Portsmouth Hospitals University NHS Trust

Queen Alexandra Hospital

Inspection report

Southwick Hill Road
Cosham
Portsmouth
PO6 3LY
Tel: 02392286000
www.porthosp.nhs.uk

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Queen Alexandra Hospital

Inspected but not rated

The maternity service at Queen Alexandra Hospital in Portsmouth is consultant led, providing care and treatment for women with high risk pregnancy or medical complications. The Mary Rose unit also known as (B5) is a co-located midwife led unit with two birthing pools offering midwife led maternity services to low risk women. The trust's community team also offers a community and home birth service.

The maternity services provide care and treatment to women living in Portsmouth and the surrounding areas. There are approximately 5,000 babies born per year at Queen Alexandra Hospital.

The maternity services include hospital and community settings ensuring that women receive care across the antenatal, labour and post-natal periods. The service additionally includes the pre–natal diagnostic service such as fetal medicine, ante-natal screening facilities and the Ultrasound Sonography (USS) service.

The trust has three standalone maternity centres as well as a co-located maternity centre at Queen Alexandra Hospital;

• Blake maternity centre based at Gosport War Memorial Hospital

• Grange maternity centre based in Petersfield Community Hospital

• Portsmouth maternity centre based in St Mary's Community health campus.

• Ward B5 co-located maternity unit.

The trust has a fetal medicine sub-specialty

We last inspected the maternity service between 15 and 17 October 2019. The report was published on 29 January 2020. The maternity service was rated requires improvement overall. Safe and effective were rated as requires improvement, caring and responsive were rated good and well led was rated requires improvement.

We carried out this unannounced focused inspection because we received information of concern about the safety and quality of the service.

We did not rate this service at this inspection. The previous rating of requires improvement remains.

How we carried out the inspection

As part of our inspection we visited the following areas within the maternity service: labour suite, midwifery led birthing unit, post-natal ward and the maternity day assessment unit.

We spoke with 30 members of staff including medical and midwifery staff, maternity care assistants, administrators and service leads. We observed care, handovers and meetings and reviewed four sets of maternity records.

Our findings

We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information about this service.

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

Maternity

Inspected but not rated

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

- Staffing levels were often lower than planned. To manage this risk, managers regularly reviewed and adjusted staffing levels and skill mix. Staff were redeployed within the unit when needed, to keep women safe from avoidable harm and to provide the right care and treatment.
- Staff did not always recognise and report all incidents and near misses.
- The service had not conducted any recent abduction exercises, although they had a current baby abduction policy.
- The service had not conducted any recent emergency evacuation drills for the birthing pools, although staff had received training.
- Staff did not always feel respected, supported and valued by all managers. The service did not have an open culture where staff felt they could raise concerns without fear.
- Not all trust policies were up to date, complete or contained all risk factors.
- The trust had implemented a new integrated IT system in the department for patient records without a business continuity plan in case the system was unavailable due to outages.

However:

- Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately.
- The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women.
- When things went wrong, staff apologised and gave women honest information and suitable support.
- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff mostly felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually.
- The service leaders had the skills and abilities to run the service. They were beginning to understand the priorities and issues the service faced and were developing plans to improve.
- Records were stored securely.
- Leaders and teams had started to use systems to manage performance effectively. They were developing effective systems to identify and escalate relevant risks and issues and identified actions to reduce their impact.
- Staff were focused on the needs of women receiving care.

Maternity

Is the service safe?

Inspected but not rated

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance and it was visibly clean throughout. We looked at five cleaning audits across four wards and spoke to one member of staff carrying out cleaning duties on one of the wards we visited.

Staff disposed of clinical waste safely. We noticed that across the five wards visited, the waste bins were labelled and separated according to the type of waste contained, and all the sharps bins were labelled and not over filled.

We reviewed five gas cylinders and found that they were in-date and stored in line with guidance in a lockable room. All cylinders were upright and cylinders were in a trolley or chained to the wall. However, we found that the printed guidance located with the gas cylinder was due for review in 2014. We discussed this with the lead on site who removed the printed guidance and advised that they would direct staff to the current version.

