Salisbury NHS Foundation Trust

Salisbury District Hospital

Inspection report

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Ratings

Overall rating for this service	Not inspected

Our findings

Overall summary of services at Salisbury District Hospital

Not inspected

We carried out this unannounced focused inspection of maternity services and spinal services on Wednesday 31 March 2021 because we received information giving us concerns about the safety, quality, and leadership of the services. As this was a focused inspection, we only inspected parts of the safe, effective, responsive, caring and well led key questions in spinal services and three key questions in maternity services (safe, effective and well led).

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Previous ratings were not all updated during this inspection. However, the ratings for well-led went down. Please refer to the 'areas of improvement' section for more details.

See the maternity and spinal services sections for what we found.

How we carried out the inspection

During the maternity inspection we spoke with 26 staff including the interim head of midwifery, consultant obstetric lead, divisional manager, consultants, labour ward and post-natal ward managers, fetal monitoring midwife, midwives, and community midwives. We reviewed ten sets of patient records, reviewed clinical guidelines and governance documents.

During the spinal services inspection we attended the daily bed meeting and spoke with 13 members of staff including medical staff, nurses and therapists. We spoke with six patients and looked in 12 medical records and care plans.

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.

Following the inspection, we issued a section 29a warning notice to the trust as we found significant improvement was required to midwifery staffing, leadership and culture, and governance and risk management. The section 29a notice has given the trust three months to act on the significant improvements we identified.

Spinal injuries

Requires Improvement

The Duke of Cornwall Spinal Treatment Centre specialises in the total management of patients affected by spinal cord injury or spinal cord disease. This support includes ongoing advice to meet the changing needs of the patient.

The centre provides a service to a population of approximately 7.5 million people throughout the South and South West as far as Guernsey and the Channel Islands.

The centre is situated at the Salisbury District Hospital site. There is one ward within the unit. This is known as Longford Ward. The service is commissioned to provide 39 beds, and at the time of the inspection 30 beds were occupied. Due to the impact of the COVID-19 pandemic, Due to the impact of the COVID-19 pandemic; two bays, each with four beds, were being used for patients undergoing elective surgery . The gym facilities had also been adapted to use as an escalation bay, however, these beds were never needed. Outside areas such as tennis courts which were previously used by spinal unit patients, had also been used by the trust to accommodate a temporary outpatient facility for the main hospital.

The service also provides an outpatient, diagnostic imaging, and acute outreach service for patients living with a spinal cord injury or disease.

Between March 2020 and February 2021, the spinal treatment has seen 171 inpatient admissions and 1,962 outpatient attendances. A further 234 patients had been seen for Video Uro-Dynamics which is a procedure to check the pressure and flow in the lower urinary tract including the bladder.

We carried out this unannounced focused inspection of spinal services at Salisbury District Hospital because we received information giving us concerns about the safety and quality of the services. Our overall rating of this service stayed the same. The service overall is rated as requires improvement. The safe domain remained the same at requires improvement and we inspected but did not rate the effective, caring and responsive domains. Therefore, the previous ratings of good for caring and responsive remains with effective remaining as requires improvement. However, the service rating went down in the well led domain where previously this had been rated as good.

We rated it as requires improvement because:

- The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- Staff did not always complete and update risk assessments for each patient to remove or minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration.
- The service did not always have enough nursing staff and allied health professionals with the right qualifications, skills, training and experience to keep patients safe and to provide the right care and treatment. Although, managers regularly reviewed and adjusted staffing levels and skill mix to try and manage the staffing challenges, and gave bank and agency staff a full induction.
- Staff did not always keep detailed records of patients' care and treatment. Records we viewed were incomplete and inconsistent. However, records were stored securely and available to all staff providing care.
- Staff monitored some outcomes in relation to patient care and treatment, however, were unable to provide evidence as to how information was collated and used in relation to standards and individual patient outcomes.

Spinal injuries

- The service took account of patients' individual needs and preferences; however, staffing levels sometimes impacted upon the responsiveness of the service to meet individual needs. The trust response to the COVID-19 pandemic had impacted upon the resources available to the spinal treatment unit and the level of therapy it was able to offer patients.
- Leaders did not always operate effective governance processes. Staff were generally clear about their roles and accountabilities and had regular opportunities to meet. Discussion about the performance of the service was limited and based on data which may not be reliable. Staff were not always able to contribute to decision-making to help avoid compromising the quality of care.
- Leaders and teams used systems to manage performance, but these were not always effective. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, we saw limited evidence of how risk was managed effectively within the division.
- During periods of the COVID-19 pandemic, there had been a lack of leadership due to absence and changes in the divisional structure which were still being embedded.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff assessed and monitored patients regularly to see if they were in pain, and mostly gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff mostly provided emotional support to patients, families and carers to minimise their distress and involved them in decisions about their care and treatment.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However; there were examples of miscommunication issues and virtual meetings not being as effective as they could be.
- The service was refreshing its strategy in relation to spinal rehabilitation. The vision for what it wanted to achieve was part of a regional specialist commissioning review being led by NHS England. Leaders were involved in developing this.
- Staff felt respected, supported and valued by their direct leaders. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. However; staff felt separate from the wider trust.

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Infection prevention and control

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and premises visibly clean.

We observed staff using personal protective equipment (PPE). This was managed at trust level and staff told us there was no issue with supply. Patients told us staff always wore PPE and the unit was visibly clean.

We saw notices on single room doors, where infection risks were identified, advising staff of the precautions they were to take when entering the room. There were signs on all rooms used by staff indicating the maximum number of people allowed to enter to enable social distancing.

We observed the use of green 'I am clean' stickers to indicate when a room or a piece of equipment had been cleaned. There were cleaning rotas which were signed to indicate cleaning had been completed.

Hand hygiene audits were undertaken as part of the 'Perfect Ward' audit programme. Between April 2020 to February 2021 the unit scored an overall compliance of 88%. The unit scored 100% compliance each month except for May which was 91%, June 97% and October 96% however, no data was submitted in November 2020 which affected the overall compliance rate. There was no explanation as to why the November figures were missing.

Patients admitted to the unit were allocated a side room and required to isolate for 10 days before moving into a bay to minimise the risk of COVID-19 infection. This was explained to patients before they came to the unit.

The spinal unit was required to report on all Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia (the presence of bacteria in the blood causing a serious infection) to ensure they did not exceed national threshold targets. The centre had no recorded cases of MRSA bacteraemia and Clostridium difficile between April 2020 to Feb 2021.

The unit experienced an outbreak of COVID-19 in November 2020. An outbreak is classed as an incidence of infection of more than two people on the same ward. Four patients tested positive at that time. The trust initiated their outbreak control policies and the outbreak was managed effectively. A meeting was held following this outbreak with senior staff members to discuss how this had been managed. The minutes from this meeting reflected the team felt the infection had been well managed. Recommendations were made to ensure all staff were fitted for appropriate personal protective equipment. Aside from good teamwork there were no specific examples of lessons learned from the management of the outbreak.

Three patients told us they had not received their COVID-19 vaccination. This also prevented them accessing the hydrotherapy pool as part of their therapy as the trust policy stated patients needed to be vaccinated before using the pool. These patients had made complaints to the Patient Advice and Liaison Service. The spinal team had escalated this concern to the lead for the hospital vaccination centre. We viewed governance meeting minutes where these issues were discussed but saw no evidence of what action had been taken as a result. Following the inspection, we were informed the trust had a rolling schedule for vaccinations to be provided. Vaccination clinics for all inpatients across the trust were being scheduled in accordance with national guidelines.

Environment and Equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The spinal unit was opened in 1984 and the building showed signs of aging. Aside from the ward area there were two gyms, a hydrotherapy pool and a large dining room. A large outside area was available for patients called Horatio's garden, which provided a tranquil place away from the unit. Patients could access the garden with a member of staff, even whilst remaining in bed if necessary. As part of the trust wide escalation plan in response to the COVID-19 pandemic, the main gym had been converted to provide additional bed space. This space was never used for this purpose, however, it left less room for patients to use for therapy. An outside tennis court was not in use as a temporary

building was placed there to accommodate outpatient appointments from other parts of the trust. Leaders had completed risk assessments to allow patients to use some parts of the gym once again. However, staff were not aware when these areas would be returned fully to the unit. We saw no evidence of individual impact assessments being undertaken in relation to the loss of areas for patients receiving rehabilitation..

We found a fire door which opened onto a first storey ramped area. The exit was not being used as an emergency exit at the time of the inspection however, the door was not alarmed and could pose a safety risk to patients. We raised this at the time of the inspection and action was taken by staff to install an alarm. However, it was not clear how the alarm would be responded to if it was activated and this needed to be included in a risk assessment of the area.

Equipment for urgent and emergency situations was kept in tamper evident trolleys and hospital policy stated this was to be checked daily by staff. We viewed records of these checks and found they were signed and dated daily. Emergency grab bags were located in the pool area. We found medications to be in date; however, we found a blood sample testing kit and a feeding tube connector which were out of their use by date. This was raised with the matron at the time and disposed of immediately.

The environment was cluttered. Storage space had been reduced by the loss of two bays for escalation purposes. There was limited storage space at patient bedsides. We found wheelchairs, walking aids and trolleys being kept in corridors. We observed the dining room was cluttered and prevented access for some patients. For example, the way in which the tables were positioned did not allow space for a person using a wheelchair to pass and we saw chairs stacked against walls which could pose a hazard.

Leaders told us discussions were due to take place in 2021 in relation to planning refurbishment of the unit.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff were expected to carry out risk assessments for each individual patient, including risk of pressure ulcers, falls and nutritional risks. We viewed 12 records and found risk assessments were missing or incomplete in nine records.

Staff were observed using a turning rota to prevent pressure ulcers developing. Patients reported staff were aware of the risk of pressure ulcers and were encouraged to set their own alarms to facilitate turning regimes. The unit had reported 32 pressure ulcers in the period between March 2020 and April 2021. One patient who developed a pressure ulcer during that time met the criteria for a serious incident investigation.

A psychology screening programme was being introduced for patients on the spinal unit. This assessment was expected to be completed within four weeks of the patient admission to the unit. Staff were being supported to undertake training in enhanced psychology assessment skills to be able to complete the screening tool. The introduction of this tool was in response to the fact there was no dedicated clinical psychologist on the unit. The psychologist was absent from the service and the trust wide psychology team was providing support. The screening tool was hoped to support the referral of patients to the trust wide psychology team, and to support staff to identify and manage the risk of deterioration in a patient's mental health.

