East Suffolk and North Essex NHS Foundation Trust

Trust Board of Directors Meeting

Report Summary

Date of Meeting: 6 July 2023	
Title of Document: CQC Inspection Report on Colchester Hospital Maternity Services	
To be presented by: Giles Thorpe, Chief Nurse	**Author:** Sarah Preston, Interim Associate Director of Governance (Risk & Compliance)
1. Status: **For Approval**	
2. Purpose: To update the Board on the Trust's progress with the CQC Action Plan for Colchester Maternity Services	
Relates to: CQC Inspection to Colchester General Hospital in March 2023	
Strategic Objective	SO2 Lead the Integration of Care SO3 Develop of centres of excellence
Operational performance	n/a
Quality	Deliver safe services for our patients as per Health and Social Care Act 2008
Legal/Regulatory/Audit	CQC Inspection
Finance	N/a
Governance	CQC has powers under the Health & Social Care Act 2008 to inspected regulated activities conducted by the Trust
NHS policy/public consultation	N/a
Accreditation/inspection	CQC Framework
Anchor institutions	n/a
ICS/ICB/Alliance	The Trust has shared the report and plan with the ICB for shared learning
Board Assurance Framework (BAF) Risk	Links to BAF Risk 4 'Patient Safety & Quality'
Other	Nil

3. **Summary:**

The Care Quality Commission (CQC) conducted an unannounced statutory inspection of services at Colchester general Hospital on 7 March 2023, focused on Maternity services. The formal report of that inspection was published by the CQC on 5 May 2023. A copy of the report can be found here: RDEE4 Colchester General Hospital (cqc.org.uk)

The rating awarded at that inspection for the service were:

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

As per usual process following a CQC inspection, an action plan has been prepared and is attached for approval of the Board. When approved it will be submitted to the CQC and progress of the action plan will be monitored at the Quality and Patient Safety Committee,

supported by the Patient Safety Group and Clinical reference Group.

Whilst the inspection in March 2023 relates to Maternity services based at Colchester General Hospital, all actions arising will also be replicated at services at the Ipswich Hospital site to ensure shared learning and consistency of service provision across both acute sites.

The CQC issued 3 MUST do actions and 5 SHOULD do actions as follows:

Actions the Trust MUST take to comply with its legal obligations:

1. The trust must ensure they fully implement a system to assess risks to women attending the triage unit and prioritise their care appropriately. Regulation 12(1)(2)
2. The service must ensure that medical staff complete mandatory and safeguarding training and ensure compliance with the trust target. Regulation 12 (1) (2)(a)(c)
3. The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit. Regulation 18 (1)

Action the trust SHOULD take to improve:

1. The trust should ensure all areas are secure and only authorised personnel have access.
2. The trust should ensure patient and staff records are stored securely to maintain confidentiality and compliance with the trust policy and national legislation.
3. The trust should ensure medicines are managed and stored appropriately, and medicine storage temperatures are monitored and recorded in line with trust requirements.
4. The trust should ensure staff adhere to control measures to protect women, themselves, and others from infection.
5. The trust should ensure senior leadership is visible and actively work to improve staff morale.

4. Recommendations / Actions

The Board is asked to:

a) Note the outcomes of the CQC inspection of Colchester General Hospital published 5 May 2023
b) Approve the proposed action plan in response to that inspection.

Improvement plan following CQC inspection of Maternity Services at Colchester Hospital, March 2023

Unannounced focussed (risk based) inspection of Maternity Services at Colchester Hospital, March 2023 (report published 5 May 2023)

