Somerset NHS Foundation Trust

Musgrove Park Hospital

Inspection report

Musgrove Road
Taunton
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Ratings

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

Our findings

Overall summary of services at Musgrove Park Hospital

Requires Improvement 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Musgrove Park Hospital.

We inspected the maternity service at Musgrove Park 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.

Musgrove Park Hospital provides maternity services to the population of Taunton and Somerset.

Maternity services included a Triage Ward with 4 beds and a side room; Antenatal Ward (Willow Ward) which included 4 induction of labour beds, 6 antenatal beds and 1 side room with en-suite facility; a midwifery led alongside birthing centre (Bracken Birth Centre) which included 2 pool rooms with en-suite facilities and 6 postnatal beds; a Postnatal Ward (Fern Ward) which had 11 beds across 2 bays, 2 transitional care beds in a shared bay and accommodation for up to 5 parents whose babies were on special care. There was a labour ward with 7 birthing rooms, 1 of which had a birthing pool and a procedure room; 2 recovery beds and 1 theatre. In the last year approximately 3000 babies were born at Musgrove Park Hospital.

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

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

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

- Our rating of Inadequate for maternity services changed the ratings for the hospital overall. We rated maternity services as inadequate in both safe and well-led.

We also inspected 2 other maternity services run by Somerset NHS Foundation Trust. Our reports are here:

- Yeovil District Hospital - https://www.cqc.org.uk/location/RH5O4

- Bridgwater Community Hospital - https://www.cqc.org.uk/location/RH5K6
  How we carried out the inspection

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

We visited triage, labour ward, the antenatal and postnatal wards, transitional care, and the Bracken Birth Centre.

We spoke with 8 doctors, 10 midwives, 2 support workers, 7 women and birthing people and their birthing partners and/or relatives. We received 12 responses to our give feedback on care posters which were in place during the inspection.

Our findings

We reviewed 7 patient care records and 9 medicines records.

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

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

Inadequate ↓↓

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

- Staff were not always up to date with training and key skills and there was a lack of effective oversight from leaders.
- Not all staff had been trained to the appropriate level to protect women and birthing people from abuse.
- Women and birthing people presenting to triage were not appropriately risk assessed and prioritised based on the presenting risk. Staff did not have a standardised, evidence-based risk assessment guidance to follow in the triage area.
- The service did not control infection risk well as the environment was unsuitable.
- There was a lack of adequate emergency equipment across the service.
- The service did not always have enough midwifery staff to ensure the safety of women and birthing people. The service did not have an effective local audit programme to ensure the quality and safety of the service.
- Learning from incidents was not always embedded.
- 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.
- Staff did not have access to up-to-date policies and procedures to support them in their role. However:
- The service engaged well with women and birthing people and the community to plan and manage services.
- There was a positive culture amongst the staff team who were keen to improve the service.
- The service had a safeguarding team who were available to offer support to staff when needed.

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 action as we believed a person would or may be exposed to the risk of harm if we had not done so.

Is the service safe?

Inadequate ↓

Mandatory training

The service did not make sure everyone completed and kept up to date with mandatory training.

Maternity

Staff were not always up to date with their mandatory training. The trust target for compliance was 90%. Records showed low compliance rates for training modules. For example, 16% of midwives had completed reduced fetal movements training, 24% of midwives had completed diabetes training, and 26% of midwives had completed, equity and personalised care training.

Following the inspection the trust advised us that the data they had supplied during the inspection was for e-learning training and did not reflect face-to-face training compliance. The trust said that following the trust merger they had decided to enhance some areas of training with face-to-face training and that these face-to-face training sessions would be completed by staff within the next 2 years, from April 2023.

Moving and handling training for midwives and midwifery support workers (MSW), was delivered by way of completion of a booklet and included pool evacuation training over a 2-year rolling programme. Data showed 67% of midwives and 78% of MSWs had completed this training. There was a risk not all staff knew how to safely evacuate women and birthing people from the birthing pool in an emergency.

The service made sure staff received practical obstetric multi-professional training (PROMPT). Data showed 93% of midwives, 91% of MSW and 88% of medical staff had completed this training. Training was also above the trust target of 90% for smoking cessation, , pre-term birth, bereavement care and infant feeding.

Data showed 88% of all staff had completed fetal monitoring training, and 98% of required staff had completed neonatal life support training.

Student midwives had access to a practice development midwife as well as a preceptorship midwife once they had qualified. The service supported a programme of international midwives who would join the service as a band 4 midwife support worker until they had successfully completed their Objective Structured Clinical Examination (OSCE's) at which point they would join newly qualified midwives on the preceptorship programme for 12 months.

A nurse associate was the professional development lead for midwifery support workers, staff told us they were supported to develop in their role and access relevant training.

Managers allocated staff time away from clinical duties to complete the training, midwives were allocated a study week once a year with 7.5 training days rostered, this was overseen by the practice development team.

Safeguarding

Not all staff understood how to protect women and birthing people from abuse. Staff had not received training at a level appropriate to their role to ensure they knew how to recognise and report abuse.

The trust was already aware that staff were not trained to the correct level in safeguarding adults in line with national guidance. Following the inspection, the service leaders told us the named safeguarding midwife, supported by the safeguarding learning and development lead would urgently review training and map relevant staff to Level 3 safeguarding adult training. 85% of staff had been trained to level 2 safeguarding adults training. The National Safeguarding Intercollegiate Guidelines state that all registered health care staff risk assessing women and birthing people should complete training to level 3 in adult safeguarding.

Maternity

Staff were required to complete children's safeguarding training up to level 3. At the time of the inspection 80% of midwives and 37% of doctors had completed this training. This was below the trust target of 90%. There were no action plans shared with us to how the service was going to improve staff compliance for children's safeguarding training. At the last inspection of this service in March 2020 we found safeguarding training for medical staff was below the trust target.

There was a mandatory field on the electronic record system to record at every contact whether the woman and birthing people had been asked about domestic abuse.

Where safeguarding concerns were known, women and birthing people had birth plans with input from the safeguarding team. However, on the day of inspection staff did not always access this information or demonstrate knowledge of how to effectively manage and communicate safeguarding concerns between the team to mitigate potential risk.

Staff told us that they would speak to the safeguarding leads if they had concerns and spoke positively about a dedicated team of midwives who supported women with additional needs. Care records detailed where safeguarding concerns had been escalated in line with local procedures and whilst we saw that safeguarding alerts were on the electronic records system not all staff were aware of these and were reliant on verbal information being handed over.