We observed call bells were not always answered promptly. Patients told us call bells were not always answered quickly and we saw patients waiting despite staff being available to respond. We viewed minutes from a patient meeting which took place in December 2020. Patients had noted the call bell system had failed and a patient had waited 20 minutes

before someone came to them. Following several complaints, the unit had introduced a call bell system where response times could be audited. We requested the audit data for call bell response times and were told no audit had been completed. Following the inspection, we were informed the call bell system that had been introduced did not easily allow for analysis of patient waits and the service were looking at alternative ways to collect and analyse this information.

Medical staff completed risk assessments for venous thromboembolism (VTE) (formation of blood clots) in line with the National institute for Health and Care Excellence NG89 (2018). This recommends all medical patients have a risk assessment as soon as possible after admission, or by the first consultant review and are re-assessed within 24 hours of admission.

The spinal unit completed a monthly audit of completion of VTE risk assessments. Results showed a 100% completion rate each month between April 2020 and February 2021. This exceeded the trust target of 95%. Although the audit was missing data from November 2020 with no explanation. We were also provided with the 'perfect ward' audit data which differed to these results. This ward to board performance presentation for Longford Ward was undated but referred to a VTE assessment compliance rate of 92.1%. This would be below the completion rate target. It was therefore unclear whether audit data provided an accurate reflection of performance and questioned the reliability of governance and oversight of issues and ability to identify potential areas which needed improvement.

Staffing

The service did not always have enough nursing staff and allied health professionals with the right qualifications, skills, training and experience to keep patients safe and to provide the right care and treatment. Although, managers regularly reviewed and adjusted staffing levels and skill mix to try and manage the staffing challenges, and gave bank and agency staff a full induction.

There were no specific standards for the staffing of spinal cord injury centres which is recognised nationally. There is an NHS standard contract for specialised services of which spinal injury is a part of, however, as this was not recognised nationally, leaders told us they were not adhering to this at present. They were involved in the spinal cord injury network which was looking at developing a staffing recommendation and would adjust their staffing as required when this was due to be implemented in Autumn 2021.

Patients told us staff were visible and available; however, during the mid-morning period between breakfast and lunchtime patients told us staff looked rushed and under pressure.

Staff told us of some frustration at having to release staff to other wards during times of escalation within the COVID-19 crisis. This was felt to leave the unit short staffed with a reliance on bank staff to fill gaps.

A trust wide safer staffing tool was used by senior staff to assess patients' needs and determine the necessary level of staff needed. This check took place twice a day.

At the time of the inspection there were 35 whole time equivalent (WTE) registered nurses. There were registered nursing vacancies at band 6 of 1.20 WTE and band 5 0.99 WTE. However, there was additional band 7 hours to accommodate for this shortfall. There was a vacancy of health care assistants of 4 WTE and band 3 10.26 WTE. Using band 7 nurses to accommodate shortfalls in staffing could impact upon their ability to complete managerial tasks and maintain oversight of quality and safety.

Spinal injuries

Where there was a shortage of staff, shifts were undertaken by bank staff known to the unit. Agency staff was kept to a minimum and regular bank staff were used to maintain continuity for patients. We saw data which showed in January 2021, 33,063 hours of bank staff were used compared to 1,789 hours of agency staff. In February 2021, no agency staff were used compared to 46,213 hours of bank staff. When agency staff were used an induction to the ward was completed.

We saw there had been three incidents recorded of staffing shortages between March 2020 and February 2021. In one incident, staff sickness was noted as the cause for an inability to provide bowel care, breakfast for patients and enough time to complete nursing notes adequately. We saw another incident which reported low staffing had contributed to sub optimal care and poor staff morale.

Therapists had supported the ward staff during the peak of the pandemic when there had been a shortage of nursing staff. They assisted with supporting patients to wash and dress and staff told us they felt they worked well together as a team.

There were absences within the therapy team at the time of the inspection. There was a vacancy of 0.91 WTE of therapy assistants and 1.80 WTE vacancy for occupational therapy. The team had also experienced gaps in staffing due to absence and shielding. This had left staff feeling pressured.

We were provided with data relating to sickness absence and saw the unit had a 6.13% absence rate in January 2021 which was above, and therefore worse than the trust target of 3%. The trust wide sickness rate for the same period was 5.31%.

There had been a creative use of staff by upskilling health care assistants to gain skills and competence in therapy tasks. Therapists had also adapted the provision of therapy to include group sessions and the use of a colour coded system to ensure therapy was undertaken safely.

There was no dedicated clinical psychologist for the spinal unit at the time of the inspection due to absence. A psychology assistant was in post to support access to psychological support through the trust psychology team and staff felt this had been a positive introduction. We viewed minutes of a patient meeting which took place in January 2021. Patients had raised concerns about the lack of access to psychology and felt they were not receiving the support they needed. There were no actions evident on the meeting minutes as to how this would be rectified. The risk was identified on the departmental risk register with the owner being the divisional manager, however, this was not currently sitting on the divisional risk register. Patients experiencing spinal cord injury have a significant need for adequate psychological support which they can access rapidly.

Records

Staff did not always keep detailed records of patients' care and treatment. Records we viewed were incomplete and inconsistent. However, records were stored securely and available to all staff providing care.

We reviewed 12 care records and found nine nursing assessments and care plans to be incomplete or inconsistent. For example, we found blank nursing assessment documentation and one record which had no nursing assessment of a wound or skin care needs. However, on the day following admission, there were nursing notes to suggest the individual had a dressing and broken skin. This made it difficult for staff to understand if the wound was present prior to admission or occurred at the unit.

Spinal injuries

Records were stored securely and available to staff providing care, however, records were kept in two places on the unit. A medical file was kept in a locked office and care plans were kept within a bedside folder with the patient. We viewed these records and found it was difficult to gather the key information about the care for a person without reading both together. Even then, clinical history, aims of admission and rehabilitation plans were not explicitly stated.

Staff told us records could be inconsistently completed which was a frustration. A lack of clear documentation had been highlighted as an issue in terms of patients not being ready in the morning for therapy as staff did not have access to clear communication in the documentation. This had improved since the introduction of grouping patients via a colour coding system and development of a patient timetable for therapy.

Record audits were undertaken as part of the perfect ward application. We viewed these audits for January, February and March 2021. The overall score for these audits were 93% completion in January and March 2021 and 91% completion in February. There was no indication in these audits of how many records were viewed and where these audits highlighted areas that were performing poorly, for example, moving and handling risk assessments not being completed in 67% of the records, there were no actions noted or indication over how these issues would be rectified.

Is the service effective?

Inspected but not rated

We inspected but did not rate effective in relation to pain relief and patient outcomes. The previous rating of requires improvement remains.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and mostly gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Some patients told us there could be a wait for pain medication to be given and understood that other people may be a higher priority in terms of the need for pain relief. Most patients told us staff regularly checked their levels of pain and used a scoring system to determine what relief was required. One patient told us there had been a misunderstanding with the multi-disciplinary team over a reduction in their pain relief, but this was quickly resolved.

Staff told us there was an increased awareness about caring for patients in pain and a focus on providing pain relief as soon as possible.

To reduce medicine administration errors, nursing staff wore red aprons when carrying out medication rounds to try and reduce distraction.

Patient Outcomes

Staff monitored some outcomes in relation to patient care and treatment, however, were unable to provide evidence as to how information was collated and used in relation to standards and individual patient outcomes.

The spinal treatment centre contributed to a national database for data collection and analysis purposes. The centre recorded outcomes including delayed transfers of care and the length of stay. The data provided was a measurement of

activity and not an indicator of quality of the service. A standard operating procedure was created to ensure the data was reviewed regularly. We were provided with evidence of an action plan created in response to negative indicators where the spinal treatment centre was performing poorly compared to the national average. For example, the service was performing poorly in relation to providing a face to face acute outreach visit to patients within five days of referral. This was noted to be in part due to the restrictions around COVID-19. Action had been taken to ensure, if medically able, patients had a virtual call utilising technology to discuss admission.

In 2019 the service had been awarded a Commissioning for Quality and Innovation (CQUIN) payment for demonstrating improvements in quality in specified areas of care. This was for providing data to a national database in relation to completion of an American Spinal Injury Association score (ASIA) and Spinal Cord Independence Measure (SCIM). ASIA is a neurological assessment for patients with spinal injury and was undertaken on admission, at 6 months, 12 months and 18 months and on discharge. Leaders told us outcome measures were now being determined as part of the spinal cord injury network work streams. It was hoped new outcome measures could be developed to allow units across the country to compare against each other more effectively and provide a standardised model of care to enable this.

The Fundamental Standards for Adults Requiring Spinal Cord Injury Care, NHS standard contract is the document which all centres use as baseline standards. The service informed us the national database for comparing services was no longer seen as fit for purpose. A new standardised national model of care was being finalised and expected to be implemented in Autumn 2021. New national standards of delivery were being developed and services would be expected to adhere to these. A national database was expected to be used for benchmarking and assessing performance. We were provided with a clinical pathway developed by another trust in collaboration with the spinal centre. However, we found limited evidence of the service using this clinical pathway. There was a discharge policy which referred to rehabilitation milestones, but in the 12 care records we viewed we could not see evidence of this being followed.

Physiotherapists and occupational therapists used local, individualised outcome measures and clinical measures to monitor the progress, decline and outcomes for each individual patient, in the absence of any nationally recognised therapy-based outcomes. We asked for audit data for these measures and how they were used to improve services. We were informed the service had only recently started to collect data on outcome measures and therefore this was not available. There were clinical guidelines available nationally for example, Spinal Cord Injury Centre Physiotherapy Lead Clinicians United Kingdom and Ireland: Clinical guidelines for standing adults following spinal cord injury (2015); however, we were not provided with evidence as to how this guidance was being followed and staff told us there were no recognised national targets in terms of therapy provision.

Is the service caring?

Inspected but not rated

We inspected but did not rate caring in relation to emotional support and staff and patient involvement. The previous rating of good remains.

Emotional Support

Staff mostly provided emotional support to patients, families and carers to minimise their distress.

Spinal injuries

Patients staying on the unit at the time of the inspection told us they were happy with the level of care provided and reported staff to be patient and understanding. Staff were described by patients as being open and honest when asked questions.

All staff we spoke with were passionate about supporting people with a spinal cord injury and recognised the significant emotional impact such an injury had on individuals.

The service did not have an allocated psychologist for the unit at the time of inspection. Any member of staff could refer a patient to the trust wide psychology team for further assessment. A psychology assistant was present on the ward. The psychology assistant was able to discuss needs with the patient and explain the role of psychology and the benefits of assessment. The head of psychology told us the staff on the unit were responsive and knowledgeable in when to refer an individual for psychology support.

