University Hospitals of Derby and Burton NHS Foundation Trust

Queens Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Queens Hospital

Requires Improvement 

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

We inspected the maternity service at Queens Hospital as part of our national maternity services 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.

Queens Hospital Burton is the principal provider of acute hospital services for the residents of Burton upon Trent and surrounding areas including South Staffordshire, South Derbyshire and Northwest Leicestershire. It provides a range of maternity services including both antenatal and postnatal ward as well as an antenatal clinic. There are approximately 2700 deliveries each year, with caesarean sections and options for pool-based birth.

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.

The trust is part of the University Hospitals of Derby and Burton NHS foundation trust.

We reviewed the rating of the location therefore our rating of this hospital stayed the same

Queens Hospital is rated requires improvement in Safe and Well-Led and good in Effective, Caring and Responsive.

We also inspected 1 other maternity service run by University Hospitals of Derby and Burton NHS Foundation Trust. Our reports are here:

Royal Derby Hospital - https://www.cqc.org.uk/location/RTGFG

How we carried out the inspection

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

We visited Maternity assessment Unit (Triage) Labour ward / Delivery Suite the antenatal and postnatal wards.

During the inspection we spoke with 20 staff including the Head of Midwifery, Obstetricians, Doctors and Midwives. Attended handover meetings and reviewed 6 records.

We received more than 307 'give feedback' on care forms through our website, with 58% (n177) of the feedback being positive with the remainder 42% (n130) being negative. Feedback received indicated women and birthing people had mixed views about their experience. There were themes around negative experiences and interactions with staff, lack of

Our findings

consent, staff causing women to feel anxious or burdensome, long wait times and limited information on their treatment. We received feedback about women and birthing people reported being asked to remain at home instead of attending the Maternity Assessment Unit (MAU) but after they had attended, they were told they should have attended earlier. Positive comments described staff as knowledgeable and attentive, with the ability to act decisively when required in order to ensure women and babies were kept safe.

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

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

Maternity

Inadequate 

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

- Staff were not compliant with up-to-date training in key skills and were not always kept up to date with training on how to recognise and report abuse. Staff did not always complete risk assessments for each woman or birthing person in order to remove or minimise risks. Additionally, staff did not always recognise and report incidents reducing the ability to identify learning from incidents.
- The service did not always control infection risk well. Staff did not always follow control measures to protect women and birthing people, themselves and others from infection and managers did not regularly complete cleaning audits.
- There was no stable leadership team, with high unplanned turnover and/or vacancies. This meant leaders did not have the necessary capacity to lead effectively. The approach to service delivery and improvement was reactive and significant failures in audit systems and processes were impacting on the management of risks and issues.
- Staff did not always feel respected, supported, and valued. There were trends in feedback from women and birthing people where they were not treated with kindness or respect during interactions with staff or when they were receiving care and treatment.
- Limited equipment, facilities and ongoing building maintenance had impacted on patient safety and care and was not always safe.

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

Is the service safe?

Inadequate 

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

Mandatory training

Staff did not always complete mandatory training developing their knowledge, skills and experience to enable them to deliver good quality care. Staff were not always supported to participate in training and development, or the opportunities that wereoffered did not fully meet their needs.

Staff were not up to date with their mandatory training. Records showed that 55% of midwifery staff and 86% of medical staff had completed the required mandatory training courses against a trust target of 90%. Fifty-four per cent of staff had completed cardiotocograph (CTG) training, 60% had completed skills and drills training and 60% had completed neonatal life support training.

Staff were required to complete the trusts mandatory training programme to ensure staff had the skills and experience to enable them to deliver good quality care, however staff did not always complete it. Staff were required to complete Practical Obstetric Multidisciplinary Training (PrOMPT) once a year. Data from the maternity specific training report

showed compliance with PrOMPT was low. As of July 2023, at Queens Hospital showed, 73% of obstetric consultants, 41% of obstetric trainees, 63% anaesthetic consultants, 35% anaesthetic trainees and 60% of midwives were compliant with yearly PrOMPT. This meant the service could not be assured staff had the appropriate skills to keep women and birthing people safe.

At the time of the inspection we were not provided with pool evacuation training compliance rates as part of the submitted data we were not provided with pool evacuation training compliance rates as part of the submitted data. We were therefore not assured that staff had completed skills and drills in order to ensure they could safely evacuate a service user from the pool in an emergency. Following the inspection, the trust provided pool evacuation training data which showed 16/104 staff had completed pool evacuation skills training and 25/37 staff receiving a pool evacuation training presentation on or before the inspection on 22 August 2023. Following the inspection the trust provided data showing improved training compliance.