The named and deputy named midwife for safeguarding, offered quarterly and as and when needed safeguarding supervision to their team of midwives as well as annual safeguarding supervision to the wider midwifery team.

There were systems and processes in place to ensure information is shared with other professionals such as GPs and health visitors.

We were told that the safeguarding team worked closely with the local authority and contributed to groups within the local authority safeguarding team and were part of the Southwest safeguarding network. They told us they were respected and listened to and that there was an escalation policy in place in case of professional disagreements.

Staff followed the baby abduction policy and undertook regular baby abduction drills. However, we found that the unit was not secure, some of the issues we found had been highlighted during a baby abduction drill 2 months prior to the inspection. Insufficient action had been taken at the time of inspection to ensure ward areas, windows and doors were secured and monitored. Following the inspection, we raised our concerns, and the trust took immediate action to improve security. They provided assurance that security across maternity has been reviewed and upgraded with windows and doors identified as part of the inspection, were secured.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. We saw how interpreting and translation services were used to ensure women were supported to understand what was happening during a procedure. This was done with care and compassion.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Equipment and the premises were not always visibly clean.

Maternity

The maternity service was situated in an old building that required numerous repairs and maintenance.

The integrity of the building impacted on how well these areas could be effectively cleaned; however, the service did not have an effective plan for managing the infection control risk this presented.

Medical equipment was not always stored correctly. For example, we found single use emergency equipment was not in its packaging. We also found medical equipment that was out of date and coated in dust. Chairs were also found to be torn which impacts how effectively these could be cleaned. This was raised with the trust who took action to remove and replace these.

On the Bracken Birth Centre, we found paint and white spirit stored in an open cupboard in a day room which was used by new mothers and children. Under the requirements of the Control of Substances Hazardous to Health (COSHH) regulations these need to be stored safely and securely. This posed a risk to people and children visiting the birth centre and were immediately removed when we highlighted and requested this.

Staff did not always follow infection control principles including following the correct uniform policy and storage of towels and linen. We observed staff wearing jumpers in clinical areas and not all staff were bare below the elbows. We observed domestic staff not using personal protective equipment correctly, specifically the use of gloves when moving between different clinical areas.

Leaders completed regular infection prevention and control, hand hygiene and bare below the elbow audits; however, these had not picked up the issues we found on inspection. Data showed hand hygiene audits were scheduled monthly, however, there was no audits completed between April and June 2023 on the antenatal clinic, or in May 2023 on the Bracken Birth Centre after compliance of 71% in April 2023. No hand hygiene or bare below the elbow audits were completed on the labour ward in September or October 2023 however where audits were completed over the last year compliance was consistently above 90%. The service had implemented an action plan to address the shortfalls identified in audits and these were discussed at monthly cleaning standards meetings.

The service had completed an audit on surgical site infections and readmissions between November 2022 and March 2023 and found the percentage of readmissions due to infection or inpatients being treated for infection from caesarean sections was 0.9% and 5% reported an infection following a caesarean section. Actions were put in place to further improve this position.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always ensure people were kept safe. However, staff managed clinical waste well.

The building was not fit for purpose due to its age, layout, and design. A new build was expected in the future meanwhile the service leaders had tried to reconfigure the layout to work within the limitations, but more work was needed to mitigate risk. We saw water damage to the building, plaster that had come away from the walls and flooring that needed replacing had been secured by hazard floor tape. We heard from staff, women, and birthing people how the environment made it difficult to effectively regulate the temperature and ventilation within the service.

The maternity unit was not fully secure and because of the limited security there was free movement within the maternity service which could not be effectively monitored. We raised this with the service following the inspection and the trust took action to address the issues.

Maternity

There was no process in place for the provision of a second theatre team or dedicated theatre team available in an obstetric emergency. There was a lack of comprehensive and robust procedures or guidance for staff on how to manage a situation in which simultaneous emergencies may occur. There was only 1 theatre within maternity which was the primary facility for all caesarean sections (both elective and emergency). The service had converted a labour room on the labour ward into a "procedure room," this was primarily for repairing of perineal tears and cervical sutures, however, should there be obstetric emergencies at the same time, the procedure room was available for use as a second operating theatre. There were plans to improve the procedure room further with changes to the layout of the room. On the day of inspection, we found the procedure room door had no lock to secure the room, allowing free access from the labour ward. This presented a risk in terms of infection prevention and control and to the privacy and dignity of the woman or birthing person in the room.

We found gaps in the daily and weekly safety checks of specialist equipment which staff were required to complete. For example, there were 8 days in one month that the daily resuscitation equipment checks which is used for babies had not been completed. Over a six-month period, there were 8 weeks that both the emergency boxes used during a diabetic emergency and a pre-eclampsia emergency were not completed.

There was not enough emergency equipment available to cover the number of birthing beds and areas across the footprint of the service. For example, there were not enough resuscitaires which are used to provide lifesaving resuscitation to babies. There was also not enough adult and baby emergency equipment for the size and footprint of the service. Leaders had not identified this and were unaware of issues; for example, one resuscitaire was unusable as it had a broken wheel, we raised our concerns with the trust who completed a risk assessment, provided guidance for staff on what to do in an emergency and ordered more equipment for maternity services.

The service did not ensure the safe, secure, and effective storage and management of expressed breast milk (EBM). We found that fridges and freezers used to store EBM were not clean, de-frosted and the temperature of the fridge and freezers were not monitored and recorded. We also found contents of the fridge were not properly recorded and there was out of date milk stored. This posed a risk to babies drinking this milk. The trust was aware that the fridge and freezer currently used were not sufficient and were awaiting replacements, although no mitigation was in place to manage the presenting risk. We raised this with the trust as a concern and they provided assurance that this would be addressed and the process for safe management would be reviewed.

The birth partners of women and birthing people were supported to attend the birth and provide support. We saw how partners with babies on transitional care were supported to stay overnight with pull out beds provided. The service also offered accommodation within the hospital for those parents who had babies on special care but themselves were medically fit.

Due to the small, open bay style wards (Nightingale wards) there was limited space and privacy for women, birthing people. This was raised as a concern as part of the give feedback on care by people using the service. Staff told us that there were limited rooms to allow for private conversation on the wards which led to staff at times using offices when conversations with women and birthing people required for privacy away from the ward.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply and a standard operating procedure on how to clean the pool after use.

The service ensured there was a birthing evacuation net in each room that had a birthing pool. There was a portable ultrasound scanner, sufficient cardiotocograph machines and observation monitoring equipment. However, data provided showed that not all equipment had been checked and tested to ensure it was safe.

