welcoming and supportive environment with refreshments and crafts. This would be for anyone affected by miscarriage, ectopic or molar pregnancy, termination of pregnancy for fetal anomaly, stillbirth and early neonatal death. The Honeysuckle Team had strong links with 2 local counselling services who provided support to men, women and children.

We observed and carers said staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The trust used 'language line' and 'Translator on Wheels' and had access to British Sign Language interpreters. Female doctors and those from different cultural backgrounds were available where requested by women using the service.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients said they received adequate food and drinks during their stay.

Staff had access to communication aids to help patients become partners in their care and treatment.

The specialist nurse for children and young people was involved in supporting under 18-year-olds when accessing care. For any planned admissions the lead nurse would contact the young person before their admission to identify and support any requirements.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not line with national standards.

Managers monitored waiting times but could not always ensure patients accessed services when needed or received treatment within agreed timeframes and national targets. Cancer waiting times for patients seen within two weeks of an urgent GP referral were within the highest 25% of trusts nationally. However, waiting times for treatment within 31 days following a decision was among the lowest 25%.

At the time of inspection, performance against the 2-week waiting time following an urgent GP referral was 92.6%, performance for waiting times for treatment within 31 days following a decision for treatment was 60.53%. Service leaders identified that delays in 62 day waiting times were often due to due to late referrals from outside services and the issue of external diagnostics. There was ongoing work to address this through the regional cancer alliance network.

Performance against the accident and emergency four-hour target from arrival to admission, transfer or discharge, was better than the national and regional averages, with October seeing an average of two hours and 33 minutes. However, this deteriorated in November to 87.14% with trust below the four-hour target of above 95%. From breach incidents recorded in November some of this could be attributed to a surge in demand on particular days without the space in gynaecology emergency department (GED) and staffing gaps, including medical cover to achieve the four-hour targets.

Patients accessing the early pregnancy assessment unit would attend the gynaecology emergency department in the first instance. Following initial triage, patients would be then directed to the appropriate pathway for ongoing care, either in gynaecology or maternity services. The current access criteria for the early pregnancy assessment unit was being reviewed, however we heard there were frequent pressures in the GED due to the mixed pathways and surges in patient flow.

Managers and staff worked hard to make sure patients did not stay longer than they needed to however, this was not always within their control due to medical staffing demands. For example, feedback from friends and family frequently reported having to wait 45 minutes post scan for doctors to sign the required forms following termination of pregnancy.

Managers worked to keep the number of cancelled appointments to a minimum.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and where possible within national targets and guidance. However, there were challenges in some parts of the service. Clinics frequently needed to be cancelled in ambulatory care as a result of sickness absence, resulting in increased waiting times for patients, including oncology patients. There was also limited access for MRI scan services and lack of available expertise for reporting scan images. This resulted in a 5 to 8 week wait for cancer patients.

Staff planned patients' discharge carefully and worked with other services where patients needed follow-up support.

Gynaecology

Staff supported patients when they were referred or transferred between services. However, there could be delays in meeting national standards where patients needed to be transferred to other NHS locations for more complex treatment or surgery.

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. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. There was close working between the patient experience team and divisional leaders to respond to any patient complaints when these arose. Managers identified that complaint themes were mostly related to waiting times in different parts of the service. In the gynaecology emergency department, there were also frequent complaints about lack of refreshments being available.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good ↑

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

Leadership

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

There was evidence of good leadership at divisional and ward level which was an improvement on our last inspection. Many staff we spoke with said there had been positive developments in the service since the last inspection, particularly with the establishment of the new leadership structure and roles within the division. The leadership structure was clear and worked well in day-to-day practice. We observed there was a good level of communication and interaction between staff on all the wards and departments in day-to-day practice. There were clear communication systems for sharing information from ward level to service managers, who were routinely available to respond to any issues. Leaders we spoke with had core experience in gynaecology and had clear oversight of the service. Local ward managers observed that because of the strengthened leadership in the division there were improved communications and relationships between the gynaecology service and more senior levels of the trust.

Gynaecology

There was a senior leadership structure for the gynaecology division, comprising a business manager, clinical director and head of nursing. . The leadership team reflected they were fairly new as a divisional team, having been established over the last 6 to 18 months, however they felt there had been significant improvement which was strongly focused on patient care. Senior leaders attended trust wide board and committee meetings to represent the service as required. There were four matrons for the gynaecology service, each overseeing different service lines for inpatients, outpatients, emergency services and service quality. Leadership was cohesive at all levels, with regular weekly matrons' meetings and a monthly meeting between matrons and ward managers.