Staff compliance with yearly fetal monitoring training and competency assessments was low. Data from the maternity specific training report showed, as of July 2023, compliance at Queens hospital was: 45% of obstetric consultants and 54% of midwives were compliant with yearly fetal monitoring training and competency assessments. This meant the service could not be assured staff had the appropriate skills to identify and appropriately escalate deterioration in fetal health.

In an attempt to improve staff training compliance, the service offered optional extra bank payments for staff to complete mandatory training in their own time and away from clinical duties. Following the inspection the trust took additional measures to improve staff training compliance by offering additional spaces to staff on training courses as well as providing additional training courses.

The service allocated study days throughout the year and organised training sessions with a mix of staff to ensure training was multi-professional simulated obstetric emergency training.

Safeguarding

Staff had not always kept up to date with training on how to recognise and report abuse. Additionally, the trust did not have an up-to-date baby abduction policy.

There was insufficient attention to safeguarding children and adults training. Staff had not always kept up to date with training specific for their role on how to recognise and report abuse. Training records showed that 77% of staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. This meant the service could not be assured staff had the appropriate skills to safeguarding vulnerable adults and children.

However, staff we spoke with could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff could identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them, lateral checks would be made, and information could be shared via the Child Protection Information System (CPIS). Staff asked women and birthing people about domestic abuse. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff we spoke with could explain 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.

The service had recently completed a baby abduction drill on 2 August 2023. Fourteen members of staff were involved in the drill, and learning points were identified as a result of the exercise. Staff explained and we saw in the baby abduction policy, how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection. No recommendations following the drill were shared with the inspection team and, the policy had not been reviewed since 2017. Following the inspection, the provider told us they had made progress towards updating their baby abduction policy.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always follow control measures to protect women and birthing people, themselves and others from infection and managers did not regularly complete cleaning audits. However, equipment and the premises were visibly clean.

During the inspection cleaning records were not available in all areas and gaps were found in checklists demonstrating that not all areas were cleaned regularly. An audit of incidents reported by staff showed that medical staff had not always followed infection control principles including hand hygiene and use of personal protective equipment (PPE) as outlined in the trusts policy “National Infection Prevention & Control Manual June 2023”. Additionally, the layout of handwashing facilities in the temporary midwifery assessment unit meant they were not located in all areas where frequent handwashing would be required.

Although there was a process for infection prevention control and hand hygiene audits, data showed monthly audits had not always been completed. Between August 2022 and August 2023 hand hygiene audits on delivery suites were only completed in 4 out of 12 months. However. based on the evidence presented, compliance was above 94%. Following the inspection, the trust told us they had reviewed their hand hygiene governance and audit processes to ensure clear audit processes were in place.

We observed staff cleaning equipment after contact with women and birthing people. Staff cleaned seating areas between use in the antenatal clinic and equipment was visibly clean and ready for use however we noted some inconsistencies in the use of “I am clean” stickers, stickers used to identify when the equipment had last been cleaned. On the day of the inspection, we found the maternity areas were visibly clean and had suitable furnishings which were clean and well-maintained. However, feedback provided by women and birthing people highlighted unsanitary and unhygienic conditions of the shower facilities.

Environment and equipment

Limited equipment, facilities and ongoing building maintenance had impacted on patient safety and care and was not always safe.

The service did not have suitable facilities to meet the needs of women and birthing people's families. During the inspection, we found women and birthing people had limited access to showers whilst admitted on the antenatal and

postnatal ward, there were 2 showers to be shared between 26 beds. Staff we spoke with told us women and birthing people were encouraged to shower with the door slightly ajar due to ventilation issues but there was no privacy/shower curtain to protect their privacy and dignity. Following the inspection the provider informed us they had installed shower curtains in order to maintain the privacy and dignity of women and birthing people.

We found that temporary building renovation was impacting on Queens Hospitals' capacity to provide induction of labour and elective caesarean sections as it was limiting the 6-day service to 4 days a week. Queens Hospital Burton used a risk based system to prioritise women and birthing people's induction of labour and could be completed out of hours if required.

The service did not always have enough suitable equipment to help them to safely care for women and birthing people and babies. We found regular instances of equipment not working when needed, these instances led to staff being unable to effectively monitor babies heart rate. We saw evidence which showed staff could not take newborn babies' temperatures due to limited numbers of thermometers. The trust continued to have software malfunctions with the equipment used to monitor cardiotocography (CTG). The trust were actively monitoring this risk through the trust risk register and business unit and divisional governance meetings, the service had worked with the manufacturer and a software update had been completed. Staff were monitoring and updating systems to minimise the risk of malfunction/ abnormal function. However this relied on human factors and remained a high risk. Additionally, we noted on the antenatal and postnatal ward, that staff had 3 CTG machines to share between 9 service users which could increase the likelihood of delays. Following the inspection, the service sent reassurances they would review the number of thermometers and order additional stock as required.