Maternity

Equipment was not always serviced regularly. We reviewed equipment testing compliance data and compliance rates for equipment testing and servicing was 60% for 2023.

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

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

Assessing and responding to risk

Staff did not always complete and update risk assessments or take action to remove or minimise risks.

The service did not use an evidence-based, standardised risk assessment tool for maternity triage. There was a lack of guidance for staff around how to risk assess, manage, and escalate risk within maternity triage. The maternity triage policy (version 1, issued 14 August 2019) was out of date as of the 14 August 2022 and did not reflect current practice. Waiting times to be seen and reviewed by a midwife and/or medical professional were not recorded in a standardised way and there was no system to ensure that women and birthing people were seen in order of medical priority based on presenting symptoms and risk rather than time of arrival. Whilst staff could explain that certain symptoms, such as reduced fetal movements would be prioritised, this was based on clinical judgment of an individual midwives rather than a standardised approach. Staff used multiple recording systems to document the attendance of women and birthing people in triage, which made it difficult to effectively monitor and audit processes. The triage area consisted of an open bay with 4 beds and a side room and a waiting area in the main reception. However, there was no allocated oversight by an appropriate clinician, of women and birthing people waiting to be seen, whose condition could potentially deteriorate.

A snapshot audit of the workflow through triage was carried out between May 2022 and July 2022 by a midwife. We were told this was shared with leaders, however there was no evidence that action was taken to act on the concerns presented and recommendations to use a standardised risk assessment triage process. Staff told us they were keen to improve on how triage was working and had ideas of how to improve this; however, there was no evidence that this was being supported and progressed by leaders within the service. Audits of maternity triage had not been carried out and this wasn't included on the risk register for Musgrove Park Hospital.

There was a policy in place which outlined the process for induction of labour. However, staff told us that they needed more guidance around when delays occur and that delays could lead to women and birthing people becoming upset. Staff told us induction of labour was managed by the labour ward coordinator and the consultant on the day, who would prioritise women and birthing people based on clinical judgement of risk; this information was displayed for the team on a white board in a side room.

The service did not have separate theatre lists for elective caesareans and emergency caesareans, this approach could lead to delays in those women and birthing people having an elective caesarean and doctors told us this led to an inconsistent experience for women having an elective caesarean. We saw delays in elective caesarean sections had been incident reported.

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 7 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. However, the service did not complete audits in this area.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. For example, staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. Leaders carried out an audit for February-October 2023 rather than regular quarterly audits to see how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The data presented for that time period covered 105 records on the labour ward and the Bracken Birth Centre. Results showed the correct method of fetal monitoring was carried out in 97% of cases, CTG was interpreted correctly in 89% of cases, false assurance from misinterpretation of CTGs occurred in 6% of cases and there was a delay in acting on a pathological CTG in 6% of cases. Fresh eyes were completed hourly in 95% of cases. The service staff told us results from this audit were due to be presented at an audit meeting in January 2024, where an action plan would then be put in place.

Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. There was a team of midwives who would provide support for women and birthing people requiring additional support throughout their pregnancy to offer a level of continuity which included mental health support. Staff told us this worked well in terms of ensuring consistency, oversight, and improved communication.

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

Shift changes and handovers included key information to ensure medical background and risk was discussed, however, more detail was required around known safeguarding concerns. Staff were given very brief details and signposted to access the electronic records.

Staff had 2 consultant-led, multi-disciplinary handovers each day to ensure all staff were up to date with key information. The handover shared information using a format which described the situation, background, assessment, recommendation for each person. We did not witness any areas of learning shared as part of the midwifery handover process, but this was part of the medical handover.

Staff completed newborn assessment observation and early warning score forms (NEWS) on their electronic records system. We saw 1 example of this which was fully completed and escalated appropriately. The British Association of Perinatal Medicine recommend the use of Newborn Early Warning Trigger and Track (NEWTT) as best practice and the service told us they were aware of this and working towards implementing NEWTT.

Leaders did not provide clinicians with guidance by way of a policy or have oversight of staff compliance in relation to NEWS. The service did not audit staff use of the NEWS tool and there was no specific policy in place to guide staff on when and how to use the tool. Following raising our concerns a retrospective audit of NEWS between January 2022 and December 2023 on the services electronic records system was undertaken. This showed 71% of babies who required NEWS forms due to being under observation had one recorded, and 69% of those under observation and requiring escalation to the paediatrics team had one recorded. We were told, further audits were scheduled for 2024 and findings were to be discussed at the maternity and neonatal governance meeting. At the time of inspection, despite a Healthcare Safety Investigation Branch safety recommendation at Yeovil district hospital in August 2023, (following the merger in April 2023) there was no action plan to improve the compliance of NEWS observations at any of the trust's other sites.

Maternity

Service leaders had not carried out a ligature risk assessment in line with an NHS National Patient Safety Alert which was issues in 2020 as they were not aware these were required within the maternity department. Following the inspection, the service told us they would complete this, review the relevant policies and ensure a standard operating procedure was put in place. The service also ordered ligature cutters.

The service provided transitional care service for babies who required additional care, the aim of transitional care is to avoid the separation of mum and baby. This was located on a separate corridor opposite the postnatal ward. We spoke to families whose babies were receiving care on the transitional ward and they spoke highly of the care and support they had received. They told us how midwives were quick to respond to the call bells and paediatricians provided support for their babies and completed regular checks.

Staff completed risk assessments prior to discharging women and birthing people into the community, however there were incident reports of failures to communicate with third-party organisations of the birth and discharge of babies where this was required.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Staff did not always have the right skills and training to keep women safe from avoidable harm and to provide the right care and treatment. The service did not always make sure all staff were competent for their roles. Not all staff had received an appraisal of their performance or support with their development.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Staff told us low numbers mainly impacted wards other than the labour ward and lack of staff made them feel unsafe.

The service monitored maternity staffing through reporting on the number of times staffing levels were or were not sufficient to meet the needs of women and birthing people (acuity) each week to the monthly maternity and neonatal governance meeting. Data showed in July 2023, acuity was met 66% of the time, in August 2023 72% of the time and September 2023 55% of the time. The figures reflect the number of staff in reported positions at regular intervals throughout the day. The trust told us that staff would be deployed to different areas across the service to meet the rising acuity and complexity across the service.