However, we observed one occasion where an improper reaction was displayed by a staff member when a patient was being encouraged to be independent. During the lunchtime period we also saw a patient having difficulty cutting and eating food provided for them. Despite dining staff being available to assist, there was a period where this individual went unnoticed.

Understanding and involvement of patients and those close to them

Staff mostly supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

We spoke with six patients who were staying on the inpatient unit at the time of the inspection. Patients mostly felt included in decisions about their care. However, one patient told us their requests were not always accommodated if they did not fit in with the ward routine.

Patients told us they were encouraged to facilitate their own reablement and were involved in their care and treatment. One patient told us should they attempt any activities which could result in injury staff quickly and sensitively addressed this.

The unit had increased the frequency of patient meetings from monthly to every fortnight. We viewed the minutes of these meetings. We saw patients were given the opportunity to provide feedback both positive and negative; however, it was difficult to see what action had been taken in response to patient feedback as the minutes did not include any actions or plans to take forward.

Due to the COVID-19 pandemic, a no visitor policy had been enforced trust wide which had impacted the spinal unit and patients who were spending long periods of time there. Patients we spoke with understood this decision but hoped this would be changed soon. Staff told us they were aware patient visits would aid recovery and hoped the trust would resume visits. However, they recognised the need to support safe visiting to prevent infection.

Staff consistently reported helping patients access virtual communication with family and encouraged patients to bring in their own telephones or tablet devices to support this. However, we received concerns from patients who had stayed on the unit between March and October 2020. Two patients had reported their families were not included in discussions about their care and felt their discharge had been affected negatively due to this. Poor internet had also impacted upon individuals being able to communicate with their loved ones. This had been escalated by the leadership team but was not evident on the divisional risk register.

Spinal injuries

No complaints had been received by the service since November 2020.

Is the service responsive?

Inspected but not rated

We inspected but did not rate the responsive domain in relation to meeting people's individual needs. The previous rating of good remains.

Meeting People's individual needs

The service took account of patients' individual needs and preferences; however, staffing levels sometimes impacted upon the responsiveness of the service to meet individual needs. The trust response to the COVID-19 pandemic had impacted upon the resources available to the spinal treatment unit and the level of therapy it was able to offer patients.

Patients reported being visited by a wide range of staff during ward rounds and were involved in decisions about their care.

There had been changes in response to the COVID-19 pandemic which had impacted upon the service. The short stay assessment beds were currently not able to be used as part of the ward had been given to support additional bed space for elective surgery patients. This was coming to an end and short stays were due to be offered again by the 19 April 2021. Leaders were hopeful the list of patients waiting for this service would be reduced within 16 weeks.

The hydrotherapy pool had been closed during the pandemic and only recently reopened, meaning patients were unable to access this therapy for a period of a year. We saw no evidence of individual assessments taking place to understand the impact of these changes or to provide an alternative. Leaders told us they had completed risk assessments for the reopening of the pool and had looked to other services in relation to how to reopen safely.

One gym had also been identified as an escalation bay in anticipation of the need for additional bed space in response to COVID-19. The gym was gradually being reused by patients following a risk assessment of the area, however, there was little clarity as to when the gym would be fully reopened for patients to use. An outside area previously used for exercise was also being used to accommodate a temporary outpatient building for the main hospital site. Again, little was known by staff about when this would be returned.

Staff had utilised outside space within Horatio's garden to provide 'games in the garden' events which were successful.

Staffing levels sometimes impacted on the responsiveness of the service to meet patients' individual needs. Staff would attempt to take a flexible approach to the care, treatment and therapy of patients and spoke of the rehabilitation journey as a partnership where patients could plan their day. However, we spoke with one patient who felt their routine had to fit with the rest of the unit. Complaints received from patients who had attended the unit also noted concerns with care not being individualised and therapy not being appropriate for their needs and rehabilitation aims.

During the pandemic, difficulty with short staffing led to some patients not being dressed in time for therapy. Changes to therapy groups and a colour coded patient timetable assisted with this and staff reported this was happening less often now. Due to sickness and other absence during the pandemic therapy was not consistently provided as planned.

Spinal injuries

Learning from Complaints and Concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, there were examples of miscommunication and virtual meetings not being as effective as they could be.

Patients told us they were able to raise concerns and felt comfortable doing so. They were also aware and used the Patient Advice and Liaison Service where necessary.

The matron informed us staff were encouraged to resolve complaints informally as soon as possible. Between January 2020 and March 2021 there had been 24 complaints or concerns raised. No complaints had been received since November 2020. The complaints related to poor staffing, a lack of therapy time and concerns over the quality of care.

CQC had received five concerns from patients who stayed on the spinal inpatient unit between March and November 2020. These concerns related to poor staffing, poor access to psychological support, a lack of therapy time and concerns over the lack of involvement in decisions around goals and rehabilitation.

Patient meetings took place every two weeks and feedback boxes were situated throughout the unit and reviewed each morning at the daily multidisciplinary meeting. We saw no evidence of 'You Said, We Did' notices visible on the unit but the matron advised us this was being worked on. We were provided with evidence of previous improvements, for example sensor bins being placed on the unit, however, these were from some years ago.

There were improvements which could be made in terms of the use of virtual meetings to discuss complaints. Given the COVID-19 restrictions, complaint meetings were often undertaken using videoconferencing. Due to the way in which meetings were run, it was sometimes difficult to hear all staff responses and could lead to miscommunication. In one complaint there was a concern that no permanent record of the meeting could be made, as no minutes were taken, and no follow up letter provided.

Is the service well-led?

Requires Improvement

Our rating of well-led went down.

Leadership

Local leaders had the skills and abilities to run the service. Some local leaders had been in post for a number of years. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. However, during periods of the COVID-19 pandemic, there had been a lack of leadership due to absence and changes in the divisional structure which were still being embedded.

The spinal unit came under the responsibility of the division of medicine. This was a result of a divisional restructure and a change since the last inspection. Therapy staff were previously located in the musculoskeletal division with the rest of the team under the surgery division. This change occurred in September 2020.

Spinal injuries

During periods of the COVID-19 pandemic there had been a lack of leadership. Due to absence, the unit was without a business manager, a clinical lead and a clinical psychologist. We saw this was discussed at the clinical governance meeting in September 2020 and highlighted as a risk to the service. Since this time the business manager had returned, and a clinical lead appointed. A new matron also came into post in October 2020. The unit, at the time of our inspection was still without a dedicated clinical psychologist, but actions were being taken to minimise the impact of this whilst being reviewed.

The spinal unit leadership team consisted of a speciality business manager, ward manager, matron, a clinical lead consultant and therapy leads. There was improved visibility and availability as the service entered a different stage of the pandemic and senior staff returned. Staff reported teamwork had improved since the introduction of the matron and management were available to raise concerns.

Local leaders reported good relationships with the senior leadership team within the medicine division. However, staff told us there was little visibility from leaders within the divisional team and a limited understanding about how governance processes functioned. A staff survey which was undertaken also noted some staff felt supported by direct leaders but felt detached from the rest of the trust.

In the initial six months of the matron being in role they had recognised and begun to take action in areas of risk that needed to be addressed. For example, a refresh of governance systems and a need for improved communication with staff and patients. The matron emailed staff with an update on both the unit and trust wide issues every week and worked in a supernumerary capacity on the unit twice a week. This was felt to have a positive impact upon the nursing workforce and allowed the matron to support staff wellbeing, offer advice and education as well as engage with patients and respond to issues as they arose.

Strategy and Vision

The service was refreshing its strategy in relation to spinal rehabilitation. The vision for what it wanted to achieve was part of a regional specialist commissioning review being led by NHS England in the south west. Leaders were involved in developing this.

Staff consistently reported a vision of reablement alongside sensitive and individualised care with patients being involved with their treatment and discharge plans.

The leadership team had been involved in working with other spinal injury centres as part of the Spinal Cord Injury Network. Several work streams had been developed and looked at different elements of care provided for those with a spinal injury to determine best practice and develop a new model of care. The aim was to implement this way of working in Autumn 2021.

It was hoped the review would provide a model for the care pathway, a framework for determining necessary staffing levels, and an ability to standardise outcome measures in order to allow for benchmarking with other services and therefore monitor the quality of the service provided.

Culture

Staff felt respected, supported and valued by their direct leaders. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. However, staff felt separate from the wider trust.

Spinal injuries

Staff were passionate about their roles and working with individuals who had experienced a spinal cord injury. They spoke of being proud of the relationships they built and wished to do the very best for their patients.

Some staff reported feeling stretched and pressured given the amount of challenge the COVID-19 pandemic had presented. Although supported by their direct leaders there was a feeling of disconnect with the wider trust. Staff felt separate from the rest of the trust and reported a concern about a lack of communication over how decisions were made, and little feedback once issues had been escalated outside of the unit. For example, staffing pressures.

Staff reported being unable to be innovative in their work as they were under pressure to complete the day to day care and treatment of patients on the ward.

All staff felt there had been a change for the better in terms of openness on the unit and the ability to raise concerns without fear. Staff demonstrated a good awareness of the duty of candour and spoke of encouraging a culture of honesty.

Governance

Leaders did not always operate effective governance processes. Staff were generally clear about their roles and accountabilities and had regular opportunities to meet. Discussion about the performance of the service was limited and based on data which may not be reliable. Staff were not always able to contribute to decision-making to help avoid compromising the quality of care.

Clinical governance processes had been refreshed by the multidisciplinary team in October 2020.

Local meetings took place on a regular basis and used a standing agenda to ensure all relevant issues to the service were discussed. The service undertook a clinical governance meeting which was minuted. We viewed these minutes and noted discussions taking place amongst the local leaders regarding relevant issues. As well as this there was a senior nurses meeting which took place once a month and a heads of department meeting.

There was a daily multi-disciplinary meeting held as well as a twice daily huddle and safety briefing for ward staff every morning. Therapy team meetings took place separately and both were used to cascade issues and actions to staff.

A senior leadership team meeting took place every two months. Specific items such as staffing, performance and safety indicators were not listed as standard agenda items. The meeting included risk, complaints and new matters only. Minutes from this meeting were lacking in detail and therefore it was difficult to determine the quality of the conversations taking place and how decisions were reached. There were gaps around significant topics such as staffing so this did not present a rounded picture and oversight of the service.

During the inspection we noted issues with a lack of clarity over responsibilities. For example, in terms of the responsible team for completing equipment checks. There was confusion about the governance arrangements for the emergency equipment checks, with guidelines stating the checks were the responsibility of a different ward. We found one trolley on the lower floor that did not have the correct number tag which matched the checks that had been signed for. We were told this trolley was the responsibility of another unit who also used the building. However, patients using the pool may need to use this equipment in an emergency.