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

We did not receive reassurance that monthly audits were being completed to ensure that resuscitaires were regularly checked by staff. However, during the inspection, we found that staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment was checked daily and that there were no gaps throughout the month of August 2023.

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

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply. At the time of the inspection staff had access to pool evacuation equipment. Water safety was managed through the water safety group with records and results held on estates computer systems.

Assessing and responding to risk

Opportunities to prevent or minimise harm were missed. Staff did not always complete or update risk assessments for each woman or bithing person and took action to remove or minimise risks. Staff did not always quickly act when women and birthing people were at risk of deterioration.

Leaders did not monitor waiting times to make sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. Arrival times, midwifery and medical reviews were not presented clearly on the triage list increasing the risk that service users would not be assessed within a safe and timely manner. The triage list did not clearly show if the service user had been seen by a midwife or a doctor.

Maternity

Staff did not always escalate concerns when there were signs that the condition of women and birthing people could be deteriorating. Staff used a nationally recognised Modified Early Obstetric Warning Score (MEOWS) tool to identify women and birthing people at risk of deterioration and direct staff when escalation may be appropriate. The trust had completed a recent audit in July 2023 of 20 records to check they were fully completed and escalated appropriately. The audit showed that 75% of MEOWS charts were completed and that only 10% of cases had been escalated correctly, this meant the service could not be assured all women and birthing people at risk of deterioration were escalated appropriately. However, during the inspection we reviewed 6 MEOWS records and found evidence staff had completed 5 MOEWS records escalating concerns to senior staff where appropriate.

There was a risk that opportunities to prevent or minimise harm could be missed. The service relied on staff's clinical experience to risk assess women and birthing people on arrival. There was no formal risk assessment tool in place for maternity triage, this meant women and birthing people were at risk of harm. Staff could not ensure women and birthing people were seen and prioritised in a timely manner depending on their presenting condition.

Staff were not always able to recognise and did not consistently follow ways of working as outlined in trust guidance. This meant that they did not always escalate concerns related to specific risk issues within a timely manner. For example, 54% per cent of staff had completed cardiotocograph (CTG) training and the trust had recently implemented a system to effectively carry out fetal monitoring using the "fresh eyes," approach. 'Fresh eyes' was added to national guidance: Saving Babies Lives Care Bundle version 2 guidance in March 2019. However, at the time of the inspection, staff had not been given any formal training and told us that they did not feel confident in its use. In addition, we found that post-partum haemorrhage (PPH) risk assessments were not being routinely completed by staff as outlined in the trust policy "Postpartum Haemorrhage – Prevention and Management Full Clinical Guideline January 2023."

Following the inspection the trust has told us that they introduced measures to address these concerns. The trust action includes weekly audits of the fresh eyes approach.

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 shared key information to keep women and birthing people safe when handing over their care to others. The care records were paper based and were used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. The trust completed 2 safety huddles each 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. Through both our observations on the day of the inspection as well as staff accounts, we found there was no standardised way to handover such as the nationally recommended information sharing tool such as SBAR, which describes the Situation, Background, Assessment, Recommendation for each person.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed these regularly.

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

Maternity

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.

Midwifery Staffing

Staff shortages throughout maternity, in addition to staff outside of trust training compliance, increased risks to women and birthing people. Staff did not always receive a yearly appraisal to ensure they were competent for their roles.

The service did not always have enough nursing and midwifery staff to keep women, birthing people and babies safe. Data reported to the July 2023 trust board showed during May 2023 there was a rise in red flag incidents during intrapartum care (labour ward). The rise was due to delays in induction of labour processes and an increase in midwifery vacancy rates. The service reported 57 red flags in March 2023, 32 red flags in April and 97 in May 2023 across the trust. The most common red flag incidents were delays between admission for induction and beginning of the process (47% red flags between December 2022 and May 2023), delivery suite coordinator not being supernumerary (19% red flags between December 2022 and May 2023) and missed or delayed care (19% red flags between December 2022 and May 2023).

Managers accurately calculated and reviewed the number and grade of midwives, midwifery assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance between November 2020 and January 2021. This review recommended 130.15 whole-time equivalent (WTE) midwives compared to the funded staffing of 129.34 WTE, a shortfall of -0.82 WTE staff.

The number of midwives and healthcare assistants did not always match the planned numbers, with vacancy rates at 14% (38.34 WTE) as recorded in March 2023, with maternity leave and sickness rates adding a further 9% (23.7 WTE) reduction to staffing levels. In order to address staff shortages, the trust used bank staff when to ensure safe staffing levels were maintained.