The service did not effectively report and monitor 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. Five of the 9 red flag incident categories were reported on in the last 12 months. These included 12 incidents of delayed or cancelled time critical activity, 17 incidents of missed or delayed care, 2 incidents of missed medication during an admission, 1 incident of delayed recognition of and action on abnormal vital signs and no incidents of a midwife being unable to provide continuous 1:1 care during established labour. This is a total of 32 red flags over 12 months. There is limited assurance on the accuracy of the number of documented red flags as there was no effective tool in place at the time of inspection to record red flags. The service told us that they would be implementing an evidenced based tool designed for maternity care, which was in use at Yeovil District Hospital, in January 2024 to ensure a more effective way to report and monitor red flag incidents.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in November 2021. This review recommended the service needed 154.44

whole-time equivalent (WTE) midwives, compared to the funded establishment of 149.07 WTE, indicating an additional investment of 7.94 WTE staff. Investment was secured following the birth rate plus recommendations and recruitment was successful in closing the identified gap. The trust told us they were over recruited to both midwifery roles and midwifery support worker roles, however there remained 1.1 WTE vacancies at this location. The service had recruited 9 new starters in October 2023; which included 8 preceptees & 1 Band 6 for community; with a further 8 WTE, band 6 midwifery roles being advertised. However, staff told us that midwifery shortages impacted the service and recruitment was on-going.

Managers moved staff according to the number of women and birthing people in clinical areas however this often left wards short staffed. Staff told us the labour ward was prioritised and they were expected to work flexibly at short notice, sometimes in areas they do not normally work. The trust told us this was to reduce clinical risk in response to demand. The maternity escalation plan had 4 alert levels: green – normal working, amber – persistent excess pressure, red – severe and prolonged excess pressure, and black – unit closed to admissions and patients diverted to neighbouring trusts. There was a supernumerary labour co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Data showed the labour ward coordinator was always supernumerary in July, August, and September 2023. However, acuity was only formally recorded on the labour wards and so did not always take into account the pressures experienced in triage, antenatal and postnatal areas.

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

The service made sure some staff were competent for their roles. Staff did not always receive a yearly appraisal.

Midwifery staff compliance with mandatory appraisals did not meet the trust target of 92% for any staff groups. As of 1 November 2023, compliance across departments ranged between 33% and 80% with an average of 47.5% of staff receiving an appraisal.

The service had recruited and supported 8 international midwives to work at the service. Additional training, competency assessment and support by way of supernumerary working was provided until they were signed off as competent to work independently.

From the information provided it was not clear that all other midwives had been assessed as competent following training provided.

The trust had specialist midwives such as a bereavement lead, safeguarding and audit midwife that covered both Musgrove Park Hospital and Yeovil District hospital. There were other specialist midwifery roles such as infant feeding, digital lead, governance and screening leads who were based at the service in Musgrove Park hospital.

A practice development team supported midwives. The team included 3 practice development lead midwives.

The chief nurse reported in the September 2023 six monthly staffing report to the trust board that 21 of the student midwives who trained at the trust had been successfully recruited to the service with planned start dates in October 2023.

The service did not have enough medical staff with the right qualifications, skills, training, and experience to provide the right care and treatment. There was no process or procedure around the induction of locum doctors.

Maternity

The service did not have enough medical staff. At the time of inspection, the service had 13 obstetric and gynaecology consultants which included 1 locum. There were also 9 specialist registrars, which included 1 locum and 8 GP trainee doctors. The service always had a consultant on call during evenings and weekends and any gaps were a result of sickness. However, the sustainability of the 1 in 12 consultant on-call rota to enable the daily evening ward round on labour ward was on the risk register since December 2022. The service told us they had recruited 2 obstetric consultants who were due to start in March 2024. The service was holding 2 consultant led ward rounds per day as required.

The service had 2 locum doctors at the time of inspection (1 consultant and 1 specialist registrar) but did not have a formal procedure to monitor compliance with recruitment or to ensure a formal induction had taken place and was evidenced. However, the locum doctor on duty during the inspection told us they were well supported and had received a comprehensive induction. The service leaders created an action plan to address this following the inspection.

The service monitored whether a consultant was called when needed (as per the service escalation policy) and whether consultants attended those obstetric emergencies. In August 2023, the attendance was 8 out of 9 of the obstetric emergencies requiring a consultant. However, in 1 case a consultant did not attend a post-partum haemorrhage, over 2 litres as according to the records they believed it was under control. Doctors and staff we spoke to told us they knew when a consultant should attend and there were no issues experienced by them.

Consultant job plans did not allow for obstetric consultants at both hospital sites to take the recommended 11 hours of compensatory rest following on-call activity and there was an expectation that individual staff would use their discretion, however there were no systems to provide cover in these circumstances.

Medical staff including junior doctors, told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

The service had a lack of rest facilities for those doctors working on call overnight and it was unclear if action was being taken to address this.

Records

Staff kept detailed records of women and birthing people's care and treatment. Electronic records were clear, up to date, stored securely. However, paper records were not well managed or secure and not all staff found records easy to navigate. The service did not regularly carry out documentation audits.

The trust used a combination of paper and electronic records. We reviewed 7 electronic records and found records were mainly clear and complete. However, ethnicity was not always recorded correctly and often stated British only. Some ethnic groups of women and birthing people are at higher risk and disproportionately experience poorer outcomes, it is therefore important this is correctly recorded, risk assessed and reviewed. Some parts of the records were still in paper form, and these were not stored securely, we raised this with the service at the time and they told us they would address this.

The service introduced an electronic patient records system in February 2023. There had been no documentation audits since this was introduced. Following the inspection, trust leaders told us a formal audit of maternity documentation was scheduled for March 2024. Not all staff were confident in navigating and understanding the functions on the electronic

records. For example, the system allowed for flags to indicate where there were additional needs around mental health or safeguarding and not all staff were aware of these. The service told us staff training was on-going and we saw guidance documents had been provided and training sessions scheduled. We also saw newsletters with updates and areas of focus from the digital team.

Women and birthing people's care record was on a secure electronic care record system used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers. Women and birthing people were able to view their own medical records online.

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

The service had digital midwifes who was able to support staff when needed with any issues relating to the electronic records systems.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However not all medicines were stored safely.

Staff followed 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. We reviewed 9 prescription charts and found staff had correctly completed them.

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

Some medicines which were to be taken "when required" (also known as PRN) were documented on the electronic record as a regular medication, and so the medication record showed this medication as being late or missed. We were assured that midwives were clear and were checking which medicines were regular, and which were PRN, but the administration record did not accurately reflect this.

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

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation. However, we found anaesthetic agents that could be misused by the public in the room which were not secured. This was raised with the trust at the time of our inspection and steps were taken to secure access to the room and medicines within the room. Checks have also been reviewed to ensure oversight.