The service had enough suitable equipment to help them to safely care for women and babies. Staff carried out daily safety checks of specialist equipment. We reviewed ten pieces of equipment, including resuscitation trolleys and resuscitiares, and their associated safety checks. The documents reflected the equipment was in good working order and it was stocked, safely positioned, sealed, in date and the safety check sheets were completed and signed.

We checked the emergency trolley on ward B5. The trolley had a tamper evident seal which secured all drawers of the trolly. However, on review of the trolley we found that the tamper evident seal, which was attached and appeared secured, did not actually secure the trolley because the door it was attached to was not closed firmly. We discussed this with the lead who advised this was not usually an issue and she would speak to staff to ensure it was being closed firmly.

Women could reach call bells and staff responded quickly when called. We observed two instances on two wards where women had rung the bell, and a member of staff responded within two minutes.

There were five of each of the following, across the four wards visited: posters with breastfeeding guidance, PALS posters, PReCEPT (Prevention of Cerebral Palsy in Pre-Term Labour) posters, Dad Pad brochures, posters on how to support carers, posters warning against female genital mutilation, and Duty of Candour posters.

Additionally, there were posters with information about contacting the language line to access approximately 100 languages and how to access urgent transport.

However, of the four wards visited, there was only one poster welcoming NHS Rainbow badges, and detailing that people of all identities were welcome.

Maternity

The service had suitable facilities to meet the needs of women's families.

We looked at two birthing pools, and found them to be visibly clean. Staff described the cleaning process for the birthing pools and this reflected the trust policy and guidelines. These instructions were made readily available to all staff members and were on display in the birthing pool rooms. Cleaning of birthing pools was carried out daily and also before each woman entered the pool. However, the cleaning carried out was not recorded or documented. No records meant that the cleaning process could not be audited. This also meant the trust could not always be assured that cleaning took place in accordance with its own guidelines.

Staff had received training to evacuate women from the pool in the event of an emergency. The trust reported 96% compliance rate with waterbirth training at the time of the inspection. However, due to covid restrictions the service had been unable to carry out any simulation drills regarding the evacuation process. This meant that, despite having received training, staff may not have embedded skills needed during an emergency situation.

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 upon women at risk of deterioration

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used the 'Modified Early Obstetric Warning Score' (MEOWS).

Staff completed booking risk assessments for each woman at their initial booking appointment, which included social, medical and obstetric assessments. Staff updated the trust electronic records with womens information including: social background, ethnicity, co-morbidities and body mass index. This enabled staff to determine if the woman was a high or low risk pregnancy. Women with high-risk pregnancies, for example, due to a multiple pregnancy, diabetes and pre-eclampsia were regularly monitored and reviewed by an obstetrician.

Staff completed risk assessments for each woman on admission or arrival to the department, using a recognised tool, and reviewed this regularly, including after any incident. The service used the Birmingham Symptom Specific Obstetric System (BSOTS). The system involved completion of a standard clinical triage assessment by a midwife within 15 minutes of a woman's attendance to define clinical urgency, guide timing of subsequent assessment and immediate care. The service had implemented the BSOTS model in May 2020 and launched a virtual training program, which was completed by 91 staff at that time. This represented 100% compliance across all relevant staff groups. A further 74 staff, not directly involved in the triage process, completed the same training in March 2021.

Women attending the Maternity Assessment Unit clinic were all assessed using the BSOTS, in accordance with trust policy. Data provided by the trust showed on average 90% of service users were triaged within the 15 minutes target. For example, in December 2020 95% of women were triaged within 15 minutes. However, we noted sometimes there were significant delays in the Maternity Assessment Unit with some women waiting up to 4 hours to be seen. This was sometimes the case for women triaged as green using the BSOTS pathway. To mitigate risk, women were re-assessed using the BSOTS model at regular intervals. Additionally, women were advised to prior to attending to bring snacks and drinks in case of delays or long waits.