The ward manager could adjust staffing levels daily according to the needs of women and birthing people. The service had a daily staffing meeting to review staffing that day and upcoming days across both sites. Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

Managers supported staff to develop through yearly, constructive appraisals of their work however 79% of staff had completed an appraisal which is outside of the trusts target of 95% compliance. A practice development team supported midwives. The team included 2 practice development lead midwives with one situated at Queens Hospital.

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 a good skill mix and availability of medical staff. There were enough medical staff to keep women and birthing people and babies safe in line with Royal College of Obstetricians and Gynaecologists guidance. The medical staff matched the planned number. The service had low vacancy rate of 0.24 vacant full-time consultants and 0.76 vacant full time middle grade doctors. They carried out a twice daily ward round.

Maternity

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work.

The service had a consultant on call during evenings and weekends, however they were responsible for antenatal, postnatal and gynaecology emergency theatre which could impact on their availability. Following the inspection, the service had reviewed the current on call systems and reported it would be unlikely gynaecology would impact on obstetrics and could request additional assistance if required. Additionally, the trust confirmed plans were in place to audit the responsiveness of consultant and medical members of the team to ensure services could be provided safely in addition to adapting escalation pathway to ensure a detailed process is in place.

The trust had not completed an audit of the maternity triage unit to review waiting times following a request for a medical staff member to attend, however staff told us it was sometimes difficult to have a patient reviewed in a timely manner if the doctors were not always available.

Records

Staff did not always complete risk assessments and keep documentation in patient records up to date. Queens Hospital used a mix of paper and electronic patient record systems. Records were stored securely and easily available to all staff providing care.

Staff did not always follow integrated birth plans or actions outlined in complex risk assessments as outlined in patient notes and has previously led to incidents resulting in patient harm.

Queens Hospital used a mix of paper and electronic patient record systems. All staff had access to women and birthing people's notes. We reviewed 6 paper records and found records had not always been in line with trust policy, for example only 2 out of 6 risk assessments had been completed for the management of women and birthing people who experienced a post-partum haemorrhage following their birth.

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

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 that needed to be administered during their admission. We reviewed 2 prescription charts and found staff had correctly completed them.

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 checked.

Staff completed medicines records accurately and kept them up to date. The service used a paper based prescribing system. Midwives could access the full list of midwives’ exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted or when they moved between services. Medicines recorded on both paper and digital systems for the 6 sets of records we looked at were fully completed, accurate and up to date.

Incidents

Staff did not always recognise and report incidents. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was too slow. There was little evidence of learning from events or action taken to improve safety, managers did not always ensure learning from incidents was embedded to prevent re-occurrence of similar incidents.

Staff did not always report incidents in line with trust policy. For example, the Major Obstetric Haemorrhage (MOH) paper to the executive leadership team in August 2023 showed 42 cases of MOH which occurred in May 2023 across the trust (29 at Royal Derby Hospital and 13 at Queens Hospital Burton). However, only 17 were reported through the trust electronic incident management system. To mitigate the risk of low incident reporting, as of August 2023 the service had a weekly triangulation meeting with the digital midwife and maternity risk team to review MOH emergency activation data and the MOH incidence reported through the electronic incident management system.

The service did not investigate incidents in a timely way. Data from the maternity update to trust board in July 2023 showed the service had a total of 272 open maternity incidents across the trust at various stages of the incident review process. This was a decrease from 457 in March 2023 and 311 in April 2023. We reviewed the last two completed patient safety reviews and found that there was involvement of the families involved in the incidents', a detailed chronology was completed with care and service delivery problems considered and learning identified.

The service reported incidents, themes, and trends to the trust board. The last update to trust board in July 2023 showed that levels of incident reporting had shown a small increase with the highest number of incidents being reported in May 2023 (197) for two years. The top three themes of incidents reported for April and May 2023 were staffing, communication and escalation.

The service reported in the July 2023 maternity update to board that the themes and trends from internal and the external investigations undertaken in the last 12 months included: maternity triage pathway, fetal growth pathway including management of fetal movements, cardiotocograph (CTG) categorisation and escalation, lack of senior obstetric medical oversight/inappropriate delegation and management of MOH. During the inspection we found risks related to the maternity triage pathway with staff not completing the telephone proforma or monitoring waiting times effectively, staff not consistently following processes or for management of MOH. However, we noted there was some evidence of improvements made in relation to areas such as CTG monitoring, but these systems were new and had not yet been embedded.

Seventy two hour incident forms require staff to record ethnicity, first language, gender identity and neurodiversity. However evidence of additional analysis of this information was not provided during the inspection. We could not be assured the trust considered and acted in a way in which it ensured women and birthing people were adversely affected in both treatment and outcomes in relation to ethnicity or disadvantage.