Some medication doses are prescribed based on the persons weight, the electronic medication record did not record the person's weight, and this was recorded a separate electronic system, this increases the risk of the wrong dose being given. The trust told us this function was available on the EPMA. However, this function was not being utilised at the time of inspection.

The trust did not have a system in place to monitor staff's competencies around medicines management. Staff completed an e-learning course on medicines management.

Incidents

The service did not manage safety incidents well. Staff recognised and reported incidents and near misses and managers investigated incidents. However, lessons were not always learnt and shared with the whole team and the wider service. When things went wrong, staff did not always apologise and give women and birthing people honest information and suitable support.

The service had not learnt from an incident which occurred in May 2023 where there were simultaneous emergencies overnight and a second theatre team were not able to be sourced from the main theatres. There was poor communication, management and escalation which led to significant delays in women and birthing people receiving care and treatment. At the time of the incident and at the time of the inspection, there was no clear guidance for midwives and theatre staff around protocol in this situation, escalation or roles and responsibilities. Leaders could not be assured that should such a situation happen again staff would be able to manage this more effectively. We raised this as a concern with the service and whilst leaders had drafted a standard operating procedure this was not yet finalised and signed off and did not provide sufficient detail to guide staff. Leaders told us they recognised the importance of providing greater clarity and accountability around the staffing provision for theatres.

Staff did not always effectively carry out duty of candour. There was no evidence that duty of candour was met in several cases we reviewed as part of the inspection. Within investigation reports the service had explicitly documented that duty of candour had not been completed. These were documented to be followed up by individual staff members, however we found that there was no further update provided to evidence completion.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. Leaders reviewed the number of incidents reported, type and grade of the impact at monthly maternity and neonatal (MatNeo) governance meetings. For example, the September 2023 MatNeo governance meeting showed the highest reported incident was undetected small for gestational age (SGA) babies with 13 incidents of birth below 10th centile out of 94 total incidents; and the October 2023 data showed 14 incidents of birth below the 10th centile out of a total of 82 incidents. There was no evidence from the minutes and actions provided that the high number of incidents was being reviewed to identify trends and themes and to improve detection rate. The service acknowledged there were capacity issues within the obstetric sonography, (which is one way to detect SGA babies) and this is a recorded risk on the risk register. However, SGA detection rates was not included within the impact of this risk and so it is unclear whether this has been identified as a causational factor.

We reviewed 223 incidents reported in the 3 months before inspection there were concerns around how these were categorised as some incidents were incorrectly categorised. The trust told us leaders reviewed all incidents across maternity irrespective of level of harm, this included incidents such as PPH and stillbirths. However, we saw no evidence by way of minutes or actions plans from these meetings.

At the monthly maternity and neonatal (MatNeo) governance meetings leaders monitored progress with rapid review reports, root cause analysis reports, perinatal mortality reviews and cases reported to the Maternity and Neonatal Safety Investigation Programme (MNSI). Whilst an overview and update were provided, actions and timeframes for actions to be completed were not always evidenced and so it was difficult to track progress.

Maternity

The service did not always complete incident investigations in a timely way. At the time of inspection there were 6 serious incidents open over 60 days for maternity service. Of these, four addressed a theme relating to shoulder dystocia. The service had four shoulder dystocia incidents in 4 months (May to August 2022). A joint action plan was created to address them in September 2022. However, there were still actions that had not been completed within the time frames set with limited updates included.

We did not identify from any evidence submitted that managers reviewed incidents potentially related to health inequalities.

Managers did not share learning with their staff about never events that happened elsewhere. There was little evidence of shared learning from the trust's other maternity service, Yeovil District Hospital and there were missed opportunities to implement learning and drive quality across both sites.

The service had an incident reporting and management policy for staff to follow which set out actions staff must take along with roles and responsibilities.

Managers had identified from investigation reports that the support and de-briefs offered to staff and the process around this was not embedded or effective and this was added to an action plan to address. However, the date for completion was documented as July 2023 and this was not yet completed. Staff told us that they could ask for support from their direct line manager, and this would be facilitated. They also told us they had good support from their peers.

Is the service well-led?

Inadequate ↓↓

Leadership

There was a newly established leadership team in maternity services. The maternity leadership team for the trust was formed as part of the trust merger in April 2023. Some leaders had been in post for only 2 weeks before the inspection. Leaders were not always visible to staff. Executive leaders did not demonstrate an understanding and effectively manage the priorities and issues the service faced.

Maternity services at the trust were managed as part of the service group for children, young people, and families. This included services such as child and adolescent mental health services (CAMHS) women's sexual health and maternity services.

The service group had a senior leadership quinumvirate for the Children Young People & Families service group, consisting of the that consisted of the service group director, the director of midwifery (DOM), an associate director of patient care for the service group, the associate medical director for obstetrics and gynaecology, sexual health and dental, who was a vascular surgeon and the associate medical director for paediatrics and CAMHS, who was a paediatric and neonatal doctor. The trust told us that MPH also had a dedicated quadrumvirate, with membership consisting of: Head of Midwifery, Clinical Lead Obstetrician, Clinical Lead Neonatologist and Service Operations manager.

Actions from senior leadership team meetings were not tracked effectively. The quadrumvirate leadership team told us they met every 2 weeks. There were no minutes to these meetings, but they kept an action tracker of actions agreed. This tracker showed all items as completed. However, not all items had a date that they were completed and 1 item marked as green stated it needed further action.

The director of midwifery (DOM) reported to the safety champions twice a month. There were 3 board level safety champions, which were the chief nurse and 2 non-executive directors. The safety champions then reported up to the board. The DOM informed us that they attended the Quality & Governance Assurance Committee (Q&GAC) meeting on a regular basis. We were told this a board level committee, chaired by a non-executive director with a number of board members present. The board devolved responsibility for monitoring quality in maternity on behalf of the board. The DOM does not attend the board itself, information on maternity is presented by the non-executive chair of Q&GAC, supported by the Chief Nurse

We reviewed the maternity safety champion meeting minutes for the last 5 meetings and found that there was poor attendance from the Trust board level safety champions. From meetings held in May 2023, July 2023, August 2023, September 2023, and October 2023 there was only 1 occasion out of 5 when 2 safety champions and the DOM were present. This at times led to the meeting not being quorate, which was minuted but led to no improvement in attendance. We also saw that the effectiveness of the meetings was questioned, attendees noted improvements were needed around learning shared at the meeting, but this led to no evidenced improvements in this area. Those in attendance were unable at times to progress actions due to lack of attendance from key members. We also spoke with the 3 board safety champions. They were consistently positive about the assurance they received about the service and did not demonstrate an awareness of the challenges in the service. The service could therefore not be assured of the effectiveness in the board safety champions being cited on maternity issues and driving quality and safety improvements.