Staff carried out comprehensive risk assessments for women at the time of their first antenatal appointment. 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. In addition, staff carried out venous thromboembolism assessments on all women in the community who had reported a positive Covid result.

Maternity

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. We observed both the morning midwifery and multi-disciplinary team (MDT) shift handover meetings. All women were discussed so that midwives knew about all women and not just those they were individually looking after. Specific discussions regarding safeguarding issues or sensitive cases, took place separately in a clinic room to ensure confidentiality.

The MDT handover was attended by the co-ordinator, ante-natal and post-natal ward leads, the obstetric team (both day and night), the anaesthetic team, neonatal intensive care (NICU) retrieval nurse and the midwifery senior management team. However, not all staff attended the MDT meeting as the clinical handover had already occurred. Women's names were used, induction of labour cases were discussed, ante-natal women were reviewed, there was a review of NICU beds, staffing, acuity of women and risks were discussed.

A "situation, background, assessment and recommendation" (SBAR) tool was used effectively in discussions regarding women. 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.

Due to the an issue in accessing patient records at the time of inspection, we were only able to review four sets. Of the four sets of womens records we looked at, only two had recorded Vitamin D supplements being discussed or offered. From June 2020, in order to address the impact of Covid 19 on Black , Asian and minority ethnic women, providers were required to discuss vitamins, supplements and nutrition in pregnancy with all women. Women with dark skin or those who always covered their skin when outside could be at particular risk of vitamin D insufficiency and should therefore consider taking a daily supplement of vitamin D.

Midwifery staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix to ensure safe care was delivered despite staffing shortages. Managers gave bank and agency staff a full induction.

The service was staffed in accordance with Birthrate Plus, a nationally recognised acuity tool, to assess staffing requirements based on women's needs. Staff were moved between all clinical areas including the community to ensure that acuity levels were met across the service. The trust provided information which showed the Birthrate Plus acuity assessment was last undertaken in February 2020 and was based on 5,308 births per year.

However, the service did not always have enough midwifery staff to keep women and babies safe. Senior leaders described how they mitigated risk when staffing routinely did not meet acuity levels. Leaders explained the service escalation process which was detailed in the escalation policy. The policy detailed the minimum number of midwives needed on the ward areas and that escalation should go through the services supernumerary bleep holder who would redeploy midwives not engaged in clinical duties to ensure cover.

Managers told us that maternity staffing levels were discussed at all safety huddles. Additional safety huddles were called as required. The head of midwifery attended the safety huddle if an escalation occurred. The bleep holder managed the daily staffing which included the deployment of staff across the department to manage mitigations, escalations and review prospective staffing rotas. Staffing was discussed at safety huddles and requests for bank shifts had been made.

The trust told us that despite their current staffing challenges one to one care was prioritised. They moved staff and mobilised those in specialist roles for example as part of escalation to protect this aspect of care. Data provided by the trust after the inspection showed one to one care was provided in excess of 95% of births for March and April 2021.

Despite these mitigations, all staff we spoke with raised concerns regarding midwifery safe staffing. The service was aware and had developed recruitment plans to fill gaps and there was data which outlined recruitment activity.

The labour suite coordinator was a supernumerary role in line with national recommendations. The service monitored the supernumerary status of the coordinator as part of their quality dashboard. Data provided by the service showed from April 2020 to November 2020 the coordinator was supernumerary on all shifts recorded.

The service had introduced the Continuity of Carer (CoC) model in September 2019 and had gradually introduced teams from the staffing establishment. CoC is recommended in the Better Births 2016 report to ensure safer care and better outcomes for women and babies. In March, April and May 2021 the CoC model was rolled out to 5.9% of the service. The prediction for June, July and August 2021 9.14%. This is in line with the CoC plan. The service had identified the geographical areas for higher risk women and had incorporated that into their rollout plan effectively.

Service leaders told us that midwifery staffing had been particularly difficult during the pandemic due to staff shielding and increased sickness caused by the virus.

To help address the staffing shortages there had been a rolling recruitment drive and staffing concerns were escalated and discussed at the service's monthly maternity quality safety meeting.