Maternity

The local Integrated Care Board (ICB) commissioned the Healthcare Safety Investigation Branch (HSIB) to complete an independent thematic review following maternal deaths and maternal collapse events which occurred between January 2021 and May 2022 at University Hospitals of Derby and Burton NHS Foundation Trust. The purpose of the review was to establish if there were any systemic related themes were present across these incidents. The review reported in February 2023. We reviewed the progress the trust had made against the five HSIB safety investigations that were made in relation to the major obstetric haemorrhage process, communication with women, birthing people and families who had experienced a significant event and the rapid review processes following. Despite this, the rates of MOH since June 2023 had risen and were rising above the national average. Following the inspection, the trust provided evidence of weekly audits to monitoring staff's use of the risk assessment proforma within patient notes. Results are fed back to the MOH group for further learning.

Is the service well-led?

Inadequate ↓↓

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

Leadership

Leaders did not have the necessary capacity to lead effectively. There was no stable leadership team and experienced high unplanned turnover and/or vacancies. Leaders were not always visible or approachable in the service for women and staff. Staff were not effectively supported to progress into more senior roles.

Maternity services were managed as part of the maternity & maternity, gynaecological and genito-urinary medicine business unit in the division of women's and children's services. The division across the trust was managed by a Director of Midwifery (although this post was vacant at the time of inspection), a Divisional Nurse Director, a Divisional Director of Women's & Children's Services and a Divisional Medical Director.

There was no stable maternity leadership team with vacancies being filled by staff in interim roles. The maternity & maternity, gynaecological and genito-urinary medicine unit was managed by an interim head of midwifery, an interim deputy head of midwifery, an interim general manager a gynaecology clinical director and an obstetrics clinical director. There was an obstetrics clinical director post was vacant at the time of inspection. The interim head of midwifery was supported by an interim deputy head of midwifery for risk & governance, a lead midwife for continuity of carer, an intra-partum matron, an inpatient matron, a community midwifery matron and a gynaecology matron. At the time of inspection, all the matron roles were cross-site roles working at Royal Derby Hospital and Queens Hospital. The trust had plans to recruit additional matron staff into a new management structure to allow two matrons to have dedicated roles on each site.

The board level Non-Executive Director maternity safety champion was newly appointed and not available for interview during the inspection period. CQC spoke with the Executive Chief Nurse an additional board level maternity safety champion.

The maternity staff survey reported that they would like greater visibility of senior managers, including visiting Queens Hospital clinical areas. The maternity staff survey showed staff reported they would like greater visibility of senior

managers, including visiting Queens Hospital clinical areas. This was confirmed during the inspection when staff we spoke to told us senior managers were not always visible or available. Staff told us an operational matron of the day had been recently introduced the week before the inspection took place and had already positively impacted staff at the service.

Workforce Race Equality Standard (WRES) Data Collected as part of the NHS Staff Survey showed that 54% of all staff reported believing that the organisation provided equal opportunities for career progression or promotion.

Matrons did not regularly work clinically on labour ward to provide clinical leadership, advice and support or to ensure staff could take breaks.

Leaders understood the challenges to quality and sustainability within the service and had developed plans to manage them. However, effective systems of oversight were not in place at the time of the inspection.

Vision and Strategy

Maternity services did not have a clear vision and strategy at the time of inspection. The service had recently set up a comprehensive plan to improve maternity services.

The service was developing a vision and strategy for the service at the time of inspection. Managers held a strategy session on 28 July 2023 to discuss clinical priorities across the local maternity and neonatal system and what that meant for the trust, divisional and business unit priorities. Key priorities included: workforce development and improving compliance with national maternity safety initiatives such as the Clinical Negligence Scheme for Trusts (CNST), the Ockenden report and the Saving Babies Lives care bundle version 3.

There were several maternity improvement programme workstreams which included: safe practice, capacity, governance, digital, people, training, communication, and service development. Priority areas within this included: safe management of major obstetric haemorrhage, fetal monitoring, informed choice and consent, improving culture and civility including escalation and oversight and maternity triage. The maternity improvement programme was supported by the NHS England maternity improvement team.

Culture

Staff did not always feel respected, supported, and valued. There were trends in feedback from women and birthing people reported they were not treated with kindness or respect when receiving care and treatment or during other interactions with staff. However, staff and women and birthing people felt they could raise concerns without fear.

Poor safety culture was a recorded risk and had been on the maternity risk register since November 2019. The NHS England Maternity Services Diagnostic Report completed February 2023 raised concerns about an ‘us and them’ culture between the trusts two acute maternity locations.

Staff did not always feel respected, supported, and valued**.** We reviewed the maternity staff survey (2022) feedback presented to staff as of June 2023 and found areas for improvement in the women and children’s division included: appraisals, health & wellbeing, and flexibility. Not all staff reported equitable job opportunities or safe working conditions in relation to staffing levels or that hard work was recognised by management. Managers promoted trust wide wellbeing resources such as the employee assistance programme at monthly maternity unit meetings.

Maternity

During the inspection we found there were multiple instances where staff became visibly upset. Staff gave examples where they felt let down by the trust; in particular, staff described changes made in response to the announcement of the CQC inspection, changes which had been in "progress" for long periods of time before the inspection was announced.

Most staff were focused on the needs of women and birthing people receiving care. However, we received mixed feedback from women and birthing people during the inspection. Following the inspection, we received feedback from 307 women and birthing people in response to a poster campaign. We reviewed the feedback and found 177 of 307 responses were positive describing exceptional and timely care. The negative feedback we received highlighted concerns related to informed consent where staff had overridden or argued against their wishes, as well as making them feel patronised and anxious. Additionally, staff did not always consider the dignity of women, leaving them in situations where they felt exposed or vulnerable.

Women and birthing people, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in clinical and visitor areas. Staff understood the policy on complaints and knew how to handle them. The service had a process for de-escalating complaints to resolve women and birthing people's concerns about their care in a less formal way.

Managers investigated complaints and identified themes but did not always investigate complaints in a timely way. Between 2 March 2023 and 4 August 2023, 44 formal complaints were reported to the trust, and were investigated and responded to in line with the trust policy. At the time of the inspection 13 investigations had been completed with the remainder ongoing. In addition, eight complaints required additional investigations.

The service had started to roll out cultural competency training. Staff from the practice development team attended sessions in June 2023 that covered cultural bias and supporting a culturally sensitive approach. The practice development team planned to share learning from this training to the wider maternity team.

At the time of the inspection supplementary information cards had been created to further assist with communication for women, birthing people and their families who spoke Polish.

The service had an equality, diversity and inclusion policy and process. However as of July 2023 only 83% of Obstetric Team and Acute Midwives had completed the Equality, Inclusion, Human Rights training against the trust targets of 95%.

Governance

Leaders did not operate effective governance processes to ensure the safety of the service. Lack of a stable leadership team, with high unplanned turnover and/or vacancies impacted on staff's ability to lead effectively.

The maternity risk and governance team was under-resourced at the time of inspection. The interim deputy head of midwifery for risk & governance lead worked two days a week. They were supported by two band 7 senior risk midwives, one who worked full time on the Queens Hospital Burton site and one who worked 3 days a week on the Royal Derby Hospital site.

Maternity

There were significant delays to the Perinatal Mortality Review Tool (PMRT) process. Data showed as of August 2023, there were 13 cases were being reviewed, 16 were at report stage, 3 were assigned from other trusts and 2 cases had not started the review process. The service reported in February 2023 they were non-compliant with the maternity incentive scheme requirement to start all PMRT reviews within 2 months of the death. Managers discussed the challenges to complete PMRT reviews at the July 2023 maternity governance meeting.

Leaders had reviewed the numbers of stillbirths between those from ethnic minority groups against the outcomes for all patients. Findings were presented to the trust board in July 2023 and showed the still birth rate for patients from ethnic minority groups was higher than the stillbirth rate for all patients, in line with national findings. The service acknowledged the need to further understand the problem to improve outcomes and ethnicity was included as a factor in perinatal mortality reviews.

Queens Hospital and Royal Derby Hospitals merged to form one organisation/trust in 2018, however, we found that policies and procedures had not always been aligned across the two locations. The trust had identified and recorded "Patient harm due to staff incorrectly selecting the wrong site guideline from the Trust intranet" as a risk on their maternity risk register from November 2020. In order to mitigate this risk regular meetings were held at Queens Hospital in order to ensure guidelines were reviewed and identified changes were made as a priority, however it was unclear how effective this mitigation was.

Staff did not always have access to up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed policies including the fetal monitoring and the reduced fetal movements guideline April 2021. These were not in line with national guidance. The service updated the fetal monitoring and reduced fetal movements guidelines immediately following our inspection visit in order to amend ensure CTG review by midwife and independent fresh eyes was to be completed hourly. Additionally, the trust had not updated their Baby or Child Abduction Policy since 2017 which was due for an agreed extension review date of October 2022.

At the time of inspection, the service did not audit compliance with guidelines to ensure they were effective, for example staff did not routinely document medical or midwifery review times. Staff we spoke with told us that maternity triage waiting times were not audited and no evidence was provided as part of our data request. As part of the newly implemented continuous quality monitoring standard operating procedure, the service planned to complete targeted audits of newly implemented guidelines.

A review of governance structures at the trust and in the women & children's division was in progress at the time of inspection. The review would support managers to streamline governance processes and meetings with clear lines of communication to ensure clear staff understanding.

Leaders monitored key safety and performance metrics through a series of governance and performance meetings. There were four levels of governance meetings starting with: maternity & gynaecology business unit meeting, women& children's divisional meeting, divisional performance review meetings with the executive team and the quality assurance committee that reported up to board.

We reviewed minutes of the last 3 maternity governance group meetings attended by the head of midwifery, obstetric clinical director, deputy head of midwifery, matrons, and specialist midwives. A standard agenda was used to discuss topics including but not limited to maternity training compliance, risk management, maternity quality reporting, compliance with Saving Babies Lives care bundle and quality improvement.

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.

The service submitted the continuous quality monitoring standard operating procedure to the commission on 21 August 2023. This document was in draft form so we could not be assured that the new oversight mechanisms were effective as they were not yet in use.

Management of risk, issues and performance

The approach to service delivery and improvement was reactive. There were significant failures in audit systems and processes which impacted on the management of risks. Additionally, risk registers and action plans were in place, but the pace of progress was slower than expected.

Audit programmes, if they existed at all, did not adequately measure the quality of service provision. For example, the audit to review compliance with the modified early obstetric warning score (MEOWS) had only been recently restarted and had only been completed in July 2023. Vital information was missing from the audit and therefore the trust was unable to confirm if 10% of MEOWS charts for women and birthing people were reviewed as part of the audit, had been escalated correctly.

The local audit programme was not sufficient to monitor and improve performance over time. The trust had recognised this risk and was implementing a continuous quality monitoring standard operating procedure. This was in draft at the time of inspection. The service had an annual audit programme and participated in relevant national clinical audits. For example, the service participated in the Avoiding Term Admissions into Neonatal Units audit. Data showed for quarter 4 (February 2023 to April 2023), term babies transferred to the neonatal unit account for 2.38% of babies delivered in this period. Data showed 40% of these term admissions to the neonatal unit were avoidable. In quarter 4 from February 2023 to April 2023. The service reported in February 2023 that it did not meet safety recommendation 3 of the maternity incentive scheme that requires all babies transferred to neonatal care to be audited and audits and action plans to be reported up to the trust board.

Clinical outcomes were not in line (worse than) with the national average Data showed as of July 2023 the still birth rate for births across the trust was 5.11 per 1000 births. This was above the national average of 4.1 were stillbirths for every 1,000 births.

Data on the maternity assurance tool that was reported up to the trust board was not sufficient to effectively monitor and improve services at the time of inspection. For example, data in relation to women who had a 3rd or 4th degree perineal tears and post-partum haemorrhages (PPHs) of over 1500ml were not monitored on the maternity assurance tool that was reported up to trust board but was included in the maternity dashboard. The rate of women who have had a PPH at the trust as of June 2023 (40 per 1,000 births) was higher than the national average (31 per 1,000 births), and in the highest 25% of all organisations. The trust had recognised that trends were higher than national average and had taken actions in order to address them. As a response to this trend, the trust had started a workstream in 2021 aimed at reducing morbidity and mortality caused by obstetric bleeding and linked in with the national Obstetric Bleeding Strategy UK team as an active member. The trust created an action plan based on the recommendations of the Obs Cymru Project with the aim of improving PPH management and clinical outcomes. However, many of the stages remained only partially implemented or required further embedding into the service.

Maternity

Leaders monitored compliance with the Ockenden review, mandatory actions used to improve maternity services regularly at trust board. The July 2023 maternity update to board showed the trust was fully compliant with 1 out of 7 of the immediate essential actions from the 2020 Ockenden report. The trust reported as of June 2023 they were 57% with all the sub-elements of the 7 immediate essential actions.

The service kept a live maternity risk register which identified insufficient midwifery and medical staffing, maternity mandatory training requirements, and increased risk of patient harm and maternal morbidity as their highest risks. These risks were mitigated by agreement being secured from trust board to invest in additional midwifery staffing. The trust delivery group agreed the maternity safety case in June 2023 to invest £5.4 million across the midwifery and medical workforce.

The trust was eligible to claim additional funding by the NHS Resolution Clinical Negligence Scheme for Trusts (CNST). The last maternity update to trust board in July 2023, showed the service met only 2 out 10 CNST safety standards. Failure to achieve compliance with all 10 safety actions in the CNST was a recorded risk since December 2020. The current risk level as of August 2023 was recorded as 9 (high risk). In addition to requests for discretionary funding to support progress, the trust had appointed a dedicated midwife who was responsible for overseeing the work programmes in place to achieve compliance with all 10 safety actions.

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

Information Management

The service collected data to analyse however key information used to evaluate performance and outcomes was not being collected. The information systems were integrated and secure. Staff could find the data they needed in order to make decisions.

The service collected data on key performance indicators as part of a live maternity dashboard allowing senior managers to analyse and compare date from other locations. However, key performance indicators were missing from the data added to the dashboard and were therefore not sufficient to effectively monitor and improve services at the time of inspection. Additionally, information collected did no differentiate between ethnic minorities. There was a lack of attention to the analysis of key performance indicators by ethnicity and deprivation.

Queens Hospital used a mix of paper and electronic patient record systems. The service had plans to implement an electronic maternity records system by Autumn 2024. Divisional managers had attended initial meetings to discuss the rollout of the new electronic system in July 2023.

The information systems were integrated and secure. All IT systems were password protected and paper-based patient records were stored securely.

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

Engagement

Leaders collected information on women and birthing people and staff. They worked with public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Maternity

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

The service had links with the local Maternity and Neonatal Voices Partnership (MNVP). The MNVP had completed a visit in July 2023 and reported areas for improvement were recommended, including but not limited to better signage and information. Members of the MNVP we spoke with told us that there were other themes around lack of breastfeeding and follow up for women and birthing people as well as some poor staff attitude and communication issues.

Additionally, the MNVP has worked with the trust to improve patient awareness of complaints process, after highlighting a theme where women did not know how to complete a formal complaint, they created a complaints process as well as the matron of the days contact number.

People could feedback to the service through surveys, complaints and through the MNVP. The MNVP also worked with local charities such as spring housing who support young parents and homeless people.

The CQC Maternity Survey results for 2022 showed, in comparison to other trusts, University Hospitals of Derby and Burton NHS Foundation Trust scored about the same for 46 questions and 'worse than expected' for 5 questions. Areas of improvement identified by the survey included the quality of information provided to women and birthing people antenatally and about induction of labour.

The 2022 General Medical Council National Trainee Survey (GMC NTS) which trainees complete in relation to the quality of training and support received, showed scores for most indicators, including 'overall satisfaction' were similar to the national average.

We received 307 responses as part of the 'give feedback on care' campaign completed as part of the inspection, with 58% (n177) of the feedback being positive with the remainder 42% (n130) being negative. There were themes around negative experiences and interactions with staff, lack of consent, staff causing women to feel anxious or like a burden. They also described long wait times and being given limited information on their treatment. Positive comments described staff as knowledgeable and attentive, with the ability to act decisively when required in order to ensure women and babies were kept safe.

Learning, continuous improvement and innovation

Evidence of quality improvement and innovation was limited. However, there was some limited evidence that staff were committed to continually learning and improving services.

The service was involved in a limited number of research studies. For example, the service was involved in a national research study looking alternative interventions to assist women and birthing people with smoking cessation in late pregnancy.

Areas for improvement

Action Queens Hospital 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.

Queens Hospital maternity services

Maternity

Action the service MUST take to improve:

- Ensure staff have access to an evidence-based standardised risk assessment and prioritisation tool for maternity triage. Regulation 12 (2) (a) (b)
- Ensure actions to reduce the risk of and manage post-partum haemorrhage and major obstetric haemorrhage is embedded and routinely followed by staff. Regulation 12 (2) (a) (b)
- Ensure compliance with accurate interpretation and escalation of fetal monitoring traces is regularly audited. Regulation 12 (2) (a) (b)
- The trust must ensure there is enough CTG equipment, and that staff receive regular training and competency assessment and consistently follow trust policy. Regulation 17 (1) (2) (a)
- Ensure staff complete yearly obstetric emergency skills and drills training, including pool evacuation training. Regulation 12 (2) (c)
- Ensure staff are up to date with yearly appraisals and maternity mandatory training including, cardiotocograph interpretation, safeguarding adults' level 3 and safeguarding children level 3. Regulation (12 (2)(c)
- Ensure infection prevention control audits regularly are completed. Regulation 12 (2) (h)
- Ensure staff follow handover processes and to ensure patients are seen within target timeframes. Regulation 12 (2) (a) (b)
- Ensure effective governance and oversight of audits and action plans developed to improve performance, including analysis of key performance indicators by ethnicity and deprivation. Regulation 17 (1) (2) (a) (b)
- Assess and implement systems and processes to ensure service users are treated with dignity and respect as well as taking reasonable steps to ensure service users can shower or carry out tasks in a way that protects their privacy and dignity. Regulation 10 (1) (2) (a)

Action the trust SHOULD take to improve:

Queens Hospital Maternity Services

- Should make sure staff meet service users' needs and reflect their preferences as well as ensuring full informed consent is obtained before providing appropriate care and treatment that meets service user's needs.

Our inspection team

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