We saw maternity briefing reports for the quality and governance assurance committee (Q&GAC) which was a subcommittee to the board. Areas of concern would then be highlighted for escalation and discussion at the public board meeting. It was not clear from the Q&GAC briefing minutes provided who attended those meetings, or if there was an overarching action plan to track progress. The reports were discussed at board level and staffing within maternity was included as part of overall staffing discussions. We also saw that the board had reviewed the risk register which included risks over 15 which also sat on the corporate risk register, this included risks around theatres and estates with maternity. The board could not be properly cited on issues around audits, poor attendance at meetings (which impacted compliance with the maternity incentive scheme) poor compliance with training and appraisals as these were not included in the Q&GAC meetings. The service had poor oversight of the issues faced. Discussion at service group level were held monthly at a Quality, Outcome, Finance and Performance (QOFP) meetings. However, there was no evidence of how this information was escalated or shared outside of this meeting.

The figures presented to the board did not match up with data we received around incidents for the service or from the data supplied from the maternity and neonatal (MatNeo) governance meetings. In the board papers, figures showed that there had been no babies born in an unexpected poor condition between the months of October 2022 and September 2023. The combined MatNeo governance meeting showed data from August 2022 to September 2023 where there had been 5 occasions where therapeutic cooling of babies was needed, on 4 of these occasions' babies needed to be transferred to a specialist unit in another hospital trust. There was also a missed opportunity to provide the board with regular key safety performance information such as delayed induction of labour and meeting national guidance for

emergency caesarean sections. Following the inspection the trust advised us that at the time of the inspection the MatNeo governance meeting was not covering both hospital sites. This meeting did not cover Yeovil District hospitals maternity service. This was not clear when reviewing the documentation, nor was it clear from the board papers if the executive board had oversight of the maternity service at both hospitals

Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis as part of their role as safety champions but not all staff were familiar with the senior leadership team.

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.

There was a systems strategy, combining maternity and neonates' The strategy had been written in 2023 after the recommendations from the Ockenden 2020 and 2022 reports. Also, with the merger between Somerset Foundation Trust and Yeovil District Hospital in mind. They had a vision for what they wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Staff could explain the vision and what it meant for women and birthing people and babies. The progress and oversight of the strategy was monitored at a systems level.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the 3-year delivery plan to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Culture

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

Staff told us they felt respected, supported, and valued by their managers and peer. Staff were positive about the direction that the service was going in following the trust merger and were keen to have a new hospital building as they acknowledged the limitation the current site posed. Staff told us they felt able to speak to leaders about difficult issues and when things went wrong.

The service prioritised staff wellbeing. The service was part of the NHS National Health and Wellbeing Offer for Maternity Services. Findings from a visit and survey of staff in January 2023 found a highly motivated team with a positive culture. Areas for improvement included staffing, workload, and space for rest breaks. Staff spaces for rest break had been documented on the risk register and staff spoke positively about the changes made to shift patterns and the flexibility this offered. The service also recognised staff achievements in the regular governance meetings.

However, the service had not responded to the latest NHS staff survey. We requested the most recent maternity staff survey and associated action plans. The service submitted an action plan relating to 2021 NHS staff survey for Yeovil District Hospital only and not Musgrove Park Hospital.

Maternity

The CQC maternity survey requested feedback from people who gave birth in February 2023 (and January 2023 for smaller trusts). Questionnaires were sent out between April and August 2023; responses were received from 165 people at Somerset NHS Foundation Trust. The survey showed that Somerset NHS Foundation Trust scored “about the same” in comparison to other trusts in all areas. However, they scored “better than expected” for clear communication and “somewhat better than expected” for kind and understanding care and partner length of stay.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples’ care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. People using the service spoke highly of the staff that had cared for them and the support they received.

The trust had an equality and impact assessment tool that was used when creating and reviewing policies and procedures and all policies and guidance included an equality and diversity statement. The use of the assessment tool had been discussed at board meetings and the board felt more should be done to ensure that the tool was used to assess reports prior to them going to board. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

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

Managers investigated complaints, identified themes, and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. We reviewed the trusts responses to the last three complaints and found complainants questions were responded to in detail and a full apology given. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

We did not see evidence of leaders exploring and understanding how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. There was no evidence that incidents were reviewed in relation to whether ethnicity or health inequalities may have impacted outcomes.

Governance

Leaders did not operate effective governance processes to monitor and improve the quality of the service. Leaders did not have clear oversight of the service.

The service did not have an effective program of regular local audits to ensure the safety and quality of the service was monitored and processes to learn from incidents were not effective.

The service did not have effective governance processes. The governance structure did not always support the flow of information from front line staff to senior leaders and vice versa. Governance and safety champion meetings took place but were not always well attended by senior leaders. We saw discrepancies in information about key safety and performance metrics at a service level to information and key safety and performance metrics discussed at executive board level.

Maternity

We reviewed the last three meeting minutes of the governance meetings and the combined maternity and neonatal governance meetings. We found that the number and type of incidents were broken down, the risk register was discussed, and issues such as complaints, training, acuity, guidelines, and safeguarding were also discussed. However, there was a lack of clear action and accountability from these meetings to drive improvement.

Maternity quality surveillance data reviewed at this meeting was minimal and only included raw data of the numbers of PPH incidents, shoulder dystocia, 3rd and 4th degree tears rather than statistical process charts to map trends over time. Further work was needed to make the information presented more meaningful and provide context.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service had completed an audit of WHO checklists between April 2022 and March 2023. Findings from the audit were collated in October 2023 and were due to be presented at the audit meeting in December 2023, where an action plan would then be formulated. That was a delay of 7 months from the completion of the audit to implementing an action plan. Leaders told us any concerns would be highlighted and shared at the monthly maternity and neonatal governance meeting, but we saw no evidence of this happening. The WHO checklist audit showed that there were 1094 cases that went through maternity theatres and 88% of these cases were compliant with completing the checklist. Trends around incomplete checklists were similar to those found the previous year. The trust had 2 serious incidents which related to theatres in a six-month period. Following the inspection, we were advised that actions implemented at Yeovil District Hospital had also been embedded at Musgrove Park Hospital. However, we did find this during our inspection. Frequent and timely audits and actions were not in place following these incidents to share findings and drive quality improvements.

Data and key performance metrics discussed at governance meetings was not up to date information and provided a snapshot in time rather than over regular intervals, there were long delays before this was shared at meetings and actions put in place. For example, WHO audit data was collected and reported on yearly (April 2022-March 2023) and there was significant delay between completion of the audit, to creation of an action plan (October 2023) and sharing that information with the wider team (December 2023).

The evidence provided as part of the inspection which documents the process for reviewing neonatal deaths was not in line with national guidance. We reviewed 2 mortality reviews from the November 2023 meeting and found the Perinatal Mortality Review Tool (PMRT), a nationally recognised methodology to review baby deaths was not used to grade the severity of these incidents. There was no reference to the parents' views being sought in the reviews. We raised this as a concern with the trust and they assured us that the process was being followed, including meeting the recommended timeframes. They told us this information was documented in the final reports; we saw 1 example of a final report however, we cannot be assured this process was followed in all reviews.

The service did not ensure staff had access to up-to-date policies, procedures, and guidance. Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust merged to form one organisation in April 2023. Following the merger governance teams were in the process of reviewing and aligning policies between the two locations. From the 12 policies and procedures requested for trust, 5 were out of date (Recognition of the severely ill woman, Sepsis, Triage and Prevention and management of postpartum Haemorrhage-(PPH)).

Despite incidents occurring leaders did not have effective governance processes to ensure timely access to emergency obstetric theatre staff from the main hospital site. We requested, and did not receive, audits of timeliness of decisions

for knife to skin for caesarean sections. The service had acknowledged from a thematic review, that there was an issue with the categorisation of caesarean sections and staff told us there were still issues in this area. Staff also told us they were concerned that there wasn't a separate elective and emergency caesarean list. The service had not taken action to assure themselves of their performance in this area.

Leaders did not have effective oversight of training compliance and competencies or appraisal rates. This had not improved since the last inspection in March 2020.

The service did not carry out regular audits to gain assurance and oversight of staff compliance with guidance and documentation or take timely action to share findings and drive improvement.

Leaders had not completed quarterly audits of MEOWS records to check they were fully completed and escalated appropriately and so the service cannot be assured that national tools are appropriately used and escalated. We saw action plans with recommendations from Healthcare Safety Investigation Branch (HSIB) now known as Maternity and Newborn Safety Investigations (MNSI), dated September 2022 which stated, "MEOWS charts were not utilised within triage and labour care settings impacting recognition and escalation of abnormal observations". Whilst we saw and staff told us these tools were now in use in these areas, the service had not taken appropriate and timely action to assure themselves of compliance and effectiveness in relation to the use of MEOWS.

Management of risk, issues, and performance

Leaders and teams did not use effective systems to manage performance. They did not always identify and escalate relevant risks and issues or take actions in a timely manner to reduce their impact.

There were significant failures in audit systems and processes. Out of the 8 audits requested by CQC only 1 was completed regularly. The service had not audited the use of Modified Early Obstetric warning score (MEOWS), triage, handover tool (Situation Background Assessment (SBAR)), World Health Organisation theatre checklist (WHO), NEWS or the electronic care records system.

When improvements had been made at the service, they were not monitored to ensure they were fully implemented or that best practice were being followed. For example, a maternity electronic record system was implemented in February 2023. However, there had been no audits of the system to ensure staff were using the system effectively. In governance meetings leaders identified a decrease in incident reporting but could not assure themselves whether this was due to changes to the electronic care records or poor record keeping.

Leaders had not effectively mitigated known risks. For example, there was no elective caesarean surgical list at Musgrove Park Hospital and so women and birthing people could face unnecessary delays in going to theatre. This was listed on the MPH risk register as high risk (16), however there were no "controls (actions) outstanding" or "controls implemented" listed.

The service had not recognised safety risks that were identified during the inspection. For example, leaders at the service had not recognised that the service had insufficient resuscitaires to meet the needs of the service based on number of birthing rooms, nor had they completed risk assessments for areas of the service that did not have immediate access to a resuscitaire. Following the inspection and our feedback, the service acted by ordering more resuscitaires and putting risk assessments in place.

Maternity

Managers monitored the top five risks at the monthly combined maternity and neonatal governance meetings. As of September 2023, the top recorded risks in maternity were the lack of robust maintenance programme to maintain the maternity building, significant shortages in the sonography department (staff who carry out ultrasound scans) and that the service had access to one obstetric theatre (and one procedure room). These risks were mere not effectively mitigated at the time of inspection. For example, the maternity building risk was only recorded since August 2023 despite being a long-standing risk and the mitigation recorded was 'business continuity planning.'

The sonography staffing risk had been recorded on the risk register since March 2021 and the mitigating actions were vague 'secure funding for additional capacity to meet current and future demand' and it was not clear what the current progress was to mitigate this risk.

The lack of access to a second obstetric theatre risk was recorded since March 2021 but there were no mitigating actions.

The service took part in national audits. Data was obtained and reported at trust level to the National Maternity Dashboard. Results across all metrics were within expected limits and so the trust was not considered an outlier. For example, the rolling 6-month average rate for perineal trauma (also referred to as 3rd and 4th degree tears) in March 2023 was 37.2 per 1,000 births across the trust against the national average of 27 per 1,000 births. The rolling 6-month average rate in March 2023 of post-partum haemorrhage of 1500 mls or above, was 44 per 1,000 births across the trust, against the national average of 29 per 1,000 births. The rate on a rolling 6-month basis in March 2023 for the number of pre-term babies born per 1000 births was 54.7 which is lower than the national average of 63 per 1000 births.

The service provided briefing reports as part of the maternity incentive scheme on their progress with Saving Babies Lives Care Bundle Version 3 (SBLCBv3). Version 3 was published in May 2023 and all NHS maternity providers are responsible for implementation by March 2024. The aim of SBLCBv3 is to provide detailed information to providers and commissions on how to reduce perinatal mortality across England. It identifies six areas of care and uses evidence based/best practice to drive improvement.

As part of the Maternity Incentive Scheme reporting process, progress is reported by way of self-assessment by the trust and then by the LMNS (local maternity and neonatal system) validated assessment status. The trust report dated 11 October 2023 outlined that all 6 elements were fully implemented for 34% of the interventions (LMNS validated assessment status). However, the service had self-assessed that they had fully implemented 41% of the interventions. Many of the LMNS suggested improvement activity was in relation to audits to lack of guidelines and pathways.

The trust was eligible to claim additional funding by the NHS Resolution Clinical Negligence Scheme for Trusts (CNST). The last maternity update to trust board in November 2023 showed the service met 10 out 10 CNST safety standards. They held monthly maternity incentive scheme (MIS) meetings to review compliance. The service had employed a cross-site project lead midwife for MIS year 5 whose role was to support with gathering evidence and preparing reports required for submission to the trust Quality and Governance Committee (Q&GC).

Information Management

The service did not always collect reliable data or analyse it in a timely manner. Staff could not always find the data they needed, in easily accessible formats. The information systems were not always integrated and secure. However, data or notifications were consistently submitted to external organisations as required.

Maternity

The service did not always collect reliable data, and it was not always evident that the service leaders had analysed the data in a timely manner. For example, in relation to audits and red flags. We also saw that information presented in the MatNeo Governance meeting did not correlate with what was presented to the board.

They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

The electronic patient records system was not yet fully integrated and records such as Cardiotocography (CTG's) and NEWS records were not yet computerised.

On the day of inspection staff supporting inspectors to access information from patient care records had difficulty navigating the system and accessing data.

Data or notifications were consistently submitted to external organisations as required.

Engagement

There was a limited approach to sharing information with and obtaining the views of staff and people who used

the service. Leaders did not respond to feedback in a timely way in order to improve services.

Following the inspection the service introduced rostered midwifery days for staff to meet with senior leaders to ask questions and discuss current issues. Midwives had access to Professional midwifery advocates and a recruitment and retention lead for support. The national health and wellbeing team at NHS England had visited both sites of the trust in January 2023, the aim is to support trust to improve and develop a program of improved health and well-being for maternity staff. Following the inspection the trust shared a summary of the feedback from listening events that was shared with staff. Immediate actions taken included; introducing measures to make health and wellbeing initiatives more accessible with a more proactive and preventative approach, and a re-vamp of existing rest areas. However, issues around rest spaces were raised at the time of the inspection. No further action plans were shared around on-going work from this visit.

Staff were enthusiastic about the service and the potential for improvement. A monthly maternity matters meeting was held in which staff would receive updates and there were opportunities for question-and-answer sessions with leaders.

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The service listened to the feedback provided from women and birthing people about the use of electronic records. Feedback was also collected by the MNVP from women and birthing people around their experience of breastfeeding as part of the breastfeeding strategy, however it was unclear what the next steps were based on the action plans shared.

The trust and the MNVP had developed an informed decision-making tool and were in the process of drafting a 'care outside of guidance' guideline. This is when women or birthing people choose to birth in an environment not recommended by clinicians.

The trusts' pace of change in terms of co-production with the MNVP could be improved. For example, some actions were behind schedule such as, supporting the development of birthplace choices across Somerset and enhancing use of personalised care plans.

Maternity

The MNVP issued 'star awards' to midwives who they had received especially positive feedback about. We saw that midwives had been nominated for 'star awards.'

The MNVP had completed a '15 steps review' of Musgrove Park Hospital in March 2023. Numerous recommendations were made, themes included the environment not being welcoming, comfortable or fit for purpose, including being cluttered, better and clearer signage and information needed, ensuring this is also in an accessible format and infection control issues. Whilst the trust commented that steps would be taken to work towards the recommendations, we asked for but did not receive evidence of an action plan. We also found similar issues which were identified in the 15 steps in March 2023 at the time of our inspection 8 months later.

We requested but did not receive an action plan following the 2022 NHS staff survey, only the 2021 NHS staff survey was provided from the previous year.

Support for trainee doctors could be improved. Results from the 2023 General Medical Council National Trainee Survey (GMC NTS), which trainee doctors complete in relation to the quality of training and support received; were compatible with the national average scores in 14 indicators. However, the results were worse than national average (but not an outlier), for four indicators ('reporting systems,' 'handover,' 'induction' and 'regional teaching') which all reduced from the 2022 survey.

Feedback from women and birthing people showed care, especially in relation to postnatal care could be improved. The CQC Maternity Survey results for 2023 showed, in comparison to other trusts, Somerset NHS Foundation Trust scored about the same for 50 questions, 'better than expected' for one question and 'worse than expected' for no questions. For six questions there was a 'statistically significant decrease' in scores when compared to 2021 results, the majority of these related to postnatal care.

We received 18 responses to our give feedback on care posters which were in place during the inspection. Of these responses 8 were positive feedback and 10 raised concerns about the service. Positive feedback related to the friendly and supportive staff and concerns raised about the service related to feeling listened to, the environment, pain relief and communication.

Learning, continuous improvement and innovation

There was limited evidence of learning and continuous improvement.

There was limited evidence of how learning from incidents had been fed into training to improve outcomes. Staff told us that there was shared learning they could access electronically and the opportunity to attend monthly drop-ins, but the uptake from staff was not clear.

Staff at Musgrove Park Hospital were involved in the PERIPrem initiative, which was a package of care aiming to reduce the number of pre-term births and also improve the outcome for those babies born prematurely.

They also took part in a staff coaching pilot, to improve staff engagement and satisfaction with their work. This showed positive results for those that took part, but it was unclear whether this was going to be rolled out to other staff and adopted across the service.

Maternity

The service did not have a quality improvement champion to coordinate and drive improvement, we also saw no evidence of training initiatives around quality improvement. We saw how steps had been taken to improve communication with staff such as white boards in staff areas with governance and other key information about risk and performance. Staff also told us how the new system for sharing new guidance was working well.

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:
Maternity

- The service must ensure they apply and demonstrate compliance with Duty of Candour requirements. Regulation 20.
- The service must ensure staff are up to date with maternity mandatory training modules. Regulation 12(1)(2) (c)
- The service must ensure the security of the unit is reviewed in line with national guidance. Regulation 12 (1) (2) (a) (d)
- The service must ensure staff are up to date with the appropriate level of safeguarding training in line with national guidance. Regulation 12(1)(2) (c)
- The service must ensure that policies are available, up to date and reviewed in accordance with the review date. Regulation 17 (1) (2)
- The service must ensure all staff must receive annual appraisals. Regulation 18 (2) (a)
- The service must ensure that staff adhere to infection, prevention and control policies and procedures. Regulation 12 (2) (h)
- The service must ensure medicines and breast milk is stored safely and securely. Regulation 12 (2) (f)
- The service must ensure there are risk assessments for women and birthing people presenting to the triage service and best practice is considered to mitigate any identified risk. Regulation 12(2)(a)(b)

Action the trust SHOULD take to improve:

- The service should ensure the monitoring of incidents by ethnicity to evaluate incidents and clinical outcomes to ensure equality in maternity care.
- The service should consider providing additional support to staff around the use of electronic patient records.
- They should consider how ‘medicines as required’ (PRN) medicines and patient weight is recorded on the electronic medicines record.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 3 other CQC inspectors, and 2 midwifery specialist advisors and a Specialist obstetric advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.