We observed some areas where there had been leaks from the ceiling and a toilet which was not able to be used by patients due to needing repairs. Governance meeting minutes noted these issues had been escalated in February 2020 but at the time of the inspection actions had not been taken to fix the problems.

Spinal injuries

We noted discrepancies within audit data provided to the inspection team. For example, we requested ward to board reports from the spinal unit which demonstrated the process by which senior leaders were aware of the quality and safety issues impacting on the spinal unit. We were provided with an undated document which provided data from the perfect ward audits being undertaken across the trust. However, these figures differed from evidence we were provided. For example, in terms of VTE audits as mentioned previously in the report. There was a risk these reports may give an inaccurate picture of quality and safety and therefore false assurance for senior leaders and the trust board. Audits also did not identify issues with documentation which was found on the inspection.

Given there had been several decisions and changes made to the spinal unit taken by the wider trust in relation to COVID-19, there was a concern about a lack of transparency and involvement in decisions being taken which affected the spinal unit resources, and potentially the quality of the care and treatment they were able to provide for patients. For example, staff being redeployed to other areas resulting in necessity for bank and agency staff to be used on the spinal unit, the gym being used as an escalation bay, loss of outside exercise areas to a temporary outpatient building, and the loss of the use of the hydrotherapy pool for 12 months.

Risk Management

Leaders and teams used systems to manage performance, but these were not always effective. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, we saw limited evidence of how risk was managed effectively within the division.

We reviewed the spinal unit risk register and saw risks were identified. Risks on the risk register included lack of a dedicated clinical psychologist, poor Wi-Fi, impacting upon ability to record observations and undertake staffing review and allocations as well as the impact upon patients unable to contact relatives and for them to be included in decisions about care. Risks were assessed and given a score. These risks were not RAG rated but each had an owner responsible attached. However, there were absences on the risk register, for example the impact sickness absence had upon staffing particularly in therapy and how these risks were being mitigated as well as the loss of resources in relation to the COVID-19 response. Actions were not clear, and several items had been on the register for long periods of time without conclusion. For example, nursing staffing since 2016 and poor wi-fi coverage since November 2019. The risk register better reflected the issues around a lack of psychology support dedicated to the unit but lacked specific actions being taken.

We viewed senior leadership team meeting minutes for December 2020 and saw risk was a standing agenda item. The meeting was attended by the clinical lead, ward manager, therapy lead and the divisional clinical director and divisional manager. These minutes lacked detail relating to the rationale and reasoning for risks being downgraded or removed from the risk register. Due to this, it was difficult to determine the quality of the discussion around these risks and whether senior leaders recognised and escalated risks appropriately. For example, risks around vacancies had been recorded only as ‘downgraded’ or ‘removed’. There was a lack of detail in terms of the gym being reused.

We viewed the divisional risk register and saw one risk specific to the spinal service. This risk related to the replacement programme of ventilator equipment. The risk register we were provided with demonstrated divisional leads RAG rated risks and each risk had been reassessed on a monthly basis. However, there was not sufficient detail included on the register and no actions attached to each risk.

Vacancies within the workforce was a risk identified on the spinal unit risk register. These gaps in staffing were improving but still impacted the nursing, and therapy workforce especially where there were staff affected with sickness and

absence. This had created pressures for staff on the spinal unit, this was particularly evident for therapy staff. Staff told us staffing issues had been escalated to their line managers but from there they were unclear what action had been taken and had not received any feedback in respect to this. Despite being recognised as a risk by leaders this risk was not explicit on the divisional risk register.

Areas for improvement

Spinal services

The trust must ensure:

- risk assessments are completed for each individual patient to ensure care and treatment is provided safely. Regulation 12 (2) (a)
- exits are risk assessed with consideration of patient safety. Any alarm system used needs to have staff available to respond. Regulation 15 (1) (c)
- governance arrangements are reviewed and senior leadership team meeting includes a comprehensive standard agenda. Decisions taken at senior leadership meetings must be clear and transparent and reflected in meeting minutes. Meeting minutes must be of sufficient quality that the detail of the discussion is captured and clear. Regulation 17 (1)
- audits are undertaken to assess, monitor and improve the quality and safety of the services provided. Audits must be accurate, meaningful and purposeful to ensure senior leaders are aware of areas where action is needed. Actions should be taken as a result of any shortfalls to improve quality and safety Regulation 17 (2) (a) (b)
- risk registers are reviewed to ensure there is clear oversight and timely management of all risks, these are escalated to the divisional leadership team and action taken. Information should be cascaded from this meeting to the department. Regulation 17 (2) (b)
- records are contemporaneous and complete. Risk assessment documentation must be clear and completed. Regulation 17 (2) (d)

Spinal services

The trust should:

- review all areas to ensure they are safe, uncluttered and wheelchair accessible.
- review how stocks of equipment and consumables are monitored including checks for expiry dates and take action to dispose of items as necessary.
- respond in a timely way to call bells and requests for assistance. Audits of call bell response times should be used to establish if there are any times where call bells are not being responded to determine if staffing levels are impacting upon the ability for staff to respond.
- review how skin care needs are identified, assessed and monitored to reduce numbers of pressure ulcers.
- provide a holistic assessment of individuals to enable patients to access therapy on an equal basis.
- provide pain relief in a timely way.

Spinal injuries

- review staffing levels for nursing, therapy and psychology staff. Despite the NHS standard contract for specialised rehabilitation services not being a nationally recommended staffing tool, staffing levels do not reflect the levels indicated there. There is evidence of poor staffing impacting upon patient care and treatment and staff feeling pressured.
- review governance arrangements for checks of emergency equipment.
- provide care and treatment that meets the needs of individuals and allows involvement in decisions about care and treatment.
- minute actions from patient meetings to allow patients and staff to be clear on what action needs to be taken and by whom. Those in attendance at patient meetings should have a level of seniority to ensure patients are listened to and actions can be taken in response to concerns.
- measure outcomes for data collection and analysis purposes. The data should be actioned to meet any shortfalls and drive improvement.
- provide a contemporaneous written record of complaint resolution meetings.
- consider and assess the impact of trust escalation plans on patients within the spinal unit especially in relation to continuing loss of gym and outside activity space.

Maternity

Requires Improvement

Maternity services at Salisbury District Hospital include antenatal, intrapartum (care during labour and delivery), and postnatal maternity care. Services were delivered from the main hospital site and antenatal clinics were also held in local community settings such as GP surgeries across Wiltshire. There were ten maternity beds on the labour ward and 19 beds that could be used for antenatal or postnatal care. The community midwifery team carried out antenatal and postnatal care as well as providing a home birth service. During this inspection we inspected maternity services at Salisbury District Hospital and spoke with community midwifery staff.

The trust reported 2,052 babies were born at the trust from October 2019 to September 2020.

A local neonatal unit was located alongside the maternity unit providing level two care for babies born after 27 weeks and those requiring less than 48 hours ventilation. Babies who needed level three care were transferred to the closest local hospital with these facilities.

We inspected the following areas at Salisbury District Hospital: labour ward, day assessment unit and postnatal ward.

Our overall rating of maternity services went down. The service overall is rated as requires improvement. Safe remained the same at requires improvement and the well-led key question went down to an inadequate rating. We inspected but did not rate the effective domain.

We rated maternity services as requires improvement because:

- The delivery of high-quality care was not assured by the leadership, governance, or culture. There was insufficient leadership capacity to support necessary improvements and there was no strategy for the service.
- There is an increased risk that people are harmed or there is limited assurance about safety. There were periods of understaffing and inappropriate skill mix.

However:

- Women and babies had good outcomes because they receive effective care and treatment that met their needs most of the time.

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not always have enough staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers did not review staffing levels in line with national guidance.

- Safety concerns were not consistently identified or addressed quickly enough. The service had a culture of blame around incident reporting that leaders had recognised and were working to improve. The approach to reviewing and investigating incidents was too slow and there was little evidence learning from adverse events led to improvements in safety.
- Staff did not always complete checks to ensure emergency equipment was safe and ready to use and staff were not aware of protocols for cleaning and evacuation of the birth pool.
- Audits showed tools to monitor deterioration were not always used effectively.
- Records were not always stored securely.

However:

- The service had enough medical staff with the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.
- Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted when women were at risk of deterioration.
- Staff kept detailed records of women's care and treatment. Records were clear and up to date.

Environment and equipment

Staff did not always complete checks to ensure emergency equipment was safe and ready to use and staff were not aware of protocols for cleaning and evacuation of the birth pool.

The design of the environment followed national guidance. There was one obstetric theatre that was easily accessible from the labour ward. An anaesthetic room could be used as a second theatre in an obstetric emergency. The service had recorded the risk of the lack of a second obstetric theatre on the risk register. The risk was added to the risk register in October 2018 and the risk was rated as two, tolerable risk and there were not recorded actions to mitigate this risk.

Staff did not always carry out daily safety checks of specialist emergency equipment. We checked the adult resuscitation equipment on the labour ward and found daily checks were not recorded on seven dates in March 2021, seven dates in February 2021 and two dates in January 2021. There was a risk the equipment may have expired, be unavailable or in need of repair. We checked two resuscitaires on labour ward and these were checked daily.

The service did not have clear processes for cleaning the birth pool. The birth pool on the labour ward did not have 'I am clean' stickers to show staff it was clean and ready to use. The procedure for cleaning the birth pool was not displayed in the room and staff we spoke with told us they used clinical cleaning wipes and a domestic cream cleanser to clean the pool. We raised our concerns about the lack of cleaning schedule with a senior midwife at the time of inspection and asked the service to take urgent action to address this. Following the inspection, the service sent us a copy of a standard operating procedure for local decontamination of birthing pools which was written in April 2021, after our inspection. The standard operating procedure did not contain details of daily water flushing to prevent legionella or instructions for how to clean or dispose of a mirror, sieve or thermometer used during a water birth. The trust had a trust wide water safety policy and told us following during the factual accuracy process the standard operating procedure would be updated to include legionella prevention.

The procedure for evacuation of the birth pool was not displayed next to the pool. We reviewed the evacuation procedure following the inspection and the trust told us staff received training in evacuation of the birth pool through a video training session.

We noted the chairs on labour ward used for birth partners were damaged. The labour ward manager told us new chairs were on order and a risk had been raised on the risk register relating to the infection control risk.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted when women were at risk of deterioration. However, audits showed tools to monitor deterioration were not always used effectively.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. There were processes to identify and respond to changing risk, deteriorating health and medical emergencies. Staff completed the Maternity Early Obstetric Warning Scores (MEOWS) to monitor and recognise the deteriorating patient, including those at risk of developing sepsis. We reviewed ten MEOWS charts of which nine were completed and escalated correctly. The service did not regularly audit completion of MEOWS charts. A MEOWS audit from June 2020 showed that of the 28 charts sampled they were all completed and escalated correctly so this was not re-audited for six months.

The December 2020 MEOWS audit showed staff did not document all elements of clinical observations on the MEOWS chart. The audit showed, 58% of notes had a respiratory rate documented for each entry, lochia was only reported in 58% of the neuro response was documented in 67%, pain only 42% of the times they were seen to have observations completed. Similarly, the January 2021 audit showed 53% had a temperature recorded. Both December 2020 and January 2021 audits noted where yellow and red scores were not calculated or incorrectly calculated, in all cases where escalation to a senior obstetrician was required, this was undertaken. However, there was a risk that if scores were not calculated correctly using all elements of the MEOWS chart deteriorating women may not be recognised and escalated in a timely way.

Following the January 2021, the service took assurance that MEOWS charts were being completed and escalated so a spot check audit was not scheduled until June 2021 despite the issues with the quality of recording vital signs and observations on the MEOWS charts. During the factual accuracy process, the trust told us the spot check audit was not scheduled until June 2021 to allow time for the team to receive targeted training on MEOWS documentation and recognition of the deteriorating patients. However, the risk remained that without regular audit of MEOWS the service did not have timely data to inform governance and risk management.

Staff monitored fetal heartbeat and uterine contractions using individual cardiotocograph machines. Staff used the ‘fresh eyes’ approach where another member of staff reviewed cardiotocograph readings every hour. In the ten records we reviewed fresh eyes was recorded in the notes where relevant although in one record this was intermittent.

Staff completed risk assessments for each woman on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Following assessment by a triage midwife including recording of observations on MOEWS chart, women were prioritised for medical review within agreed timeframes following initial assessment of their symptoms. The service had updated protocols in June 2020 to use the Birmingham symptom-specific obstetric triage system (BSOTS). We reviewed the antenatal triage assessment form for reduced fetal movements and found detailed flowcharts for escalation processes. Midwives accessed medical reviews from the labour ward registrar. It was reported in the March 2020 maternity risk meeting, the BSOTS triage audit information had been collected but was not yet in a format to be presented at the maternity risk meeting. During the factual accuracy process the trust told us the maternity risk meeting minutes were unclear and they should have included that quarter four data was being collected to be presented at the next risk meeting.

Maternity

The service employed a triage midwife who worked 08:30 to 19:45 seven days a week and a telephone triage midwife who worked 9:00 to 18:00 every weekday. Women could call the day assessment unit for advice between 8.15am and 8.15pm or call into the labour ward 24hours a day if they had urgent concerns or thought they were going into labour.

Staff carried out comprehensive risk assessments for women at the time of their first antenatal appointment. In all ten records we reviewed women had fetal movements recorded at each antenatal visit from 25 weeks. Staff risk assessed women's risk of venous thromboembolism at booking, on arrival in labour and during post-natal care in line with national guidance. All ten records we reviewed showed venous thromboembolism risk assessments had been completed.

Staff completed mental health screening assessments for women most of the time. Midwives completed mental health assessments using the 'Whooley' questions, a two-question mental health screening tool, in seven out of ten of the records we reviewed. Women were asked about domestic abuse at booking and again around 28 weeks.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed a safety huddle on the labour ward and saw staff from all areas of the maternity unit were represented but there was no input from community teams. Staff told us community teams could phone into the safety huddle. Staff recorded safety huddles in a diary with details of staffing and a general overview of activity on the unit. We reviewed the safety huddle diary and found there was no record of signing in or messages left for staff so there was no record of messages being shared.

The service was working to improve the way staff shared key information to keep women safe when handing over their care to others. The fetal monitoring midwife was supporting re-design of the SBAR (situation, background, assessment, recommendation) form for inpatients and antenatal services. However, the midwifery and consultant handovers we observed on labour ward did not explicitly use the SBAR process. The SBAR tool is specifically designed to encourage effective communication in the form of a structured method for communicating critical information that requires immediate attention and action.

There were arrangements to ensure checks were made before and after surgical procedures. This included the World Health Organisation (WHO) checklist, used to identify risk factors, before a procedure. We saw in theatres good practice with use of the WHO checklist. At the last inspection there was no audit to confirm World Health Organisation (WHO) checklist was used in obstetric theatres. This had improved, audit of WHO checklist was included in audits of all theatres at the trust. However, as governance for WHO audit checklists went through surgery governance processes rather than maternity there was a risk that the maternity service did not have oversight of performance in maternity theatres.

Midwifery staffing

The service did not always have enough staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers did not review staffing levels in line with national guidance.

At the last inspection, the service did not have enough midwifery staff to provide care and treatment to patients in line with national guidance. This had not significantly improved. The service did not always have enough nursing and midwifery staff to keep women and babies safe. The service last reviewed midwifery staffing in December 2019 using the Birth-rate plus tool and identified the need to increase midwifery staffing by 5.2 whole time equivalent (WTE) (2.87 clinical midwives and 2.87 non-clinical midwives.) This staffing review proposed investment in a senior triage midwife to carry out telephone assessments and advice across the day assessment unit and labour ward.

This did not meet national institute of clinical excellence (NICE) guideline NG4 safe midwifery staffing which states, “a systematic process must be undertaken to calculate the midwifery staffing establishment every six months. The calculation should take into account historical data and acuity and dependency of women.”

The maternity risk register included the risk that midwifery staffing was not staffed to establishment and had not been since February 2019. An external clinical review completed in October 2020 found recommendations made following a staffing review using the Birth-rate plus 2 tool had not been acted on. New roles had been recruited to from existing staff rather than the business case process, depleting available front-line midwifery staff. The risk register included an update that adverts for recruitment for three WTE midwives went out in October 2020 and bank and agency midwives were used to fill the gaps in staffing. Following the inspection, the trust told us a staffing review was undertaken by the maternity team in October 2020 but this was not taken to board in the usual manner due to lose of key personnel in the management of the Covid response.”

The interim head of midwifery presented a maternity workforce review paper on 31 March 2021, the day of the inspection, and the business case was approved by the trust board on 8 April 2021. However, the workforce review did not include a review of midwifery staffing using the Birth rate plus tool as of March 2021 but relied on the previous establishment review from December 2019. Birth rate plus is a nationally recommended tool that calculates the number of clinically active midwives required to deliver a safe high-quality service.

The last report to the board on midwifery staffing in March 2020 did not use Birth rate plus and while it noted staffing challenges, and high levels of acuity in the unit, assurance was given to the board the staffing model in maternity was safe and sustainable.

Despite staffing pressures, one-to-one care in labour was prioritised and achieved at 99-100% every month April 2020 to February 2021. This was in line with National guidance from the Royal College of Obstetricians and Gynaecologists and the National Institute for Health and Care Excellence recommends that mothers, in established labour, in labour suites should receive one to one care.

However, staffing levels did have an impact on care shown by the number of staffing red flag incidents. Red flag incidents are staffing incidents that impact on the quality of care including, delayed, or cancelled time critical activity, a delay of more than thirty minutes providing pain relief or when a midwife is unable to provide continuous 1:1 care in labour. The service monitored staffing red flags on the maternity dashboard in line with national guidance. Data showed between April 2020 and February 2021 the number of red flag incidents ranged between zero in July 2020 and ten in November 2020 with the mean average being 1.7 incidents a month.

At the time of inspection there were staffing shortages on the day on labour ward. The March 2021 risk meeting minutes noted there were currently staffing issues on labour ward, so agency midwifery staff were being used. There was also a vacancy for the labour ward manager role.

At the time of inspection there were not enough staff to implement the continuity of carer model. In March 2021, the six staff in the continuity of carer community team had recently been disbanded and re-assigned to other teams. Data showed between April 2020 and February 2021 performance with the percentage of women on a continuity of carer pathway varied between 8.7% in September 2020 and 16.9% in August.

Maternity

The risk of the service being unable to provide a continuity of carer service was recorded on the risk register. The last update on action to mitigate the risk was from January 2021, which stated pilot work was complete, the consultation had paused, and the situation would be reviewed when staffing levels improved. However, there was no agreed timeframe for when this might be reviewed recorded.

Managers reviewed the number and grade of midwives and midwifery care assistants needed for each shift. Managers used an acuity tool used at 7am, 11am and 3pm, 7pm, 11pm, 3am to give an accurate view of acuity on labour ward and across the service and monitor the delivery of 1:1 care in labour.

The service had lots of newly promoted midwives to band 6. New band 6 midwives were working across the maternity unit and community at the time of inspection. At the time of inspection, the band six midwives who had completed their one-year preceptorship in November 2020 had 18 months experience. Maternity governance meetings March 2021 noted a lack of senior midwives working in community teams may impact performance with vaginal birth after caesarean rates. The cultural review noted a lack of strategic approach towards staffing levels and skill mix and recommended particular attention to whether there are sufficient numbers of experienced band 6 midwives in the unit when reviewing staffing and skill mix. The service used the evidence from the cultural review to inform the business case for significant investment in maternity staffing.

The ward manager could adjust staffing levels daily according to the needs of women. The Labour ward coordinator was supernumerary and could escalate to the duty manager for support if needed. However, the labour ward manager was not clear how the acuity tool linked with the escalation policy. At the time of inspection, the labour ward manager needed to escalate to the duty manager as there were not enough midwives for one-to-one care in labour. The staff escalation policy relied on calling in community midwives on-call to work on the labour ward. However, community midwives told us they did not always feel confident to care for women on the labour ward as these women could be higher risk than homebirths. The cultural review made a recommendation for the service to consider alternative arrangements for escalation cover.

Midwifery staff were not always able to take breaks due to staffing pressures. We reviewed incidents reported by staff in the past year 1st April 2020 to 31st March 2021 and found 47 incidents had been reported relating to staffing shortages, all of which were graded as low. The recent external cultural review also found staff were often unable to take breaks due to staffing pressures.

The service had high vacancy rates. For example, on postnatal ward there were nine midwifery vacancies and three maternity care assistant vacancies. The external clinical review noted the service had struggled to recruit externally. In March 2021, the service was 4.48 WTE (Whole Time Equivalent) staff short of the midwifery establishment. High levels of staff on maternity leave also impacted on the staffing of the service. In March 2021 7.27 WTE staff were on maternity leave.