The service used bank midwives to fill gaps in shifts. Managers requested staff familiar with the service. Staff we spoke with said that they used regular bank midwives who were familiar with the service or already worked for the service. Managers made sure all bank had a full induction and understood the service.

Staff described the practice of midwives scrubbing to support within theatre. This put a strain on the midwife staffing levels. This is generally considered out of date practice, as identified by 'Staffing Obstetric Theatres - A Consensus Statement' (May 2009) published by the College of Operating Department Practitioners, The Royal College of Midwives and the Association for Perioperative Practice. Both the trust and staff told us this practice had been planned to cease for a number of years. We highlighted this to the trust leadership as a concern at the end of the inspection. After the inspection the trust confirmed that the practice of midwives scrubbing for theatre was to cease with effect from 30 June 2021.

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. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep women and babies safe. Medical staffing levels within the unit were generally sufficient. The service had 24-hour on call consultant cover. Cover was from 8am to 9pm on site and 9pm to 8am off site. The service had 20 consultants, 14 of whom were on the obstetric rota.

There was a trigger list for the on call consultant attendance overnight should staff have a concern. However, some staff described confusion about what constituted a trigger. They described not always having adequate guidance if the

concern constituted a trigger or not. Most medical staff told us they would discuss concerns with the on-call consultant via telephone, who would attend if needed. Data provided by the trust confirmed consultant attendance, when called, was captured and audited against the trigger list. Of the 31 cases listed for a variety of reasons, for the period February to May 2021, on only two occasions the consultant was not informed.

Consultants were on-site and on-call Monday to Friday 08:15 to 22:00, and Saturday / Sunday 08:15 to 12:00 and 20:15 to 22:00. During these hours consultants were immediately available for decision making and clinical input when required.

The service had plans to increase the obstetrician headcount by two whole time equivalents. This would increase the consultant cover to provide 98 hours of dedicated consultant cover for the labour suite per week. This would bring the service in line with good practice as outlined by the Royal College of Obstetricians and Gynaecologists. The service did not have an allocated post-natal obstetrician. Where required the clinical director for the service provided cover.

An anaesthetist was available 24 hours a day, seven days a week for the labour ward to administer an epidural or spinal anaesthesia.

Junior doctors told us that their training and learning experience was positive and there were no gaps in the rota. Consultants were approachable and supportive and medical staff told us they had access to clinical supervisor meetings. Junior medical staff told us that they could escalate concerns easily and received support and advice. All medical staff had undergone an induction programme.

Records

Staff kept detailed records of women's care and treatment. Records were mostly clear, up-to-date, stored securely and easily available to all staff providing care.

We observed care and treatment and looked at four sets of womens records. We analysed information about the service which was provided by the trust.

Both paper and electronic records were stored securely. Paper records were stored in locked drawer units. There was a new integrated IT system in the department for patient records. Access was via secure login details, personalised for each member of staff and permission was also granted based on the role held.

An electronic records system had been introduced in February 2021. Prior to the introduction staff had received training in the new system. Following the system introduction, managers had introduced "floor walkers" to support staff. Similar support was also available for community staff. Most staff told us that the "floor walkers" had been very helpful. The introduction of the new digital record meant pregnant women could access a real-time summary of their maternity notes through an innovative maternity application which had replaced paper records. It also meant information could be shared directly with expectant women from the maternity system. Women could add personalised information for example, plans and preferences for birth which could be discussed with their midwife. The app could be used on their smart phones, tablet device or personal computer.

However, there was an outage with the national system which meant the new system was down when we visited. This meant there was potential for inaccurate record keeping, and errors, liable to put women at risk. Additionally, staff told us the issue had not been escalated and not recorded on the internal electronic incident reporting tool.

However, blood results and scans were available to staff members via a separate electronic system.

Maternity

Some staff told us that they had raised concerns when the main electronic system was down, but did not feel listened to as no back up system had been implemented or maintained.