Leadership development was being supported throughout the service, in which ward managers and other local leaders were provided with opportunities to take ownership of different initiatives and projects within their service areas.

Vision and Strategy

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

The service had a divisional strategy which reflected the overall trust strategy aims and ambitions. Staff we spoke with were aware of and knowledgeable about the trust's core values and spoke readily of how these related to the work in the service. The trust's core values were care, ambition, respect, engagement and learning.

Among the divisional aims and ambitions there was a core focus on quality, safety and patient experience, with some of the actions included being to review and enhance the robotic gynaecology service; deliver on multiple key quality improvement projects by directorate in 2022/23; to improve gynaecology cancer services in Cheshire & Merseyside by reviewing the optimal gynaecology cancer pathway; to ensure all wards and key areas have ward accreditation; to invite patient representatives to appropriate divisional forums; to implement the NHS England Emergency Care Improvement Support Team (ECIST) action plan; and to continue achieving positive scores on patient surveys and completion of action plan from 2021/22. Other ambitions included those related to workforce, leadership development, staff well-being and succession planning.

Leaders identified workforce planning in their five-year strategy plan, with actions in progress. Key initiatives included the appointment of a consultant to cover benign gynaecology, with shortlisting for interview at the time of inspection. Leaders were cited on the issue of overnight cover in gynaecology emergency department and were looking at different models for this recruitment to medical posts.

There was a supporting action plan to achieve the divisional strategy.

Divisional service leaders attended a trust wide workforce review committee, to represent the service and highlight the issues in workforce capacity, particularly for overnight medical cover in the GED.

Culture

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

Staff said they felt valued and supported by their ward manager and ward managers reported being well supported and respected by their matrons and head of nursing. They reported a positive culture in the division with a total commitment from staff to provide a good service.

Meeting minutes and information sharing on notice boards displayed positive feedback to staff and 'good spirited' competition between the departments. For example, the service had the opportunity to win awards for 'Be Brilliant Accreditation System'(BBAS) for KPI compliance. The gynaecology ward manager had encouraged staff to improve their compliance from a bronze level to gold . There was noted to be good camaraderie across all the teams with ward managers forming a support network to discuss and improve services. Staff in theatres said they were well supported by managers and would feel confident to raise any issues if they had any concerns. This was supported by the matron and head of nursing. All staff reported that they could speak up to their leaders if they had any concerns; staff had confidence to be able to do this.

Staff in all areas expressed how they had good working relationships across the different staff working across the multidisciplinary teams. Many staff we spoke with told us there had been huge improvement in the service since the last inspection, especially with the introduction of new leadership structures within the division. Staff were consistently proud of their work, and many commented they 'loved their job'. During inspection we saw staff in different areas shared a strong commitment and motivation, which was focused on working together to provide best care for women using the service.

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.

There was evidence of good governance at ward level which was an improvement on our last inspection. All staff said and could demonstrate at different levels what their roles and responsibilities were. They were clear about the vision and strategy and were striving to be a 'Gold standard' service. White boards in ward areas showed safety and governance were key areas of focus with opportunities to share learning and success. Where incidents had occurred the incident, numbers were displayed on the white board for staff to review in more detail.

Since the last inspection new structures, processes and systems had been introduced to oversee delivery of services in the division. At ward and department level, managers held weekly governance meetings for reviewing service performance. Ward managers would escalate any immediate safety concerns, risks or issues to service matrons and leaders.

Service leaders held a monthly governance and quality meeting to review and discuss key service information, including incidents, any safeguarding, complaints and concerns received in patient feedback. The divisional governance manager and quality and safety matron worked closely together in daily practice to oversee incident reporting, identify themes and trends, with a focus on lessons learned and improvement actions. Alongside the monthly governance and quality meeting there were weekly complaints review meetings, a weekly senior nurse meeting, and a weekly divisional senior management team operational and governance review. There was a flow of relevant information from these meetings to the divisional governance board and divisional performance review meetings.

In termination of pregnancy services there was dedicated administrative support for completion of HSA forms to meet legal obligations under the Abortion Act. This compliance was routinely audited and results discussed at the Quality Improvement Group, with any actions identified.

Gynaecology

We saw there were effective and embedded governance systems at all levels across the gynaecology service, with each ward and department strongly engaged in actions to improve services.

Among these, the Bedford unit had been awarded a gold rating on 14 October 2022 for 'Be Brilliant Accreditation System'(BBAS) for KPI compliance. Local leaders in the Bedford service had been working to identify processes which would enable doctors' attendance in a more timely way. This was particularly for when reviewing patients and signing the relevant documentation for termination of pregnancy.

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.