EQA and Date	Must do/ Should do	CQC Recommendation	CQC Finding / Detail in report	Ref	ESNEFT Action	Action Owner	Assurance	Resources required	Progress	Status	To be completed by	Evidence to demonstrate compliance with action	RAG rating
CQC visit 7 March 2023 Published 5 May 2023	Must do	**Regulation 12 (1) (2): Safe - assessing and responding to patient risk.** The trust must ensure they fully implement a system to assess risks to women attending the triage unit and prioritise their care appropriately. *Page 7-8 of report*	Staff did not always know how to navigate the electronic system to find safeguarding information and we observed a patients notes who had not had any safeguarding questions asked at any appointment. The maternity triage system was recognised by the trust as being overburdened and therefore a risk to women's safety due to the functions of triage and day assessment unit being merged; there is a work-stream to review splitting the DAU and Triage to help ease the burden. BSOTS not fully embedded; not possible to complete BSOT's on the night shift as two midwives are needed for	1	Ensure full implementation of BSOT's on both sites. All core triage members of staff including bleep holders, B7 labour ward coordinators, maternity support workers and obstetricians to receive BSOT's training. Implement a robust alert system to identify safeguarding issues. Ensure safeguarding education and training for midwives.	Director of Midwifery QI Midwife Corporate Safeguarding Team	BSOTs implementation and regular audit of outcomes BSOT's training compliance tracker Documentation audit re: safeguarding questions Staff Safety Huddles Safeguarding training compliance tracker	Additional time for safeguarding training Staffing in line with birth rate plus	BSOT's Implementation programme trajectory: Sep 23 with continuous audit; this may need to be reviewed based on the training trajectory. Core staff training on schedule with remaining staff to be scheduled (train the trainer). Safeguarding - **APD meet with TB - seeking support from IT Lead midwife.** Blue folder within main notes highlights safeguarding concerns; not clear how this can be transferred to evolve. IHT - Main notes are available as women attend appointments.	Amber In progress	9 months / February 2024	**Copy of core staff training trackers -** **Evidence from Healthroster re:establishment of staff -** awaiting **FFT feedback regarding triage services** - awaiting **Copies of staff hudddes -** awaiting **BSOT's audit outcome -** awaiting	

			BSOTs, currently triage was only staffed with 1 midwife and 1 support worker at night. Patients not always seen by doctors in line with BSOTs timeframe; no doctor allocated from 5pm. This often led to patient reviews being delayed and the potential risk of delayed treatment. Data from Dec 22 - Jan 23, showed only 29% of patients rated yellow were seen within 1 hr and 1% within the orange category seen within 15 Mins.						CGH is electronic - APD to review how alerts are created and accessed. CGH - drop down on medway to identify if SG questions had been asked (if patients are unaccompanied). IHT - has Public Health q's in the notes (1,2,3); safeguarding annual training updates this information so staff understand what the questions mean and how to complete the information. Medical SG compliance 84.17% (IHT) 69% (CGH) - DD sent emails to medical staff to complete. Deep dive underway to ensure junior staff training follows when they rotate department.				

CQC visit 7 March 2023 Published 5 May 2023	Must do	**Regulation 12 (1) (2) (a) (c):** The service must ensure that medical staff complete mandatory and safeguarding training and ensure compliance with the trust target. *Page 3-4 of report*	Staff did not always receive and keep up to date with their mandatory training: the overall mandatory training for staff was 95.8% on a rolling 12-month cycle. However, the mandatory completion rate for consultants was 84.6%. **Maternity specific training:** overall completion rate 91.09%. midwives 93.2%, nurses 100%, support workers 96.49%, obstetric consultants 69.23%, obstertric doctors 94.12%, neonatal nurses 93.94%, anaesthetic consultants 81.25%, anaesthetic doctors 68.75%. **CTG training:** overall completion rate 83.62%, midwives 92.31%, obstetric consultants 92.31%, obstetric doctors 88.24%. **Safeguarding Training:** overall completion rate nursing and midwifery staff 92%, medical staff	2	Ensure mandatory training for medical staff is included in rota for SPA time Robust induction plan for trainee Doctors.	Divisional Director	Training compliance Tracker Induction training / pack for junior Doctors	Locum cover for backfill of rota to allow training to be undertaken	Part of the above deep dive - this is being reviewed. Medical SG compliance 84.17% (IHT) 69% (CGH) **Service to provide update on all other mandatory training stats for Medical staff.**	Amber In progress	10 months / March 2024	**Copy of junior Doctor Induction pack -** awaiting **Copy of training compliance tracker -** awaiting	