Women's notes were generally comprehensive. However, due to using two electronic systems (one for blood tests and scans, and another one for medical history and care notes), staff could not always access them easily and timely

Staff kept detailed records of women's care and treatment. However, we noticed some of the notes did not clearly indicate the healthcare professional's name, and the mental health assessment section was not always completed thoroughly.

Incidents

Staff did not always recognise and report all incidents and near misses. Once reported, managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support.

The trust used an electronic reporting system which all grades of staff had access to. Staff we spoke with generally knew what incidents to report and how to report them. However, both managers and staff told us they did not always recognise what constituted an incident that should be reported. For example, on the day of the inspection the electronic records system was unavailable due to a national outage. Staff we spoke did not consider reporting this using the incident reporting system, believing that 'managers will be aware anyway'.

Staff met to discuss the feedback and look at improvements to care for women. Staff told us they received feedback from incidents they had reported.

The service used a formalised and structured approach to facilitate rapid incident reviews following serious incidents. This usually took place within two days of the incident. Managers and staff were very familiar with the approach used and reported it was efficient and worked well. Serious incidents were managed in line with trust policy, which included escalation to the weekly trust incident review panel, led by the associate medical director.

Managers debriefed and supported staff after any serious incident. Managers were working to improve debriefing and support process after any serious incident. They recognised debriefs for staff following serious or distressing incidents needed to improve. Trauma risk management support was available within the wider trust and managers had plans to bring it into the service.

Staff understood the duty of candour. They were open and transparent, and gave women and families a full explanation if and when things went wrong. The trust had a duty of candour policy which staff could access through the trust's intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate or prolonged psychological harm. Staff we spoke with were aware of the importance of being open and honest with women and families when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened.

Maternity

Never Events and Serious Incidents

The service reported no never events. In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents in maternity which met the reporting criteria set by NHS England from June 2020 to May 2021.

Is the service effective?

Inspected but not rated

We did not rate this service at this inspection. The previous rating of good remains. We found:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, not all trust policies were up to date, complete or contained all risk factors.

Staff followed policies to plan and deliver high quality care according to evidence-based practice and national guidance. There was a system in place to ensure policies and clinical pathways reflected national guidance. Policies once drafted were approved by local safety or governance committees and forums. We reviewed 10 policies and three of these were out of date for review. Policies were reviewed every two to three years and it was noted that extensions to some review dates had been given due to COVID-19 pressures.

However, some policies did not mention all risk factors or the policy appeared incomplete. For example, in the Intrapartum Care Guideline there was a heading in the document for augmentation but the wording providing the guidance was not there. Additionally, there was no mention of Duty of Candour or debrief in the Perineal Trauma policy and, at the time of our inspection, there was no Vaginal Birth After Caesarean policy. This meant there was a risk that staff may not follow the most up to date guideline when providing care.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We attended the postnatal ward morning handover and observed staff discussing emotional needs alongside physical health needs.

The trust engaged in national programmes to improve delivery of maternity services. The trust provided us information in response to Maternity Incentive Scheme. This was an incentive scheme that outlined ten essential actions designed to improve the delivery of best practice in maternity and neonatal services. The service was working towards compliance and were monitoring this closely. Compliance was discussed across different governance meetings including the maternity quality safety meeting and the risk and governance meeting.

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.

Managers gave all new staff a full induction tailored to their role before they started work. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided by the service confirmed 98% of medical staff and 86% of nursing and midwifery staff had received an appraisal as at April 2021.

The clinical educators supported the learning and development needs of staff and collaboration with the Safety Team and leadership. They reported feeling motivated and supported in their roles, encouraging an open doors policy, where staff members could flag any additional training needs, and feedback on the training they undertake. Where compliance rates were low practice educators contacted team leads and staff to discuss and also liaised with the Development Department. Communication regarding any updates were sent to staff on a regular basis.