There were systems in place for leaders to have effective oversight of performance in the gynaecology division. Service leaders identified key risks in a risk register, which they regularly reviewed, using performance data and in collaboration with local managers within the gynaecology department. Service leaders reported and escalated divisional risks through trust governance systems and where they could do this, had implemented actions to mitigate the risks identified.

The top risks identified in the service at the time of inspection were limited access to MRI scan services off-site and availability of expertise for reporting of scan images. This had resulted in a 5 to 8 week wait for cancer patients, which had been further worsened by the backlog because of the COVID pandemic. The potential for harm in this was identified as major, due to possible delays in diagnosis, accessing care pathways and any treatment for patients who may require this.

Another key risk was regarding the lack of appropriate staffing to support ambulatory care when there was any sickness leave, causing clinics to be cancelled and increase the waiting times to treatment for patients including those with oncology. This risk was currently on the trust risk register and for review 18 March 2023. The department had submitted a business case for staffing and additional resource for this area, together with a quality improvement programme to assist in streamlining patient pathways.

We saw in Board papers that Boards should assess at least once a year whether their acute services were meeting the seven-day service (7DS) clinical standards to demonstrate performance to commissioners and regulators. The Quality Committee had received the report in October 2022 and noted partial assurance. Assurance was received that there was no difference in length of stay or discharges at the weekend. The Committee was not assured that there was appropriate job planned consultant time for emergency care at the weekend, although it was acknowledged this was being reviewed as part of the 5-year medical staffing strategies. Review of the care and scope of work provided by Gynaecology Emergency Department had been recommended.

We saw that following a review of the process for the discharge from colposcopy for women over the age of 50 years, it has been identified that a number of women had been inappropriately discharged to routine recall at 5 years. Appropriate screening interval following abnormality regardless of age has been confirmed as 3 yearly. The trust were in the process of completing a retrospective review of cases at the time of our inspection.

Local managers also told us of risks which were specific to their own department, including in theatres regarding theatre overruns. In the gynaecology emergency department, the capacity for managing the phone triage system over 24-hour

seven-day period was identified as a risk. Also, the mixed patient pathways for women attending gynaecology emergency department meant that pregnant women of 16 to 19 weeks +6 days gestation would present to GED rather than the maternity assessment unit. This was a known issue for which the local manager had identified a current business case, and which service leaders had identified as a potential relocation for this facility.

The key performance indicators (KPIs) focused on achieving elective recovery following the pandemic. Some of the KPIs were to eliminate 78 week waits in year with a plan to reduce the current number of patients waiting longer than 52 weeks by 50%, by March 2023; to improve compliance against the diagnostic 6 week target, with an ambition to achieve 95%; and to improve compliance against the 75% faster diagnostic target, with an ambition to achieve 70% by March 2023, aiming to achieve the 75% target by March 2024. Action plans were regularly and routinely reviewed in divisional and corporate meetings, to monitor progress.

The service leaders completed a quarterly review of incident themes, presenting a summary of themes to corporate meetings. Each specialty group have meetings and allocation for review risks.

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.

There were effective and secure data systems for staff and managers to access and use in day-to-day practice. The service collected data to monitor performance measures, provide assurance and from this to develop improvements. Staff in all areas had access to key service information and trust electronic systems. There had been an issue in gynaecology outpatients where temporary staff had been unable to access the trust systems although after escalation this had been resolved.

There were a limited number of computer terminals for theatre staff to access in the department for completing their mandatory training.

Engagement

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

The service had links with different patient groups and users of services, as well as routinely reviewing patient feedback from survey responses.

Leaders had particularly engaged with staff during an awayday in Autumn 2022, to identify staff views on what the priorities were for their service area. Staff engagement had improved since the last inspection and most staff said there was active communication with staff, both within the division and trust wide. The service had a strong emphasis on staff well-being, with 10% of employees now available as mental health first aiders. The trust had also focused on supporting flexible working for staff; several staff we spoke with described how they had been supported to access flexible working arrangements.

Staff groups in different parts of the service used social media groups to share nonconfidential information and to support team working.

Gynaecology

Learning, continuous improvement and innovation

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

Staff were focused on improving the experience of care for patients in gynaecology and many were involved in different quality improvement programmes. Amongst those we heard about was development of a separate pathway, admissions and discharge area in response to increasing demand for colposcopy services in gynaecology.

Staff in the Bedford unit where using a quality improvement approach which would allow doctors attendance in a more timely way, so that women could be more quickly discharged following their procedure.

Managers strongly supported service development and enabled staff to take leadership in these. One of the practice education facilitators was currently, being supported by the trust for completing a Master's degree qualification in leadership development.