The service used bank and agency midwives to make up for staffing shortfalls. At the time of inspection, the service was offering incentives for current staff to work additional shifts to reduce the use of bank and agency staff. The incentive scheme approach had been agreed at the maternity improvement board meeting on 11th March 2021. There were only three midwifery staff on the bank. In addition to the three midwives who only held a bank contract, 93 out of 151 substantive midwives who worked at the trust also had a bank contract. This meant the service was reliant on midwives already working in the service to work additional hours on the bank.

Maternity

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

Consultant hours on the labour ward were consistently 40 hours a week between April 2020 and February 2021. This met the Royal College of Gynaecologists and Obstetricians Good Practice Guideline (2010) which recommends consultant cover for a unit with less than 2500 births a year is 40 hours per week.

At the time of inspection, the service had recently changed consultant night cover to ensure twice daily ward rounds happened every day including weekends, in line with recommendations in the Ockenden report. Consultant ward rounds were twice daily 08:30 and 17:30 Monday to Friday with a phone board round at 22:00. At weekends there were consultant board rounds at 09:00 and 17:30 and 20:30 to overlap with junior staff. A standard operating procedure for ward rounds was agreed at the March 2021 maternity governance forum.

The service always had a consultant on-call during evenings and weekends. Junior doctors we spoke with were positive about consultant ward rounds at weekends and told us they were confident on-call consultants would attend the unit if needed in an emergency.

At the time of inspection, the service employed eight consultants and two clinical fellows, and some consultants were resident on-call and others were not. Inconsistencies in roles and responsibilities was a theme picked up in the cultural review. The clinical lead told us discussions on job plans for consultants and future requirements are at an early stage.

Records

Staff kept detailed records of women's care and treatment. Records were clear and up to date but were not always stored securely.

Women's notes were comprehensive, and all staff could access them easily. Maternity records were a combination of hand-held paper records, written paper records and electronic records. Pregnant women had hand-held records (a file of all the information related to their pregnancy) which was started at their first antenatal booking appointment. We reviewed ten sets of women's records and found all records were legible, dated, timed, and signed.

At the time of inspection, the service did not employ a digital midwife to progress plans to prepare for a paperless electronic records system. A digital midwife was proposed as a new post in the workforce review that was approved following the inspection on 8 April 2021.

Records were not always stored securely to ensure confidentiality. We observed a notes trolley open on labour ward.

Incidents

Safety concerns were not consistently identified or addressed quickly enough. The service had a culture of blame around incident reporting that leaders had recognised and were working to improve. The approach to reviewing and investigating incidents was too slow and there was little evidence learning from adverse events led to improvements in safety.

Staff raised concerns and reported incidents and near misses in line with trust policy. The maternity leadership team told us they were confident staff were reporting all incidents. The service was taking action to clarify triggers for what

counts as a reportable incident in line with the local maternity system. The clinical lead told us the service considered itself an over-reporter of incidents. We requested the incident trigger list following the inspection and found the incident trigger list in use at the time of inspection was from 2016 and an updated version was in draft with details of who was responsible for reviewing incidents and how the case would be reviewed.

Serious incidents

Eight serious incidents relating to maternity and gynaecology were reported to the Strategic Executive Information System (StEIS) by the trust from 1 February 2020 to 3 March 2021.

Embedding learning from serious incidents needed to improve. For example, following a serious incident in January 2019 the service was focusing on improving compliance with fluid balance charts. The March 2021 governance forum meeting minutes showed the fluid balance audit compliance was 60% compliant and recorded "to be reviewed on how that can be better managed" as this was an ongoing problem. At the time of inspection, serious incidents were shared at private board meetings every other month through the integrated performance report.

Staff did not always have the opportunity to meet and discuss the feedback and look at improvements to patient care. Staff we spoke with told us they did not have regular team meetings. We asked for minutes of recent team meetings and received examples of maternity monthly newsletters and community team coordination meetings.

The service used 'SWARM' rapid incident reviews following serious incidents, led by a consultant within two days of the incident. Serious incidents were escalated to weekly safety summit meetings for review led by the medical director and chief nurse.

Managers were working to improve debriefing and support for staff after any serious incident. The recent cultural review found staff did not always receive adequate emotional support and debriefs following difficult incidents. The service recognised debriefs following serious or distressing incidents needed to improve. Trauma risk management training was being rolled out across the trust and the maternity division had secured ten out of the twenty available training places for staff. The clinical lead has also met with the local maternity system (Bath, Swindon and Wiltshire maternity units) to discuss improving debrief processes.

There were significant delays to managers investigating incidents. The maternity risk register included the risk that there were a high number of serious incidents that the maternity team had not completed actions within expected timeframes. The chief nurse and chief operating officer were attending intensive support meetings with the divisional management team, interim head of midwifery and clinical lead every week between August 2020 to October 2020 to improve oversight of investigations. For example, the final incident investigation for the never event that happened in February 2020 was not signed off until July 2020.

Involvement of women and their families in these investigations could be improved. There was no patient experience lead at the time of inspection but funding for the role to support with management of complaints and involvement of women and families in incident investigations was agreed as part of the workforce review paper approved by the trust board in April 2021.

The service did not always grade the level of harm in incidents correctly. We reviewed maternity incidents reported to NRLS (National Report and Learning System) in March and February 2021 and found the level of harm was not always graded correctly. For example, the following incidents were graded as no harm:

- Massive obstetric haemorrhage leading to hysterectomy (incident ID 59752135, incident date 25/02/2021)

Maternity

- Massive obstetric haemorrhage (incident ID 58121050, incident date 25/01/2021)
- Massive obstetric haemorrhage 2500ml (incident ID 58121364 date of incident, 31/12/2020)
- Major obstetric haemorrhage 1860ml (incident ID 58121113, incident date 28/01/2021)
- Fourth degree perineal tear (incident ID 60042301, incident date 01/03/2021
- Third degree tear (incident ID 58439483, incident date 02/02/2021)

There is a risk the level of harm experienced by women in maternity services is not recognised and investigated appropriately to improve safety of services. Post-partum haemorrhage with significant blood loss over 1500ml is highly unlikely to be a no or low harm incident. Likewise, third- or fourth-degree tears usually result in moderate harm as women may need surgical follow-up appointments, blood tests and psychological support to recover.

Never events

There was one never event in the past year in February 2020. The incident was a retained swab post-procedure following repair of a third-degree tear. Following this incident, the service rolled out swab count training to theatre staff. As of September 2020, compliance with this training was 59%. The audit data showed this learning still needed to be embedded as the audit compliance was still variable. Compliance with documentation of swab count using newly implemented swab stamp pre- and post-delivery was 39% in January 2021 and 100% in February 2021.

Is the service effective?

Inspected but not rated

We inspected but did not rate effective in relation to evidence-based care and treatment, competent staff, and multidisciplinary working.

Evidence-based care and treatment

Processes for updating clinical guidance were not clear or timely. Staff followed policies to plan and deliver high quality care according to evidence-based practice and national guidance most of the time.

The service was implementing NHS England's 'Saving Babies Lives version two', published March 2019, and the perinatal institute's gestation related optimal weight (GROW) guidance. Out of the ten records we reviewed, all had growth and height of the baby plotted on a growth chart. However, the GROW assessment protocol was only recently approved at the time on inspection at the February 2021maternity governance meeting.

The service was implementing the Better Births five-year forward plan in line with other services in the Local Maternity System. The service had implemented the Saving Babies Lives care bundle and appointed a midwife and an obstetrician as fetal monitoring leads.

Staff could access clinical guidelines. On labour ward care pathways and the escalation policy was displayed on a noticeboard. However, guidelines were not always clear. For example, guidelines we reviewed on safe evacuation were not clear as they included contradictory information on draining pool for shoulder dystocia but filling pool to make woman more buoyant in other circumstances.

Maternity

Junior doctors we spoke with described positive working relationships between all members of the obstetric team and were confident to contact registrars and consultants for advice and support when necessary. However, all three junior doctors we spoke with told us that consultants did not always agree on management plans for certain clinical situations and that often following a handover between consultants, plans would change. They all stated that this had made them feel uncomfortable with some of the clinical decisions made and that some consultants openly criticised other consultant's management plans. These concerns were echoed in discussion with one of the labour ward consultants we spoke with.

Guidelines we reviewed did not include the dates they were written so we were not able to tell if they were up to date. Guidelines included clear pathways for treatment and referenced the appropriate National Institute for Health and Care Excellence (NICE) clinical guidelines. The clinical lead told us, all guidelines were drawn up and shared with consultants then formally agreed through the maternity clinical governance group.

The service was working to improve governance of clinical guidance at the time of inspection and was setting up a monthly guidelines group as of March 2021. The March 2021 maternity governance forum minutes noted gaps in the guidelines available on the trust's internal intranet and an action was recorded to discuss with obstetrics and paediatric consultants and feedback to the meeting.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives, and carers. For example, we attended the postnatal ward morning handover and saw emotional needs were discussed alongside physical health needs.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of women. The service had worked to improve staff competency in interpretation of cardiotocography. At the time of inspection, compliance with the cardiotocography (CTG) half-day mandatory training was for midwives and obstetricians 94.6%. Following the Ockenden report, weekly CTG monitoring case reviews and multidisciplinary training sessions were scheduled for the whole of 2021. Compliance with CTG training had improved significantly following the external clinical review from 40% to 90% over the autumn of 2020.

The fetal monitoring midwife was adapting CTG teaching sessions for student midwives and ad hoc training on Dawes Redman CTG machines (machines that combine CTG monitoring with an algorithm to support accurate interpretation of the results).

Managers made sure staff received any specialist training for their role. Staff completed practical obstetric multidisciplinary training every year (PROMPT). At the time of inspection while face to face PROMPT training had been cancelled since March 2020 the service was now delivering this training with a 50:50 mix of face-to-face simulation training and virtual learning. The clinical educator was organising online PROMPT sessions every other week to ensure staff were able to complete this mandatory yearly training. The maternity service had received support from the trust to overcome IT challenges to get this training online. Compliance with PROMPT training was 30% at the time of inspection but the service planned to support staff to complete the training to ensure compliance was 90% by the deadline. However, staffing pressures impacted on the staff ability to be released for training. On the day of inspection, we saw two registrars had to attend antenatal ward rather than PROMPT training they were booked onto.

The service acknowledged challenges with training staff in neonatal life support but was working to book staff in for sessions throughout 2021 to catch up. Staff had access to a simulation suite although use of this had reduced during the pandemic.

The practice development lead supported the learning and development needs of staff. At the time of inspection, the practice development lead worked clinically up to 50% of the time due to staffing demands on the service. A fetal surveillance lead was appointed in November 2020 and was working full-time at the time of inspection.

All newly qualified midwives undertook a 12-month preceptorship programme. This programme supported the newly qualified midwives to build confidence and consolidate learning gained as a student. The practice educator midwife worked alongside preceptee midwives twice a year.

The cultural review recommended introducing an induction for new starters and staff re-joining the service and introducing competency frameworks to provide clarity to staff. The practice development midwife was working on this at the time of inspection. The clinical educator supported induction of staff and told us new starters were supernumerary for three weeks.

The service had six professional midwifery advisors (PMAs) but the service acknowledged, staff uptake on support could be improved. We requested but did not receive data on the percentage of midwives who had a yearly meeting with a PMA. The service had produced a PMA action plan that included actions relating to putting posters up, line managers encouraging midwives to see the PMAs once a year and renaming the service 'Restorative Clinical Support'.

Managers identified training needs of staff and had given them the time and opportunity to develop their skills and knowledge. Managers identified poor staff performance promptly and supported staff to improve. The clinical educator told us, if staff don't have competencies signed off, individualised training support is arranged, and competencies are re-checked.

The service had a range of specialist midwives who supported midwives and women. Specialist midwives included: a fetal surveillance midwife, safeguarding midwife, two infant feeding specialist midwives and a bereavement midwife.

Appraisal data

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. As of quarter three of 2020/2021 75.9% had received a yearly appraisal, up from 68% in quarter two. Out of eight consultants and two clinical fellows employed, two were overdue appraisals due to sickness or maternity leave and one was overdue on account of lack of engagement. Junior doctors completed training needs assessments to enable them to identify training needs.

Managers did not monitor appraisal performance regularly. Appraisal rates were not included in the dashboard April 2020 to January 2021. February 2021 appraisal data showed 80% midwives had received a yearly appraisal.

Multidisciplinary working

Doctors, midwives, and other healthcare professionals worked together as a team to benefit women most of the time. However, community midwives and unit midwives did not always work well together.

Maternity

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Additional MDT meetings were planned throughout the day to discuss and update on the planned care for women within the service. We observed handover meetings on labour and post-natal wards at the start of the day. We observed good leadership at the labour ward handover, and saw that all women were discussed, and prioritised and management plans agreed for high-risk women.

The postnatal ward manager told us the postnatal ward staff had worked on a quality improvement project to implement bed side handover. However, there was a lack of focus on quality improvement in the labour ward handover with no mention of what went well and sharing learning.

Managers from all areas had a meeting in the morning to discuss capacity and acuity concerns and tried to work together at times of peak activity.

The recent cultural review found concerns were raised about the interpersonal behaviour of consultants, both towards each other and midwifery staff. However, we did not find evidence of this during the inspection. We found community teams and hospital-based staff did not always work well together which was a risk as the staffing escalation process relied on on-call community midwifery staff to support on the labour ward.

Staff worked across health care disciplines and with other agencies when required to care for patients. Midwives we spoke with reported there were good working relationships with paediatricians. For example, on the postnatal ward staff told us paediatricians regularly visited to support with completing new-born and infant physical examination (NIPE) when there wasn't a NIPE trained midwife available.

Is the service well-led?

Inadequate

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

- The maternity department did not have a stable leadership team or adequate support from the division or trust board to manage the service.
- The service did not have a clear strategy for maternity services at the time of inspection. The service had secured funding to build an alongside midwifery led unit and building was in progress but there was no plan for how this service would be staffed.
- Leaders were aware of the need to significantly improve the culture in the maternity service, but more support was needed to create and sustain change.
- The arrangements for governance and performance management were not clear and did not operate effectively. The service had not invested in enough staff to support quality and governance in maternity services although a business case had been approved to improve this following the inspection.
- Leaders and teams did not use systems to manage performance effectively.
- Risks were not always recognised, and recorded risks were not sufficiently mitigated and reviewed regularly.

Maternity

Leadership

The maternity department did not have a stable leadership team or adequate support from the division or trust board to manage the service.

Maternity services did not have a strong enough voice at divisional level due to the number of services it sat alongside in the division. Maternity services were part of the clinical support and family services division which included: obstetrics, gynaecology, paediatrics, neonatal unit, fertility, sexual health, pathology, medical engineering, radiology, medical devices, speech & language, clinical psychology, genetics, and mental health liaison.

At the time of inspection, the service was led by an interim head of midwifery, a consultant lead obstetrician and two deputy heads of midwifery. The deputy head of maternity roles did not have job descriptions at the time of the inspection, and this was raised at the December 2020 intensive support meeting but there were no clear actions to address this other than a discussion of uplifting the band 7 roles to band 8a roles in the interim. The safety & quality manager and better births project manager were both on sickness leave at the time of inspection.

The trust had not invested in training and development of midwifery staff in line with the Royal College of Midwives 2019 document 'Strengthening Midwifery Leadership: a manifesto for better maternity care' that includes recommendations for a director of midwifery at every trust, an aim for a consultant midwife at every trust, strengthened support for sustainable midwifery leadership in education and research, a commitment to fund ongoing midwifery leadership development. The external cultural review made recommendations that the service should consider recruiting additional people to address any capability or skills gaps in maternity services.

At the last inspection in 2016, there were no clear succession plans for maternity leadership roles. This had not improved. Senior midwives did not have access to formal leadership training. Succession planning had not been sufficiently considered by the leadership team.

The service did not have a director of midwifery at the time of inspection. The interim head of midwifery was supported by a director of midwifery from a local trust one day a week since December 2020.

Leaders understood the challenges staff on the front-line face but did not have enough support to manage identified risks relating to staffing and culture. At the time of inspection, the service did not have a consultant midwife as recommended by the Ockenden review and investment of a consultant midwife was not agreed in the recent workforce review. Following the inspection, the trust told us that there would be further consideration of the consultant midwife role in discussion with the local maternity system.

The clinical lead was the lead for both gynaecology and obstetrics but only had four hours a week to dedicate to their clinical lead roles. They raised this issue in the September 2020 intensive support meeting and the chief operating officer took an action to discuss at the next executives meeting. It was not evident from intensive support meeting minutes what the outcome of this discussion was.

While the maternity leadership team were positive about recent support from the executive team, the maternity leadership team did not feel supported by the board. A board level maternity safety champion had been appointed in November 2020 but at the time of inspection while the maternity leadership team had two meetings with the board level safety champion, regular meetings and agendas had not been set up, so the purpose of these meetings was not well-defined.

Maternity

We spoke with the board level safety champion following the inspection and they told us the maternity leadership team had their contact details and they had visited the department for two walkabouts.

Vision and strategy

The service did not have a maternity strategy at the time of inspection. The service had secured funding to build an alongside midwifery led unit and building was in progress but there was no plan for how this service would be staffed.

The service did not have a maternity strategy at the time of inspection. We requested the strategy for the service and were sent a document with an update on safety priorities, training, and education. The recent cultural review found staff were unclear of the strategic direction and plans for maternity services.

The maternity improvement board minutes for March 25th 2021, showed there were plans to create a strategy with short term goals aligned to a longer-term strategy. The service was already engaged with the local maternity system but needed to involve the maternity team and the maternity voices partnership in development of the strategy. The service had a transformation midwife who was focusing on implementing the maternity improvement action plan, but they were on sick leave at the time of inspection.

The service was currently building a two-bed alongside midwifery unit funded by the local maternity system. However, there were no plans available to explain how this service would be staffed.

The service did not have the staffing capacity to provide the continuity of carer model of care at the time of inspection. The 'Ivy team,' six staff who were part of a continuity of carer team had been re-allocated to work in other community teams due to staffing pressures.

The risk the service could not meet the national mandate that all providers will book 20% of women onto a continuity of carer pathway by March 2019 was added to the risk register in March 2019. The current risk level was 3, low risk, and the most recent action from January 2021 was that the continuity of carer pilot was complete and the consultation with regards to contract changes paused with a plan to review the situation and future planning when staffing levels improved. The risk had not been updated to reflect the NHS 2019/20 stipulated 35% of women should be booked onto a continuity of carer pathway by 31st March 2020.

The service did not currently have a perinatal mental health strategy document. The trust sent us an update relating to plans for the perinatal mental health service which included piloting maternity mental health clinics and extending the period of care from 12 to 24 months in community settings. The perinatal mental health service was recruiting a consultant psychiatrist to enable the service to develop further.

Culture

Leaders were aware of the need to significantly improve the culture in the maternity service, but more support was needed to create and sustain change. There were high levels of staff sickness and vacancies.

Staff were unsettled following recent clinical and cultural reviews. The trust executive team commissioned a clinical review following concerns from the clinical governance committee about timely investigation of serious incidents and also commissioned a cultural review following concerns raised by a group of maternity staff to the Freedom to Speak Up

Guardian. Both these reviews were commissioned in the Summer of 2020. The results had been fedback to band seven and six staff, consultants, and then all staff to discuss the findings. All junior doctors we spoke with were aware of the findings from the cultural reviews. However, processes for support for staff following the cultural review were not well developed.

Staff wellbeing and safety at work was not sufficiently prioritised. There were high levels of stress and work overload. The recent cultural review found the working environment and culture were impacting on the health and wellbeing of staff and staff were not encouraged to take breaks. Staff spoke of good support from their peers but did not always feel supported by the leadership team. Staff could not always access the interim head of midwifery to raise concerns about working conditions.

Community teams and hospital-based staff did not work together cohesively. The cultural review found an 'us and them' culture between the unit and community teams. Community midwives did not feel connected with the maternity unit and resented working on the labour ward in times of escalation. Community midwives told us they did not always feel safe on home visits in rural areas at night. While there was a lone worker policy that involved community midwives calling into the labour ward coordinator every two hours, community staff were not confident that this process worked and that the labour ward coordinator was always aware of where community midwives were.

The services processes for duty of candour could be improved due to lack of support for women and families involved in serious incidents. The service was aware of the need to improve compliance with duty of candour and had plans to recruit a patient experience midwife to support management of complaints and involvement of women and families in investigations.

Governance

The arrangements for governance and performance management were not fully clear and did not operate effectively. The service had not invested in enough staff to support quality and governance in maternity services although a business case had been approved to improve this following the inspection.

Maternity service business as usual governance meetings included: a monthly maternity risk meeting reporting to the trust clinical risk group and divisional management team, maternity governance meetings every other month reporting to divisional management team and clinical management board, and a maternity guideline group every other month reporting to the maternity governance group and then up to clinical management board.

At the time of inspection, the maternity governance structure was further complicated by the addition of a maternity improvement board and intensive support meetings that supplemented business as usual governance processes. These additional structures were intended to support improvements, but it was not clear how additional meetings interacted with business as usual governance meetings to drive improvements efficiently and effectively. Following the completion of the external clinical and cultural reviews published autumn 2020, intensive support meetings were held every month since September 2020 and weekly at the time of inspection. These meetings were attended by the chief operating officer and chief nurse alongside maternity and divisional senior leaders.

There was not sufficient oversight and challenge to ensure the safety and quality of maternity services of maternity services at board level. The trust wide clinical governance committee reported up to the trust board every month. We reviewed the reports to board from to October 2020 to March 2021 and found there were brief updates on maternity at each meeting. It was concerning the board appeared to take reassurance from the recent external quality report, rather than assurance as the December 2020 report stated "it was positive to note that there were no major concerns. Two areas to address were identified as the senior structure in the department (it is currently very flat) and training."

However, the report stated, urgent action was required to ensure staff are compliant with essential clinical training in emergency skills and drills and fetal surveillance monitoring, the current midwifery staffing establishment should be reviewed in detail in line with Birth Rate plus, action should be taken to improve timeliness of serious incident investigation, ensuring an impartial representative on the serious incident panel and auditing of learning from serious incidents. In January 2021 a detailed presentation of the two external reviews and the Ockenden compliance submission was provided to the Clinical Governance Committee

A maternity improvement board with a working group underneath monitored progress with the external cultural and clinical reviews Ockenden report and the CQC improvement plan October 2020 to address the requirement notice and 'should' actions from the 2016 inspection report. Actions included reviewing the current audit framework and developing a full audit programme for 2021/2022. The trust also planned to work with an external auditor to improve audit processes. The maternity improvement plan pulled together Ockenden cultural review and appendices mapped out lots of recommendations that were organized under six themes: maternity strategy & external working, workforce planning, skill mix and responsibilities, training & development, communication & engagement, values & behaviours, governance, and risk. All actions mapped back to original documentation in relation to the requirements of recent reviews, CQC actions and the Ockenden review requirements. We reviewed the minutes of the last two maternity improvement board meetings which were held every two weeks. These meetings included how to address immediate staffing concerns while the workforce business case was in progress.

We reviewed the trust response to the Ockenden report submitted to the regional midwife in December 2020 which reported the service was compliant in all areas except consultant board rounds twice daily, seven days a week and recording of risk assessments every time a woman has contact with a midwife. The service was non-compliant with the requirement to have a plan for the Birth-rate plus standard by 31 January 2021 as the last staffing review using Birth-rate plus was December 2019. However, the board did not challenge when the last staffing review had taken place when the Ockenden report response was shared with the trust board in January 2021.

Monthly maternity governance forums meetings were not effective. A monthly maternity governance forum reported up to divisional governance meetings. We reviewed the February and March 2021 maternity governance meetings and found there was no standard agenda to ensure staffing, incidents, the maternity dashboard, complaints, feedback from women, strategy, and quality improvement were discussed. While incidents and the maternity dashboard were not included in the maternity governance meeting these were included in the maternity risk meeting standard agenda. It was not clear how the maternity risk meeting and the maternity governance meeting interacted with each other to ensure governance processes were effective. Minutes of the February 2021 maternity governance meeting were very brief and did not include any action points. The March 2021 maternity governance meeting minutes stated there was a discussion around the new maternity governance agenda with a plan to hold maternity governance meetings every two months rather than every month alongside a new maternity governance guideline group to take place once a month.

Governance meeting minutes did not always include details of action to improve services. For example, the maternity governance forum minutes March 2021 noted "there was a crash call in theatre for shoulder dystocia however no one heard it. A registrar had to be called from clinic." However, there was no action noted in the minutes to review the audibility of the emergency alarms to prevent such an incident occurring again. It was also noted at this meeting vaginal birth after caesarean rates had declined but there was no action recorded to improve performance. The decline in vaginal birth after caesarean rates was also discussed at the March 2021 risk meeting and it was noted that performance varies significantly against the services target of 75%.

Staff did not have regular staff meetings and there was an over-reliance on email for communication despite staff telling us they did not always have time to check emails. Labour ward midwives told us they did not have staff meetings and

when we requested team meeting minutes, the trust was unable to send us them and confirmed these meetings were not held." A private social media group was used for staff communication. Community staff reported they got updates from public social media platforms before being informed directly by the service. Community teams met together every Monday, but this was an operational meeting and there was no evidence in the three meeting records we reviewed of sharing learning or updates from the management team.

March 2021 governance meeting noted consultants were not included in monthly newsletters which included updates on learning from audits. An action was recorded for someone to look at the efficiency of how information was shared with staff. The cultural review recommended the establishment of formal communication structures at all levels in maternity services.

Management of risk, issues, and performance

Leaders and teams did not use systems to manage performance effectively. Risks were not always recognised, and recorded risks were not sufficiently mitigated and reviewed regularly.

The maternity dashboard included performance data on Apgar scores (a scoring system used to assess newborns at one and five minutes after birth), % of stillbirths, neonatal deaths within 28 days, severe and moderate shoulder dystocia, post-partum haemorrhage over 1,500ml, post-partum hysterectomies, third and fourth degree tears, intensive care admissions from obstetrics and term babies admitted to the neonatal unit unexpectedly. The maternity dashboard was reviewed at the monthly clinical governance forums and monthly risk meetings.

Performance data was compared to minimum, median and maximum values from the 12 maternity units in the Southwest region over two calendar years, but national comparison data was not always included when it was available in the national maternity data set. For example, there was no benchmarking data for Apgar scores less than six at five minutes. The maternity leadership team was working with the local maternity system to develop a clinical dashboard to allow targeted benchmarking of data.

Data on term babies admitted to the neonatal unit unexpectedly was reviewed on the maternity dashboard and south regional neonatal dashboard and reviewed at avoiding term admissions into neonatal (ATAIN) meetings every other month.

The service was working to improve local audit programmes. At the time of inspection, the local audit programme was being rescheduled with national audit and serious incidents taking priority. The March 2021 maternity governance forum meetings noted that there were discussions in progress to improve auditing to make it more responsive. Audit results were discussed in maternity governance meetings, but audits were not always regular enough to ensure improvements were sustained. For example, following the January 2021, the service took assurance that MEOWS charts were being completed and escalated so a spot check audit was not scheduled until June 2021 despite the issues identified with the quality of recording vital signs and observations on the MEOWS charts.

The board did not prioritise review of performance against the Maternity Incentive Scheme and the board did not have current oversight of performance. At the time of inspection, the last time the Maternity Incentive Scheme had been reviewed at board was at the September 2020 where the 2019/2020 submission was reviewed.

We discussed the current performance against the standards within the scheme with the interim head of midwifery and clinical lead and they told us work to ensure full compliance with standards was still in progress for standard 1 (perinatal mortality review) standard 8 (90% of maternity unit staff attended multi-professional maternity emergencies training

session within the last training year) and standard 9 (bi-monthly meetings with board level safety champions). The trust told us they had completed a gap analysis and were progressing with safety actions 1, 8 and 9 for the submission in July 2021.The corporate risk register included an action that as of September 2020 the head of nursing was to attend the monthly meetings where these were reviewed.

The risk register did not always include detailed action to mitigate risks. For example, there were several incidents reported relating to newborn babies not being registered on the trust electronic patient record system within thirty minutes. The risk register did not include details of how the risk of this happening again was reduced. Similarly, the risk of violence and aggression against labour ward staff did not include details of mitigating actions.

The maternity risk register contained historic risks. For example, a risk relating to missed diagnosis of developmental dysplasia of the hip was raised in April 2014 but there were no recorded actions to mitigate this risk. There were also two maternity information governance risks from December 2012 that did not include progress on action to mitigate these risks. We reviewed the maternity risk meeting minutes for March 2021 and found review of the risk register was a standard agenda item.

The interim head of midwifery and clinical lead described the top risks in the service as, staffing and escalation of staffing shortfalls, interim leadership, open serious incident investigations and only having one obstetric theatre.

The interim head of midwifery acknowledged at the time of inspection there was not sufficient midwifery staffing resource to focus on the quality and safety agenda. The service had a quality and risk lead, but they were on sickness leave at the time of inspection and there were no other staff to support with audit and governance. A nurse from the neonatal intensive care unit was redeployed to support maternity with clinical audit since September 2020 but this was on a temporary basis. The interim head of midwifery and the consultant head of service had raised the lack of governance leadership capacity at the maternity improvement board on the 11th of March 2020, but this was not escalated to be included in the maternity risk register.

Reviews of deaths and unexpected outcomes were discussed at perinatal mortality and morbidity meetings every other month. However, we reviewed the minutes of the last three meetings and found discussions rarely identified learning points. The clinical lead acknowledged while the perinatal mortality review tool (PRMT) was now being used, it was not being used in real time to support sharing of learning.

We reviewed the last two perinatal mortality meetings for January 2021 and February 2021 and found learning was rarely identified and actions taken to improve care from these reviews. For example, at the January 2021 there was discussion about if new-borns given naloxone should go to the neonatal unit for observation, but no decision made or action to follow this up. Similarly, at the February 2021 meeting there was discussion around how often middle cerebral artery Doppler's should be completed but no action was noted to follow this up.

Areas for improvement

Maternity services

The trust must ensure:

- there are effective systems and processes to assess, monitor and improve the quality and safety of maternity services. Regulation 17 (2) (a)

Maternity

- midwifery staffing is reviewed every six months in line with national guidance. Regulation 17 (2) (b)
- the service has safe and sufficient staffing in line with national guidance. Regulation 18 (1)
- there are succession plans for maternity leadership. Regulation 18 (2) (a) (b)
- leadership training is available to senior midwives. Regulation 18 (2) (a) (b)
- MEOWS charts are recorded and completed correctly and in full. Regulation 17 (2) (f)
- the birth pool is cleaned in line with guidance. Regulation 12 (2) (e) (h)
- staff complete daily checks on emergency equipment. Regulation 12 (e)

The trust should:

- improve staff are awareness of the procedure for evacuation of the birth pool.
- improve completion of the mental health screening tool for women.
- consider the governance processes for WHO checklist for obstetric theatres.
- improve staff understanding of the acuity tool and escalation policy.
- review staffing levels to ensure there is sufficient staffing capacity to deliver the continuity of carer model of midwifery care.
- ensure records are always stored securely.
- consider employing a consultant midwife.
- include national comparison for metrics on the maternity dashboard.
- review the lone worker policy so it effectively supports staff health and safety.

Our inspection team

The team that inspected the maternity service comprised a CQC lead inspector, a CQC deputy chief inspector and two specialist advisors.

The team that inspected the spinal service comprised a CQC lead inspector, a CQC assistant inspector and one specialist advisor.

Both inspection teams were overseen by Amanda Williams, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	S29A Warning Notice