Managers identified any training needs staff had and gave them the time and opportunity to develop their skills and knowledge. We spoke with seven members of staff, holding various positions, all of whom reported good support to access and complete training based on their specific roles, and a good culture of ensuring staff did not have to complete training in their own time. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us there was frequent and effective communication of training needs, with feedback on training packs and sessions encouraged and collated to drive improvement. However, some staff we spoke with reported not feeling informed about the recent implementation of the new electronic system for patient records, and felt the training received around this was lacking.

Managers made sure staff received any specialist training for their role. Both community and hospital staff reported receiving targeted clinical training, according to the roles and tasks they covered, and feeling confident to carry out their roles.

Managers identified poor staff performance promptly and supported staff to improve. Staff felt there was generally a positive learning culture, and that learning from incidents was managed appropriately where they were reported. The practice educators told us no staff members had failed any assessments, and explained that if this happened the approach would be to, for example, arrange one to one sessions, write reflections and liaise with matrons.

Multidisciplinary working

Doctors, midwives and other healthcare professionals generally worked together as a team to benefit women and their babies. They mostly supported each other to provide good care.

All mandatory training continued throughout the pandemic. Staff told us none of it was paused and gave positive feedback about their training. Multidisciplinary training included face to face training sessions before the pandemic, but now was composed of eLearning, with 3-hour long sessions using six workstations. Community staff trained alongside hospital staff, with both the PROMPT and Electronic Fetal Monitoring training being multidisciplinary. PROMPT is an evidence-based multi-professional obstetric emergencies training package developed for use in local maternity units. PROMPT training at the trust included obstetricians, paediatricians, anaesthetists and midwives.

The provider had scheduled regular multidisciplinary meetings to discuss women and improve their care. During our visit, we observed one pre-ward round, two ward rounds, and three handover meetings. One of the ward rounds we observed was not multidisciplinary, although it had been designed as such. The labour ward handover we observed included a multidisciplinary team formed of the obstetric team (day and night), the anaesthetic team (day and night), the NICU retrieval nurse, midwifery senior management team (consultant midwife, inpatient matron, community midwife matron, antenatal matron), a band 7 midwife bleepholder.

Maternity

Practice educators reported good collaboration observed between midwives and doctors. Consultants were actively involved in fetal monitoring training, and described as a good support overall. Staff from both the community unit and the hospital all reported good working relationships with their medical colleagues. Additionally, staff we spoke with reported feeling confident to challenge decisions, to escalate concerns, and to seek support whenever needed.

Is the service well-led?

Inspected but not rated

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

Leadership

The service leaders had the skills and abilities to run the service. They were beginning to understand the priorities and issues the service faced and were developing plans to improve. They were generally visible and approachable in the service for women and staff.

The senior leadership team was formed of a director of midwifery, divisional (clinical) director, divisional nursing director and a care group manager. Since our last inspection in September 2019, this was a new maternity senior leadership team. The director of midwifery has been in post since March 2021. The care group manager had been in post approximately seven weeks at the time of the inspection. In addition, the service had also recently appointed a deputy director of maternity and governance.

There was a clearly defined management and leadership structure in place. We observed, and were told of, joint working between leaders both within the department, the rest of the trust and with external agencies and bodies to maximise care provision for women and babies.

The director of midwifery was supported in her role by a deputy director of maternity and governance, four dedicated midwifery matrons (each of who led on: labour ward, theatres, community, clinics) a consultant midwife and band seven lead midwives. Most of these appointments were recent and although those appointed were experienced, the roles were new and yet to be fully embedded. Senior leaders recognised the structure was in its infancy and had begun developing plans to support the new roles and staff. For example, external support to get 360 degree feedback from staff to aid better communication within the service had been sought.

The trust's chief nurse was the executive lead and board safety champion. There was a non- executive director with responsibility for the maternity service. This meant there was a high profile for the maternity service at board level. This was an improvement from the last inspection in 2019.

Maternity service presented directly to the board and this was in line with Spotlight for Maternity 2016. The 'Spotlight on Maternity' March 2016 states 'to ensure that there is a board-level focus on improving safety and outcomes in maternity services, organisations should provide the opportunity for the medical director for maternity and the head of midwifery to present regularly to the board.'