			43.58%; this is not an improvement since the last inspection. Staff were observed to have trouble identifying whether safeguarding questions on domestic abuse had been asked on a patients electronic records. Recognising and responding to women with mental health needs, learning disabilities, autism and dementia had not been completed by all staff.									
CQC visit 7 March 2023 Published 5 May 2023	Must do	**Regulation 18 (1):** The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit. *Page 8-9 of report*	The service did not have enough nursing and midwifery staff to keep women and babies safe; on the day of inspection, staffing did not meet planned numbers. Actual staffing levels did not meet planned numbers. Unit consistently short staffed. **Qualified fill rates:** in Feb 23 fill rates were 84.1% on days and 79.1% on nights. **Vacancy rate:** 2% **Sickness rate:**	3	Birthrate plus and work force reports to be shared with the board for oversight of national recommendations and undertake work force reviews bi-annually to ensure appropriate number of staff to support with achiving 1:1 care in established labour.	Director of Midwifery	Birth rate plus work force report to benchmark establishment figures. Work force dashboards (HRBP) Fill rate reports Recruitment and Retention plan	TBC pending work force review	Acuity review has taken place, Maternity and medical work force reports are being prepared for Board (end of June). **Draft report to be uploaded to evidence file.** Women receiving 1:1 care in established labour: % (CDG exception report) March - 100% April - 100%	Amber In progress	6 months / October 2023	**Copy of the work force report** - awaiting **Establishment reports -** awaiting **Work force dashboards -** awaiting	

			4.32% in Sep 22 (above 3.5% target) **Staff turnover rate:** 8.9% nursing and miwifery and 29.4% for medical. **Bank/agency staff:** high rates All women should expect to receive 1:1 care in established labour, this was acheived 88.7% in March, 96% in April, 97% in May, 99% in June, 98.6% in July, 93% in August; this is not in line with national recommendations.						May - June -				
CQC visit 7 March 2023 Published 5 May 2023	Should do	The trust should ensure all areas are secure and only authorised personnel have access. *Page 6 of report*	The premises were not always secure, we observed that the link door between antenatal clinic and the midwife led unit was left open. This was escalated to senior staff and promptly closed. We were also able to gain entry to the maternity ward by following another member of staff without being questioned or challenged, which means unathorised persons may also	4	Staff update to be provided regarding security/access to the maternity suite, across all staff groups, to ensure compliance with the Trust Security Policy, Baby Abduction Policy and Security Guidance for Maternity Services. To add security awareness to the Matrons quality checks.	Director of Midwifery	Sister / Matron quality checks Baby abduction simulation (6 monthly) / group sessions in between live simulations. Divisional Newsletter with reminders regarding secuity and access	Within exisiting resources	Checklist has been updated - **blank template to be emailed.** Within each element of training, there are security measures included. **Await copy of training schedule.** Highlight report from session with improvement plan. Policy for baby abduction updated?	Amber In progress	3 months / July 2023	**Evidence of attendance at simulation / group sessions -** Baby abduction drill for April 23 received **Copies of Matron quality checklist -** awaiting	

			gain entry to the ward.									
CQC visit 7 March 2023 Published 5 May 2023	Should do	The trust should ensure patient and staff records are stored securely to maintain confidentiality and compliance with the trust policy and national legislation. *Page 9 of report*	Records were not always stored securely, we observed staff leaving patient paper records unattended in open areas that could easily be accessed by an unauthorised person.	5	To ensure lockable trolleys are available and in use, for safe storage of patient records. Divisional Newsletter to staff with reminders regarding IG processes.	Director of Midwifery	IG/Compliance team GDPR checks Matrons quality checks	Within existing resources	Lockable trolleys in situ in public access areas / in staff only locked / coded areas trolleys are unlocked but safely stored in line with policy. Newsletter - Dr Turner. 6/22 up tp date GDPR's complete and 7/22 WPB assessments.	Amber In progress	3 months / July 2023	**Evidence of trolleys in use** - Photo evidence uploaded to evidence file **Copies of newsletter** - awaiting **Copies of Matron quality checklists** - awaiting	
CQC visit 7 March 2023 Published 5 May 2023	Should do	The trust should ensure medicines are managed and stored appropriately, and medicine storage temperatures are monitored and recorded in line with trust requirements. *Page 10 of report*	Medications that were required to be refrigerated were not always stored correctly, fridge temperatures were not always checked daily. We found expired medication on the midwife led birth unit.	6	All fridges, regardless of purpose, to be checked daily. Medication expiry date checking to be undertaken by the ward sister / midwife / department manager responsible for stocks of all drugs held in the ward / department.	Matron	Safety Huddle checklist Pharmacy control book to document fridge temperatures	Within exisiting resources	await last 3 months temp sheets from pharmacy book Copies of Safety huddle checklist - re: medication expiry date checks. Safety huddles for Ipswich site have been uploaded for March (no mention of medication), April and May. Awaiting safety huddles for Colchester.	Amber In progress	6 weeks / June 2023	**Copies of the safety huddles -** awaiting **Evidence from the pharmacy book -** Fridge sheets uploaded for March, April and May	

CQC visit 7 March 2023 Published 5 May 2023	Should do	The trust should ensure staff adhere to control measures to protect women, themselves, and others from infection. *Page 5-6 of report.*	Ward areas were not always clean or had suitable furnishings which were clean and well-maintained. Specialist equipment on the midwife led birthing unit was dusty. Cleaning records were not always up to date or readily available to demonstrate all areas were cleaned regularly. **Maternity Ward:** staff did not have a checklist system to identify what areas had been cleaned. Staff did not always use 'I am clean' sitickers on equipment across the unit. **Sepsis:** data showed inconsistency month to month in magagement of sepsis. Maternal sepsis screening tool compliance was 89% in October, 86% in Nov and 100% in Dec 2022. Non-compliance with the sepsis six pathway for IV antibiotics within 1hr; trust compliance 75% in Oct, 67% in Nov	7	To continue hand hygeine audit and encourage staff to raise areas of concern with individual groups where non-compliance is identified. All staff are required to complete their mandatory training for Sepsis. Matrons to review completion of the sepsis tool in cases where sepsis is triggered but not identified.	Head of Midwifery	Audits / checklists Dashboard - efficiency of care Sepsis bleep / screening / documentation audit Reports through Deteriorating Patient Group	Witihin existing resources	Efficiency of care audit (monthly) both go through to IP&C / infection control committee (Quarterly). **Copies of hand hygeine audits for last 3 months for baseline of compliance.** **IP&C eLearning:** Overall W&C 86.75% and Maternity CH as follows: % Mat Med services - 100 Mat Midwives - 84.41 Snr Midwives - 83.33 Specialist Midwives - 92.31 Staway - 95.65 **Update on sepsis training compliance: % (CDG exception report for both sites combined)** Midwives - 88.36 Nurses - 100 Support workers - 81.08 Consultants - 50 Doctors - 23.81 Sepsis ward heatmap updated for Colchester - **is this an audit of**	Amber In progress	6 months / October 2023	**Copies of hand hygeine audits -** audit received **Training compliance tracker -** awaiting **Monthly audit of sepsis tool completion -** awaiting **Copy of updated Sepsis Tool -** received **Copy of QI poster - Sepsis screening tool within Maternity -** received	

			and 100% in Dec 2022. **Annual IP&C audit:** partially compliant at 84%. **Hand Hygiene:** 93.88% in Nov, 97.87% in Dec 2022 and 89.13% in Jan 23.						**the new sepsis tool?**				
CQC visit 7 March 2023 Published 5 May 2023	Should do	The trust should ensure senior leadership is visible and actively work to improve staff morale. *Page 11-13 of report*	The leadership and management of the service were undergoing many changes which resulted in instability within the senior leadership. <u>This had not improved since last inspection.</u> Service did not have a Director of Midwifery. We also saw low morale due to the pressure of insufficient staffing and lack of visibility of senior leadership. Staff did not always feel well supported, listened too, respected and valued by their colleagues and senior managers. Although senior leaders listened to their concerns, there was not always updates / immediate action in response. Senior clinical staff	8	Organisation chart to be visibale in staff areas so staff are aware of the leadersip team and structure. DMT to attend induction meetings with staff to ensure staff have open access to their senior leadership teams. Professional drop in sessions to be held by the Head of Midwifery and Director of Midwifery for planned staff time with senior Midwifery team. Regular senior team walk arounds to include Non-Executive Director, Chief Nurse and deputies. Divisional	Director of Midwifery and Divisional Management Team	Staff survey Staff temperature checks Monthly maternity meeting to discuss service improvement and ward meetings.	Within existing resources	Organisation chart - DRAFT in progress (medical admin deprt) DMT are invited to induction meetings; at the time of staff rotation. Professional drop in sessions - not yet started Snr staff walk arounds - not yet started **Newsletter -** 1st one received	Amber In progress	6 months / October 2023	**Outcome from staff temperature checks / survey -** awaiting **Copy of Newsletter** - received **Copy of organisational chart** - awaiting	

			were not given the opportunity to attend lead meetings which meant they did not feel involved in the improvement of the service. Instability of leadership was affecting staff morale. Staff not always aware of the management structure and DMT were not always visible.		newsletter for wider communication.								