East Suffolk and North Essex NHS Foundation Trust

# Clacton Maternity Unit

**Inspection report**

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## Ratings

| Overall rating for this location | Good |
|---|---|
| Are services safe? | **Good** |
| Are services well-led? | **Good** |

# Our findings

## Overall summary of services at Clacton Maternity Unit

**Good**

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Clacton Maternity Unit.

We inspected the maternity service at Clacton Maternity Unit 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.

Clacton Maternity Unit serves the population of Clacton-On-Sea which is a coastal town and part of the East Suffolk and North Essex NHS Foundation Trust. The Clacton Maternity Unit has been serving the local community for 40 years. Clacton Maternity Unit is situated 18 miles from Colchester Hospital maternity services which include acute maternity services.

The Clacton Maternity Unit provides care for women and pregnant people who live with complex social needs in an area of social deprivation and is a valuable access point for those women, people and families who may struggle to access care at the main hospital site. The maternity unit serves areas of the Tendering district, which includes some of the most deprived neighbourhoods of Essex. These include a neighbourhood east of Jaywick, a small seaside town which has been ranked as the most deprived neighbourhood nationally in the three most recent indexes of Multiple Deprivation (2010, 2015 and 2019). The index of Multiple Deprivation is a measure of relative deprivation for small areas published by the government.

Maternity services include a standalone birth centre. The birth centre is open 'on demand' for local low risk women and birthing people. Other services provided at the location are antenatal appointments, twice weekly consultant led antenatal clinics for high-risk women who live in the area, ultrasound scanning, antenatal education classes, postnatal clinics, vaccinations, and newborn hearing screens. From April 2022 to March 2023 there were 17 babies born at the unit.

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

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

We have not rated this location before. This service was registered with CQC on 17 December 2018, and this is their first inspection. East Suffolk and North Essex NHS Foundation Trust was formed 1 July 2018 following the merger of Colchester Hospital University Foundation Trust and Ipswich Hospital NHS Trust. There are maternity services located at both hospital sites and the trust also covers the 'standalone' Clacton Maternity Unit.

Our rating of this hospital is rated as Good. Because we have now rated maternity services.

East Suffolk and North Essex NHS Foundation Trust have maternity services at two other locations. Our reports for these locations are here:

# Our findings

Colchester General Hospital - https://www.cqc.org.uk/location/RDEE4

The Ipswich Hospital - https://www.cqc.org.uk/location/RDEX1

**How we carried out the inspection**

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

We visited Clacton Maternity Unit on the 26th of July 2023. We spoke with 8 midwives, 2 support workers, 1 woman her partner. We received 3 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 6 patient care records, 6 Observation and escalation charts and 6 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 action plans. We then used this information to form our judgement.

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

# Maternity

**Good**

Our rating of this service is good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect women and birthing people from abuse, and managed safety well.
- The service controlled infection risks well.
- Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services.

However:

- Not all staff had received updated maternity role specific training in the timeframe expected.

## Is the service safe?

**Good**

We rated it as good.

**Mandatory training**

**The service provided mandatory training in key skills to all staff and most staff had completed it within trust time frames.**

Midwifery staff received and kept up to date with their mandatory training. Training was up-to-date and reviewed regularly by the practice development team. This team was made up of one practice development midwife, a recruitment and retention midwife and a fetal monitoring specialist midwife. They followed and monitored the "Maternity Training and Education Guideline" to ensure the training needs analysis reflected staff training needs.

There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. Ninety-four per cent of staff had completed all mandatory training courses against a trust target of 90%. However, only 82% of support workers had completed their basic life support training.

The service made sure staff received multi-professional simulated obstetric emergency training. Training included obstetric emergency scenarios, where staff would 'role play' emergency situations in real time. Records showed all staff working at the maternity unit had completed their emergency skills and drills training.

Medical staff received and kept up to date with their mandatory training. Records showed a 100% completion rate for most mandatory training courses.

The mandatory training was detailed and met the needs of women and birthing people and staff. Maternity statutory training was completed over 2 days. Day 1 covered aspects of the Saving babies Lives Care Bundle, for example, reducing preterm birth, smoking in pregnancy and fetal growth surveillance. Day 2 covered infant feeding, perinatal mental health, diabetes, and 2 hours of e-learning.