The service leadership team met weekly to discuss performance, operational capacity and any concerns. Meetings had a set agenda and reviewed areas such as safety issues and reported incidents. A the time of the inspection this was a new format and so we were unable to review any minutes of meetings held.

Maternity

Staff told us they received good support from their managers within the service at all levels. Staff were mostly positive when speaking about the senior leaders in the service and told us they were trusted and respected. Staff told us that leaders were generally visible and frequently attended handovers and huddles. Although as some roles had only recently been filled, not all staff we spoke with could recall seeing some senior leaders within the department.

Medical staff we spoke with told us their leads and educational leaders were generally supportive, approachable and open to challenge.

The trust and service were responsive to concerns we raised and fed back on inspection. For instance, in the week following our inspection the service acted promptly on the feedback we had provided. This included confirming the changes to midwives scrubbing to theatre, reviewing business continuity plans in respect of electronic patient records and assessing skill-mix of staff for home birth teams.

Vision and strategy

The service had a vision for what it wanted to achieve. The vision was focused on sustainability of services and aligned to local plans within the wider health economy.

The service had a vision for what it wanted to achieve developed with relevant stakeholders. The vision was focused on sustainability, the development of services, workforce, use of technology and was aligned to local plans within the wider health economy. It focused on providing safe, high quality, sustainable care for all and hearing the voice of both women and staff. This was aligned to the trusts vision.

The maternity service's strategy detailed the service's ambitions for the next five years and was aligned to the NHS Long Term Plan 2019 and key recommendations from investigations into maternal and neonatal adverse outcomes including national reviews such as the Ockenden report (2020).

The service worked collaboratively with neighbouring trusts, clinical commissioning groups, other stakeholders, and service users to establish a local maternity system (LMS), in response to national recommendations.

Culture

Staff were focused on the needs of women receiving care. The service mostly promoted equality and diversity in daily work, and provided opportunities for career development. Whilst most staff felt respected, supported and valued, there were areas that did not work together cohesively.

All staff we met during our inspection were welcoming, friendly and helpful. In general, staff told us this was a good place to work and that the culture of the service was good. Staff felt there had been a noticeable improvement since the appointment of the new director of midwifery. However, midwifery staff also told us that staffing shortages affected morale. There were some concerns regarding staff skill mix with regard to the home birthing teams which led to some staff feeling unsupported. After the inspection the trust confirmed they would focus on plans to improve these concerns.

Within the maternity unit we observed effective multidisciplinary working between midwifery and medical teams with strong working relationships and respect for team member's skills, from junior staff through to the most senior leaders.

While most staff described a supportive culture within the service we were told of some long-standing cultural issues. Some staff referred to difficult working relationships across grades and professions. They referred to a lack of respect, with some staff citing professional and cultural differences. Other staff spoke positively about the culture and cited staffing pressures as the main cause of stress between individuals and staffing groups.

Staff told us different grades did not always appreciate or understand roles carried out by each other and that community teams and hospital-based staff did not work together cohesively. For example, staff we spoke with at the community unit felt there was a blame culture around incidents, poor communication of incidents (they had not been made aware why the birthing pools had been closed previously), and that debriefs were not formalised.

Leaders recognised these concerns and were developing plans to better integrate these parts of the service. For example, community teams would be able to access meetings using video-conferencing and former office based roles were being encouraged to be more visible within the service.

Governance

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

The service had governance processes in place and these had been strengthened with the recent appointment of a deputy director of maternity and governance for the service. We noted the service had oversight reviewing guidelines, monitoring use of the Modified Early Obstetric Warning Score (MEOWS) scoring, documentation of carbon monoxide monitoring and the documentation of domestic violence monitoring.

We reviewed various governance meetings and noted they were well attended by senior managers and various members of the multidisciplinary team. Governance meetings covered areas such as incidents, staffing, risk register, risk management, complaints, information governance, monthly audit and quality dashboard, investigations, quality performance indicators, complaints, reviewing of guidelines reports, patient experience and medicines management.

Staff told us information relating to governance was cascaded and shared via safety huddles, team meetings and practice educators.

