Estates

Many maternity services inspected were appropriate for people's needs and kept them safe in line with national guidance, but this was not always the case. Too many maternity units are currently not fit for purpose, lacking space, facilities, and in a small number of cases, the appropriate levels of potentially life-saving equipment.

We are concerned about the serious safety risks this presents for women and babies. Common issues found on inspections included:

- a lack of space to accommodate necessary equipment and meet people's needs
- generally ageing environment and facilities, including issues with temperature and ventilation
- a lack of capacity in theatres
- a lack of adequate bereavement provision.

As well as presenting risks to women, unsuitable maternity environments can make it difficult for staff to provide the level of care they want to deliver. As highlighted by the Royal College of Midwives, a human factors approach can help improve safety in maternity care and is about "making the right thing to do, the easiest thing to do". It identifies a range of factors that affect safety and performance, such as:

- equipment should be easy to use and staff should receive training on how to use it
- noise levels and distractions should be monitored to help create a productive working environment
- working patterns, breaks, staff access to nutrition and hydration should be considered to prevent fatigue.

Research has also highlighted the benefits of shared social spaces, where staff can debrief and decompress after complex clinical situations.

However, as we highlight in this section, we found issues with equipment and ward environments which affected both staff and women using services.

Access to equipment and theatres

It is vital that maternity services have the right amount of equipment, and that all equipment is kept in good condition to maximise outcomes for women and babies. We were therefore concerned to find that a small number of services were missing required equipment, including a shortage of cardiotocograph machines used to measure babies' heart rates. Worryingly, we also found a lack of resuscitation equipment at several trusts. While there are no national guidelines for the number of standard items of resuscitation equipment that should be available, NICE guidance outlines that all birth settings should have facilities for resuscitation. These issues could have a devastating impact on neonatal and maternal outcomes.

We also issued Warning Notices on some trusts that failed to carry out regular checks on emergency equipment or did not adequately document that equipment had been checked. In addition, at one service we found a lack of clarity among staff about who was responsible for ensuring emergency equipment was safe and ready to use. This meant it was often misplaced or untidy. Conversely, only a few services had invested in replacement programmes for ultrasound scanners, neonatal resuscitaires and cardiotocography equipment to minimise these risks.

We also heard concerns about call bells. Although we found call bells were within easy reach in most maternity services and staff responded quickly when called, in a few services they were not working or only working intermittently. One antenatal ward did not have a call bell system in place. In other instances, we observed staff being slow to respond to buzzers. One person told us about having to verbally call for help when in distress or during an emergency as the call bell had failed and staff did not respond. Another person told us they were not able to reach their call bell with the sides up on their bed.

As well as a lack of equipment in some services, we also found issues with theatre capacity. It is essential that maternity services have access to dedicated operating theatres for planned and emergency caesareans as well as obstetric surgical procedures. All services we inspected had at least one dedicated obstetric theatre located within the maternity department, in line with national guidance. Most services had at least 2 operating theatres dedicated to maternity services, which were available for both planned and emergency caesarean sections as well as obstetric surgical procedures. One service responded to our recommendations made in a previous report by improving and future-proofing its maternity theatre provision.

However, in some cases, maternity theatres were out of use because of concerns about space and infection control. This meant that caesarean sections took place in the main theatre, and women and their partners had to walk through corridors and surgical wards for their procedure.

We found that where services did not have access to at least 2 dedicated maternity theatres, there were significant risks of delays to emergency caesarean sections due to lack of theatre capacity. Some trusts managed this risk by having separate surgical lists in the main hospital theatres for planned caesarean sections, keeping a maternity theatre free for emergencies.

Unsuitable ward environments

Many women told us they were unhappy with the hospital environment. Some concerns related to sensory issues, for example people complained of noisy and sometimes overheated wards. Additionally, we heard about unsuitable spaces for labour and postnatal recovery, as well as a lack of bed space.

Several people told us about uncomfortable ward environments, which were stuffy and unpleasant to be in. Fewer people reported feeling cold, but one person described a negative experience when they were placed in a storage cupboard with their baby because there was no space on the postnatal ward:

After my emergency c-section the ward was full. I was freezing from the operation and me and my baby were wheeled into a storage closet with air conditioning blasting. My baby then became cold and unwell and needed to be put under a lamp once we got into the ward... I became deeply distressed and wanted to leave.

Issues with ventilation or a lack of scavenging systems to remove harmful residual medical gases from the air meant that Entonox (as the trade name for gas and air) could not be used in all birthing rooms at one service. National guidance states that Entonox should be available for pain relief in all settings and our 2022 Maternity survey found it was used by 76% of women.

Through our Give feedback on care service, several women explained how the lack of space on wards affected their experiences. We heard of women in labour being placed in the same ward as postnatal patients, or postnatal patients being placed in a triage area because of a lack of appropriate space:

While being in Ward 9 before having my baby I was on the same ward as women who have had their babies already, which to me is unacceptable. I had bad contractions back then and was in pain which is not ideal for either me or women who've had their babies to be in such an atmosphere. The reason I was there was because there was no space in the labour ward, which is what I was told, and I find that appalling.

Furthermore, like other parts of the NHS, maternity services are under increasing pressure and sometimes there is more demand than a service has capacity for. Maintaining good and efficient flow requires a trust-wide culture of safe and efficient patient care. During some inspections we saw how staff spent time dealing with issues around flow in the maternity service specifically, which were not part of the wider trust's capacity management. We suggest maternity services should be included as part of the whole trust-wide capacity and flow processes so that appropriate skills and support can be obtained, releasing clinical staff to focus on managing clinical risk.

Several maternity services had completed self-harm and ligature assessments within all environments to meet the needs of pregnant women at risk of self-harm. Some services coupled this with further actions aimed at reducing risks that were identified, such as staff training around caring for women at risk of suicide.

National guidance on the design of maternity units stresses the importance of security to protect babies and families. We noted issues related to tailgating, whereby it was possible for people to enter a unit without passing any sort of security clearance by directly following close behind someone who had been admitted, which posed a clear safety risk.

Privacy, dignity and hygiene

The experience of giving birth can leave women feeling at their most vulnerable and it is therefore important that ward environments are set up to protect their privacy and dignity. This includes having easy access to ensuite bathroom facilities. While most services inspected had provision for women to have access to ensuite bathroom facilities during labour and postnatally, we inspected some services with limited access to toilets and showers. Some services lacked ensuite rooms in delivery suites, meaning women had to walk through a ward to use communal toilets and showers during labour.

Issues with ward layouts and a lack of space also meant there was a risk that people could overhear confidential conversations. For example, one service did not have a dedicated space for staff to discuss sensitive issues with women, making it difficult to maintain confidentiality during handovers to the birth centre. As highlighted in the triage section, we found that cramped triage areas also compromised women's privacy.

Women also told us about overcrowded and cramped ward environments, which meant they did not have enough space to get changed or attend to their babies. Some people said that beds were placed very close together on wards, which made it difficult to move around with reduced mobility, and again, made it difficult to have conversations in private. This led us to be concerned that people sometimes found it difficult to get the rest and privacy that they needed during their stay at the hospital.

Many women complained about a lack of hygiene in maternity units. For example, we heard several comments about inadequate toilet and shower facilities. Some of the comments related to unclean and dirty bathrooms, such as blood on the floor that had not been cleaned, or urine samples being left in the toilets. Several people also expressed concern about the hospital's failure to change bed sheets. Some people reported having to lie in blood-stained sheets for hours; in some cases, they said that bed linen was not changed for several days. This is particularly unhygienic, given that they were likely to be still bleeding after giving birth and wished to rest in a clean bed. Lack of bedding was also a concern. In one case, someone was asked to bring their own pillow, as the hospital was under-resourced and could not supply one:

> "I had to take my own pillow into theatre for the operation (they asked me to as they had none). This is NOT a reflection on the staff – more on the under-resourced NHS."

Poor hygiene standards sometimes resulted in a lack of dignity for women, who told us that a hospital's failure to clean facilities meant that partners were sometimes called on to clean up, in the absence of staff, or to help change bed sheets due to understaffing:

> "No-one changed the mat on my bed for hours which was soaked in blood, plus no-one changed my sanitary pad at all the whole time I was there. So my husband had to change it, which shouldn't really happen."

Bereavement provision

Pregnancy loss is devastating for parents. Through the inspection programme, we observed the impact of different ward environments and bereavement provision on this experience. We found a high level of variability in the quality of bereavement suite facilities. Where they were good, refurbishment was often funded by hospital charities or community fundraising.

To reduce the potential for bereaved families encountering or overhearing new and expectant parents, national guidance is clear that families should have a private and comfortable space to grieve their loss. We found that most maternity services had a dedicated space for women and families, often located in a private area away from labour and antenatal wards. Some services had clothing designed for very small babies and cold cots so that parents could spend time with their babies and say goodbye.

However, where bereavement suite facilities were available, they were not always in line with the National Bereavement Pathway recommendations. For example, we inspected several services whose bereavement suites were not soundproofed. In one case, where the bereavement rooms were in the labour ward, bereaved parents experiencing baby loss were being cared for in the middle of a labour ward surrounded by the sights and sounds of newborn babies. In 2 services, the location of bereavement suites was within antenatal and early pregnancy units, with bereaved and grieving families meeting pregnant women in attendance. The location of these facilities was challenging for grieving women and their families and did not adhere to current national guidelines.

Several people in these situations explained how the negative psychosocial impact of antenatal environments made their experience worse. Numerous people described having to sit in waiting areas with other 'happily' pregnant women as a triggering and traumatic experience. Many women felt that these locations were unsupportive of their loss, further highlighting their emotional pain and adding to the difficulties they were yet to face.

We recommend DHSC:

- Provides additional capital investment in maternity services to ensure that women receive safe, timely care in an environment that protects their dignity and promotes recovery.
- Works with NHS England to ensure that this additional investment is ring-fenced and maternity services receive the investment they need.