Records showed gaps in compliance to cardiotocograph (CTG) competency 73% (11 out of 15) midwives and 67% (2 out of 3) of doctors had completed the online CTG training package. Cardiotocography (CTG) is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy. This was below trust target of 90%. Staff had been allocated their training slots within the current year, but only 33% of midwives and consultants had attended the fetal monitoring study day, which had been recently reintroduced. Fetal growth monitoring (GAP) training compliance was below trust targets, as 73% (11 out of 15) midwives and 67% (2 out of 3) consultant had received this training at the time of the inspection. Training dates had been set as part of the trust's 2023-2024 maternity statutory training programme to bring all staff up to date. Managers monitored mandatory training compliance and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

**Safeguarding**

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed 100% of clinical staff had completed both Level 3 safeguarding adults and safeguarding children training. This reflected the trust's policy and in the intercollegiate guidelines for safeguarding.

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. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. This was an area of social deprivation, which meant staff often dealt with complex safeguarding referrals. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified, women and birthing people had birth plans with input from the safeguarding team.

The service employed two vulnerable women and pregnant people specialist midwives to support with perinatal mental health and substance misuse. Both worked closely with the named midwife for safeguarding, who was supported by the trust safeguarding lead and a band 6 safeguarding midwife. The service held a monthly multi-professional perinatal mental health clinic.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

**Cleanliness, infection control and hygiene**

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

Maternity service areas were visibly clean and had suitable furnishings, which were clean and well-maintained. Matrons were responsible for monitoring infection prevention control within the maternity unit. The rooms were visibly clean and free from dust. The maternity unit had been refurbished to reflect the latest national standards. For example, in the birthing rooms scavenging (air purifying) systems had been installed to ensure women, pregnant people and staff were not exposed to nitrous oxide, which is a gas used in labour to reduce pain. However, staff we spoke to were unaware if these were used in labour because the service had a very small birth rate.

Cleaning records were up-to-date and demonstrated that all areas were checked and cleaned regularly. The service performed well for cleanliness; the maternity unit had a trust award for infection prevention control. Staff had access to personal protective equipment when required and antimicrobial hand gel was available throughout the unit.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last year compliance was consistently above 95%.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

**Environment and equipment**

**The maintenance, and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the design of the birth rooms was outdated and needed to be refurbished.**

The Clacton Maternity Unit was housed in Clacton Hospital and had been there for 40 years. The unit comprised of two birthing rooms; various storage rooms; an ultrasound scanning room; consultation rooms for antenatal clinic; a kitchen, and a staff handover room.

Most of the facilities were suitable to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The lift was an essential point of evacuation in the event of an emergency transfer to the main Colchester Hospital during and after childbirth. Last year the lift was out of service for 4 months, which meant the unit could not provide intrapartum care (care during labour). Because of this the risk was added to the trust risk register and service leaders reviewed the servicing of the lift on a regular basis.

The department was spacious and light and met the needs of women and pregnant people requiring antenatal care, although the layout of the 2 birthing rooms looked dated. For example, the birthing room which housed the birth pool was small and the pool was square and could not be accessed from all 4 sides. Environmental checks highlighted areas of the unit which needed to be repaired, such as skirting coming away from the walls and limescale noted on taps in the June 2023 audit.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there was a hoist and pool evacuation nets adjacent to the pool room. Staff completed simulated training on pool evacuation.

Within the maternity unit there was a portable ultrasound scanner, and observation monitoring equipment and resuscitation equipment.

Staff carried out daily safety checks of specialist equipment. Staff stored the resuscitaire (a device used to provide additional support for breathing for newborns and for clinical emergency and resuscitation) and adult resuscitation (crash) trolley in a room opposite the main birth room. Records on the resuscitaire and adult life support equipment showed 100% compliance to staff checks. These were completed daily when the maternity unit was open. We checked the post-partum haemorrhage (PPH) trolley and found the checklist did not reflect the placement of the equipment in the drawers, and the medicines required to reduce bleeding were not immediately accessible. We found the layout of the equipment in the storeroom could delay its access in an emergency. We raised this with managers who responded immediately and implemented a PPH medicines grab box and re-arranged the PPH trolley with clearer labels. Leaders also re-arranged the heavy resuscitation equipment to ensure staff could access it immediately. Leaders told us they would ensure all staff were updated about this via handover and emails.

All equipment was recorded on the trust's asset register, and the estates teams had a programme of visits to test equipment for electrical safety as per the individual equipment's requirements. Equipment was subject to regular electrical safety tests. A new process had been introduced whereby a sticker was added to a piece of equipment to explain when testing was not required. When equipment was faulty staff requested a repair online using the automated service on the estate's helpdesk.

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 whilst waiting for removal.

Service leaders had completed a ligature point risk assessment to determine the likelihood of something being used as a ligature point. Staff received ligature point training and were clear about their responsibilities in terms of monitoring the risks for patients deemed to be at risk of suicide. Hence, the Clacton Maternity Unit was deemed low risk.

**Assessing and responding to risk**

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

# Maternity

This was a low-risk maternity unit, therefore various aspects of maternity care were not performed on site. This included induction of labour, caesarean section, or any major surgical procedure, inpatient care, and neonatal inpatient care.

Leaders tailored services to meet the needs of the local community to help limit the amount of travel to the main Colchester Hospital 18 miles away and to provide a low-risk birth centre with a strict inclusion criteria. Women and pregnant people could have their ultrasound scans, their booking, and all antenatal appointments at the unit, because the service provided 2 consultant led antenatal clinic and a diabetic clinic. Staff could provide vaccinations and postnatal clinics, which included neonatal hearing and other screening. Finally, midwives offered women antenatal and infant feeding classes within the maternity unit.

Staff completed risk assessments for women and birthing people on arrival. They used a recognised tool, and reviewed this regularly, including after any incidents. Staff risk assessed women and birthing people at their booking appointment (first full risk assessment at the beginning of pregnancy) and used the five elements of the 'Saving Babies Lives Care Bundle version 2' which are:

- Reducing smoking in pregnancy
- Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction
- Raising awareness about fetal movements
- Effective monitoring of fetal monitoring during labour
- Reducing preterm birth

Audit data from December 2022 to February 2023 showed the service compliance levels for carbon monoxide (CO) monitoring at booking and 36 weeks was at 80%. Appropriate actions were taken by managers to ensure working equipment was available, and to embed the CO assessment in practice.

Staff followed the 'Booking appointment and antenatal risk assessment' standard operating procedure to ensure women and pregnant people were safe to give birth at the maternity unit. Staff completed risk assessments on women and pregnant people at booking which were reviewed at 36 weeks and every appointment after until they gave birth.

Women and pregnant people with medical conditions, previous caesarean, complications of pregnancy and complex mobility needs were referred to the main Colchester Hospital for their childbirth experience to ensure they were near theatres, and the neonatal unit.

The service did not have a maternity triage as this was situated at the main Colchester Hospital. The service did not have a designated triage telephone service. Anyone requiring advice or care called the maternity helpline between 8am and 8pm, which was manned by midwives. They could also call the delivery suite, the birth centre, or the obstetric emergency unit if they felt concerned. The contact details were on the back of the paper maternity care records provided at booking.

The service provided a day assessment clinic for local women and pregnant people who felt unwell but were not at high risk of labour. For example, midwives could provide additional blood pressure monitoring, ultrasound scans and other screening tests like blood and urine checks.

# 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 4 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. However, because this was a small unit, leaders did not monitor compliance to MEOWS at Clacton Maternity Unit.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. Because the maternity unit served a vulnerable population who found it harder to access the main hospital for low-risk issues, service leaders had a standard operating procedure (SOP) to complete a 1st episode review of reduced fetal movements using a cardiotocograph (CTG). The SOP contained clear instructions on the process. This included staff at the main site completing a full telephone assessment, which was recorded on the patient record. If the women or pregnant person fitted the low-risk criteria, then a CTG was performed at the maternity unit to provide women and pregnant people with reassurance and when necessary, transfer them to the Colchester Hospital site.

The guideline was clear and stated 'When the assessing midwife has concerns about the fetal heart rate in labour, care should be discussed with the obstetric registrar and transfer to delivery suite (at Colchester Hospital) facilitated by ambulance. CTG monitoring should **not** be performed'. This was because the maternity unit was not designed to treat risks associated with childbirth.

Staff described labour care as a 'pop up' birth centre. Community midwives were called to care for women and pregnant people during childbirth. Labour ward co-ordinators were made aware of all booked maternity unit and home births within the area to make sure there were enough staff available. Women and pregnant people called either the main hospital or their community midwife when they suspected they were in labour and were assessed over the phone. Community midwives could attend the home to review people or invite them to go straight to the Clacton Maternity Unit.

Once women were in established labour staff followed a standard operating procedure for monitoring fetal wellbeing during childbirth. Staff used intermittent fetal monitoring equipment called sonicaids to listen to the fetal heart every 15 minutes, which was plotted on a Partogram. This is a graphical record of key maternal and fetal progress during labour. As Clacton Maternity Unit is a standalone birthing unit, two midwives were present at all births, this enabled midwives to act as fresh eyes and ears to make sure fetal wellbeing was accurately plotted.

Staff knew and understood the risks associated with sepsis. Staff received sepsis training and accessed the Antenatal Intrapartum and Postnatal Management guideline for sepsis. Because of the low number of births, the service did not audit compliance and did not have any reported cases of sepsis from April 2022 to March 2023.

Staff knew about the risk of post-partum haemorrhage (PPH) and followed a nationally recognised pathway to call for help and start treatment whilst awaiting transfer to the main Colchester Hospital.

Service managers completed a 'snapshot audit of 12 births which had occurred at Clacton during 2023. This looked at reasons for transfer from the maternity unit during childbirth. Out of the 12 births reviewed, 5 were transferred, 4 of these were for neonatal reasons and 1 for maternal reasons, where a PPH had occurred.

# Maternity

Staff were meant to follow the nationally recognised Local Safety Standard for Invasive Procedures (LOCSSIPS) safety checklist when using invasive procedures like suturing after childbirth. LOCSSIPS are designed to ensure they follow safety barrier measures to minimise risks to patients. However, a recent audit, from May to June 2023 showed that out of 3 births requiring suturing only 1 followed the correct process. Because of this community leaders were sent emails to remind their teams to follow the LOCSSIPS standards following every birth.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by healthcare professionals and was used to share information between care givers. A review of 5 transfers evidenced staff used a situation, background, assessment, recommendation (SBAR) format to hand over care to Colchester staff. SBAR is a tool used to facilitate prompt and appropriate communication between wards and services. The service evidenced a 100% compliance with SBAR handover of care.

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

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. Staff used the Whooley questions to screen for depressive disorders, at booking and at various stages of pregnancy. Any woman or pregnant person identified as suffering from major depressive disorders were referred to the specialist multi-professional perinatal mental health team for additional care.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Staff completed APGAR scores at birth and at intervals. This assessment included the baby's appearance, pulse, grimace, activity, and respirations. Any baby which required additional observations were transferred to Colchester Hospital. Because of the low birth rate at Clacton Maternity Unit, managers did not complete neonatal early warning score (NEWT) audits.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge. Women and pregnant people who used the service, were discharged as soon as they recovered from childbirth. Midwives completed discharge summaries and handed care over to the community teams, local health visitors and the GP.

**Midwifery Staffing**

**The service had trust wide issues with recruitment and retention and sickness of staff. At Clacton Maternity Unit, staffing levels matched the planned numbers at the maternity unit.**

Clacton Maternity Unit was staffed by 15 midwives and 11 support workers. Clinics ran Monday to Friday 8am to 5pm. Community midwives used the Clacton Maternity Unit as a base and offered women postnatal appointments at Clacton. Community on call midwives had round the clock access to the birth rooms.

# Maternity

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings.' A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. From January to June 2023 there were no red flag incidents. Leaders told us women and pregnant people would not be birthing at Clacton if 1:1 care was not available. Clacton did not facilitate induction of labour.

It was unclear how managers accurately calculated and reviewed the number and grade of midwives, and healthcare assistants needed for each shift in accordance with national guidance. The Midwifery Workforce Review dated June 2023 was completed by the director of midwifery. The trust wide data reflected the 2 main hospital sites and there was no reference to the Clacton Maternity Unit.

They completed a maternity safe staffing workforce review in line with national guidance in April 2023. This review recommended 14.33 whole-time equivalent (WTE) midwives Band 5 to 7 compared to the funded staffing of 15 WTE, which meant there was no shortfall of staff at Clacton.

However, there was a supernumerary shift co-ordinator on duty at Colchester Maternity Unit, around the clock who had oversight of the staffing, acuity, and capacity across Colchester and Clacton Maternity Units and reviewed staffing every 4 hours. A cross site safety huddle took place daily on both sites at 8.30am. Clacton Maternity Unit leaders accessed the huddle remotely, so knew what was going on elsewhere. The maternity unit was small with minimal births; therefore, it did not warrant a supernumerary co-ordinator.

Staff followed an escalation process if actual staffing levels fell short of the requirements**.** In case of shortfall against planned staffing, leaders redeployed staff to support any maternity area in line with the escalation policy. If additional staff were needed, they were taken from other areas, including via on-call availability.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice and expected to work in areas unfamiliar to them.

The service did not have high vacancy rates, turnover rates, and high use of bank nurses. However, sickness rates were inconsistent. Sickness rates from January to May 2023 for maternity support workers were at 24 hours or below. However, for June 2023 the sickness rate rose to 88 hours.

The total sickness rate for midwives from January to May 2023 was at 655.75 hours, and records showed that the highest rates were January 2023 where managers recorded 246 hours of sickness.

There was no vacancy rate for maternity support workers and the current establishment of midwives was at 13.75 WTE and currently staffed at 11.84 WTE. A recruitment campaign had been launched to fill the 1.86 WTE deficit to improve midwifery staffing.

The service did not use agency staff. 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 staff were competent for their roles. The practice development and recruitment and retention midwife worked together to support staff competencies. New starters were placed on an induction programme. This had

been recently reviewed trust wide due to concerns raised at the main Colchester site. Newly qualified midwives were given a preceptorship competency pathway, which included competency documentation and peer support. Newly qualified midwives told us they felt well supported at Clacton and looked forward to working there because they had more time to develop their competencies.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Records showed 100% of midwives and 89% of healthcare assistants had received their annual review.

**Medical staffing**

**The service had enough medical staff with the right qualifications, skills, training, and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. There were 3 consultants assigned to antenatal clinics at the Clacton Maternity Unit. The clinics were tailored to meet the needs of the local population and to ensure vulnerable women and pregnant people engaged with the service.

The service had low vacancy, turnover and sickness rates for medical staff. There were limited clinics, and this was not a 24-hour consultant led service.

The service had low rates of bank and locum staff. Records showed service leaders made sure locums received a full induction and completed an induction checklist.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. This was a small service, which ran 2 consultant led clinics per week and one diabetic clinic per month and one joint perinatal mental health clinic per month.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they felt supported to do their job through clinical supervision and were given the opportunities to develop. Records showed 100% of consultants had received their annual appraisal.

**Records**

**Staff kept detailed records of women and birthing people's care and treatment most of the time. Records were clear, up to date, stored securely and easily available to all staff providing care. However, audits were not site specific.**

Women and birthing people's notes were detailed, and all staff could access them easily. The trust used an electronic records system with additional paper records like observation sheets and records during labour which were then scanned onto the electronic patient record system. We reviewed 6 electronic records and found records were clear and complete. Service leaders were currently reviewing different digital systems because they planned to update their system to bring it in line with national standards.

# Maternity

A records audit dated December 2022 to Feb 2023 across two sites which included Clacton Hospital found gaps in record keeping; for example, only 13% of records showed evidence the personal care plans had been discussed and documented, and only 50% showed evidence of fetal monitoring discussions with women. It was unclear from the audit how many Clacton only records had been reviewed.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records most of the time. Service leaders told us some community midwives had difficulty accessing the digital system from remote locations due to connectivity and this was recorded on the services internal risk register.

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

**Medicines**

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

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines which needed to be administered during their admission. We reviewed 3 prescription charts and found staff had correctly completed them.

Every new midwife or nurse employee completed a medicines management training module as part of their trust wide induction.

Staff completed medicines records accurately and kept them up to date. Medicines records were clear and up to date. Staff completed medicines cards. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff reviewed each person'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 looked at.

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.

Staff learned from safety alerts and incidents to improve practice.

**Incidents**

**The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured actions from safety alerts were implemented and monitored. However, the data was presented 'trust-wide' which made it difficult to review.**

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. We were unable to review any incidents for several reasons. The trust did not separate trust wide maternity services incident data, which made it hard to extract accurate information for the Clacton Maternity Unit. Serious incident data did not state at which site the incident had occurred and although it was obvious most did not occur at Clacton the recording of incidents at Clacton was unclear, therefore it was difficult to look at no or low harm themes at the location.

Managers reviewed incidents on a regular basis so they could identify potential immediate actions. Staff told us if an incident occurred, managers would complete a rapid review of practice to help identify potential gaps in care to inform learning and improvement. Records confirmed there were no incidents open for more than 60 days.

Managers investigated incidents thoroughly. They involved women, birthing people, and their families in these investigations. There had not been any Health Service Investigation Branch (HSIB) reported incidents. Staff told us they had not had any serious incidents at Clacton Maternity Hospital within the reporting period, August 2022 to July 2023

Managers shared learning with their staff about never events which happened elsewhere. The service had a team of people who were responsible for sharing learning from incidents with staff.

Staff reported incidents clearly and in line with trust policy. Staff reported incidents via the trusts internal electronic system and showed us how they accessed this information.

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

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to the care of women and birthing people.

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medicines incident. Managers debriefed and supported staff after any serious incident.

## Is the service well-led?

**Good**

We rated it as good.

**Leadership**

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

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them. These were shared with staff.

One matron managed the Clacton Maternity Unit. One matron had overseen the service for a long period of time and the other matron was recently appointed to the service from the main Colchester site. Matrons were currently line managed by the recently appointed director of midwifery because the trust was waiting to appoint a new head of midwifery for Colchester and Clacton Hospitals.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

They supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

The maternity safety champions and non-executive director (NED) supported the service. The NED chaired quality and safety committee and was the maternity safety lead for the board. There was a set programme of visits to each location and the next planned one for Clacton was August 2023. The NED was a member of the East of England safety forum and was able to provide context of service provision at Clacton and Colchester Hospitals. Trust wide there was an improvement programme called 'Every birth every day which provided assurance reports to the trust board.

The chief nurse and the director of midwifery were maternity safety champions. The chief nurse visited Clacton most weeks and had met maternity staff working at Clacton. The safety champions told us there were plans to redevelop the Clacton maternity services, which were reviewed as part of the quality and safety committee. However, the chief nurse was due to leave, and their replacement would need to have exposure to services at Clacton to continue the planned redevelopment and engagement with staff.

**Vision and Strategy**

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

The vision and strategy for the LMNS (local maternity and neonatal system) were focused on sustainability of services and aligned to local plans within the wider health economy. The vision and strategy was implemented in 2022 and stated, 'Today's maternity and neonatal care, tomorrow's health population'. System wide there were approx. 9,000 births born in Suffolk and northeast Essex every year, overseen by a local LMNS. The aim of the LMNS was to ensure all service users had access to the same high-quality care, wherever they lived.

# Maternity

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations. Suffolk and northeast Essex is a diverse area, with pockets of affluence and pockets of high deprivation. This influenced the outcomes of pregnancy and childbirth. Systems had identified diverse outcomes within the patch. For example, very low birth weight, teenage pregnancy, smoking during pregnancy, and preterm birth. These were considered priority areas for local systems to address and benchmark levels against national outcomes. The strategy focused on reducing inequalities which required targeted care pathways and working with certain communities where risk factors were higher.

The strategy was based on five outcome statements as follows:

1. We received excellent, high-quality care throughout our pregnancy, childbirth, and early days of parenthood, which helped us to feel safe, and to be safe and well.
2. We knew what was happening throughout our pregnancy, childbirth, and early days of parenthood, we felt heard, trusted our care givers, and were involved in all decisions.
3. Our care was tailored to our individual needs, culture, and circumstances, with our family involved in decisions and care.
4. We felt prepared for becoming new parents, knew how to care for our child, and knew where to go for help when we needed it.
5. Care givers were kind, explained everything in clear and easily understood language, and were on our team, helping us to have a positive experience. outcomes.

Leaders reviewed the strategy every quarter and updated the board on progress.

**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 felt respected, supported, and valued**.** Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff and students told us they loved working at the unit.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture which 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.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said this helped them understand the issues and to provide better care.

# Maternity

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. 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 which 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 and 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. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

**Governance**

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

Leaders operated effective governance processes, throughout the service and with partner organisations. Service leaders monitored key safety and performance metrics through a series of well-structured governance meetings. Leaders created the 'Every Birth Every Day (EBED)' programme board, which was a subgroup of the Executive Management Committee and was accountable to the trust board.

The purpose of the EBED was to give assurance that the trust was fulfilling their responsibilities in line with national recommendations by ensuring strategic alignment of the delivery of the maternity transformation programme with a focus on the delivery of safe care across clinical pathways, support a positive experience for pregnant people and develops a safe and positive working environment for all staff.

The EBED Programme Board monitored work streams and divisional actions required to respond to national, regional, and local improvement priorities. These included, but were not limited to:

- The Kirkup Report
- The Ockenden Report
- Clinical Negligence Scheme (Maternity Incentive Scheme)
- Care Quality Commission inspection reports
- Continuity of Carer Implementation

The EBED programme met every month. The chair of the board had the authority to exercise an emergency or urgent decision where a particular issue required a response that could not be deferred to the next meeting. In the July 2023 report we found no direct reference to the Clacton Maternity Unit.

The EBED had 5 workstreams, workforce, safety culture, governance, organisational development and communication and engagement.

In February 2023 national maternity improvement advisors completed a deep dive into the governance systems and processes at East Suffolk and North Essex NHS foundation trust. A report was submitted to the trust and maternity service leaders and made 65 recommendations. As a result, leaders developed an action plan to address the recommendations. Records from July 2023 showed 12 recommendations related to the structure and makeup of the governance team, which was currently under review and 11 related to actions which required trust support. There were 4 recommendations waiting for additional advice from the obstetric maternity improvement advisor. Fourteen of the recommendations had been completed.

Records showed the actions needed to be separated into different working groups and a restructure of governance to move to Quality and Safety required more staff.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date.

**Management of risk, issues, and performance**

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

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

Managers and staff carried out a programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

**Information Management**

# Maternity

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The service collected reliable data and analysed it**.** 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.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure**.** Data or notifications were consistently submitted to external organisations as required.

**Engagement**

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

The maternity service established systems for engaging with internal and external stakeholders. Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to improve on patient care by gathering and incorporating feedback from both patients and staff. The trust had engaged the MNVP to explore health inequalities across the geographical area and to work in partnership with the Local Maternity and Neonatal System (LMNS) to look at funding to support the needs of the service to drive improvements for women and birthing people. The LMNS plays a key role in sharing learning and good practice across the region to promote safe care and support for women and birthing people.

Leaders understood the needs of the local population which included women and birthing people living in rural locations, families on low incomes, a high number of safeguarding cases. The service did not have a continuity of care team; however, there were other vulnerability teams which focused on women who were socially deprived. Leaders recognised more needed to be done to reshape the service to accommodate those women who were socially deprived and tailor services to meet their needs.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity.

Staff at the trust worked closely with the local authority, integrated care board (ICB) and other external stakeholders to improve outcomes for pregnant women, birthing people, and their families. For example, the trust had taken a family approach to smoking cessation and had secured funding with the ICB to support families including women and birthing people to cease or reduce smoking.

**Learning, continuous improvement and innovation**

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

# Maternity

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

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies.

## Areas for improvement

Action the service 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:**

**There were no Must actions identified duirng this inspection.**

**Action the trust SHOULD take to improve:**

**Clacton Maternity Unit - Maternity**

- The service should ensure that all clinical staff complete their cardiotocograph (CTG), fetal growth and fetal monitoring training within trust time frames.
- The service should ensure that all maternity support workers receive their basic life support training within trust time frames.
- The service should ensure that it completes all actions highlighted in environmental audits to ensure that the premises reflects national guidance.
- The service should ensure it specifies which location incidents occur at when submitting trust wide National Reporting Live System (NRLS) incident reporting, to make it clear to regulators at which site incidents occur.

# Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector and two midwifery specialist advisors. Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care oversaw the inspection team.