The service triumvirate met regularly to discuss development of the maternity service and any issues. The director of midwifery met the chief nurse weekly to discuss issues. The director of midwifery also reported to the board via the chief nurse who was trust executive lead for the service and board level safety champion. The service had a non-executive director (NED) who met virtually with the chief nurse. The NED had visited the service, unfortunately there had been no visits in 2020/21 due to the reduction of visiting associated with COVID-19.

We reviewed minutes of the divisional board meetings that were held monthly and found these to be well attended by representatives of the multidisciplinary team and appropriate discussion were held and actioned such as a review of the the risk register, staffing and concerns.

We reviewed the minutes of the maternity quality safety meetings. The purpose of the meeting was to oversee all issues that are related to clinical governance, quality and safety and approve reports and guidelines prior to submission to divisional board and trust board as required. The minutes showed the meeting was well attended, and actions were assigned to named individuals to progress.

We reviewed guidelines and policies for the department as part of our inspection that were available electronically to all staff to access when they needed. Of the 10 we reviewed we found three were out of date.

Maternity

Managing risks, issues and performance

Leaders and teams had started to use systems to manage performance effectively. They were developing effective systems to identify and escalate relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were processes in place to identify risk. Risks were identified and recorded in line with the services maternity risk management policy. The maternity service had a risk register adressing risks within the service. Risks were recorded and managed using the trust's electronic risk reporting system. All risks on the register were allocated to a member of staff responsible for reviewing and monitoring them. We observed the risk register and risks were in date and had been reviewed. Risks included monitoring compliance with saving babies lives care bundle version 2 and the NHS Maternity Incentive Scheme.

The risk register was discussed at the service's monthly risk and governance meetings and the monthly maternity quality safety meetings as a standing agenda item. The service had introduced weekly safety meetings and included in the discussion was risk. Staff were encouraged to engage with risk management.

Daily handovers included a briefing of any issues highlighted by managers. We observed this during our inspection and which confirmed the briefing included local audit results and safety information.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The dashboard was reviewed as part of the monthly risk and governance meetings as a standing agenda item and was presented monthly to the trust board by the director of midwifery.

Since our inspection in 2019 the service had allocated additional resources into the risk and governance team and had employed three additional midwives into risk, governance and clinical quality roles.

The trust had an Infant/Child Abduction and Missing Person policy. The policy stated exercises would be carried out to identify gaps in knowledge, training or planning. However, the policy did not refer to the frequency of the requirement to carry out exercises to better prepare staff should this occur. Staff told us they could not recall when the last exercise was carried out. Managers informed us exercises had been planned but delayed due to COVID restrictions. Leaders could not be assured staff would know what to do in the event of a baby abduction and carry out the plan effectively.

Areas for improvement

MUSTS

Maternity service

- The trust must ensure that all relevant maternity policies and guidelines are reviewed, reflect current guidance and updated within their agreed timeframes. Regulation 12.

SHOULDS

Maternity service

Maternity

- The trust should consider securing emergency equipment more effectively.
- The trust should consider documenting and auditing the cleaning of the birthing pools.
- The trust should consider conducting evacuation drills from the birthing pool at the earliest opportunity.
- The trust should consider reviewing the 'trigger' list for when consultants are required to attend the department when on-call.
- The trust should consider changing the practice of midwives scrubbing for theatre.
- The trust should consider how to improve waiting times for women attending the Maternity Assessment Unit.
- The trust should consider reviewing the skill-mix of staff within the home birth for the safety of both women and staff.
- The trust should consider developing a business continuity plan for the electronic patient record system.
- The trust should consider improving staff awareness regarding reporting incidents and near misses.
- The trust should consider carrying out baby abduction exercises at the earliest opportunity.
- The trust should discuss vitamins, supplements and nutrition in pregnancy with all women.
- The trust should consider expanding information displayed on the maternity dashboard to align to the COVID 4 actions.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four additional inspectors and two specialist advisors, including two obstetricians and two registered midwives. The inspection team was 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
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment