University Hospitals Birmingham NHS Foundation Trust

Good Hope Hospital

Inspection report

Rectory Road
Sutton Coldfield
B75 7RR
Tel: 01214242000

Date of inspection visit: 8 February and 9 February 2023
Date of publication: 07/06/2023

Ratings

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

Our findings

Overall summary of services at Good Hope Hospital

Inspected but not rated

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

We inspected the maternity service at Good Hope Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

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

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

University Hospitals Birmingham NHS Foundation Trust provides maternity services across Birmingham, Sutton Coldfield and Solihull. The Maternity department at Good Hope Hospital comprises of delivery suite, triage, postnatal and antenatal wards, day assessment unit, midwife and consultant led clinics, scanning services, a bereavement suite, as well as a maternity led unit, although this was not always able to accept patients.

This hospital is not rated.

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

https://www.cqc.org.uk/provider/RRK

How we carried out the inspection

We spoke to 25 staff including senior leaders, matrons, midwifes, obstetric staff, specialist midwives, and clinical governance and patient safety team to better understand what it was like working in the service. We interviewed leaders to gain insight into the trusts group leadership model and governance of the service. We reviewed 11 sets of maternity records and 20 prescription charts across the trust. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recently reported incidents and audit results.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received 7 feedback forms from women. We analysed the results to identify themes and trends.

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

Requires Improvement

We rated it as requires improvement because:

- The service did not have enough staff to care for women and keep them safe. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- The service provided mandatory and maternity specific training in key skills to all staff but did not always ensure everyone had completed it.
- Systems to manage performance were not always used effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, it was not always clear if action had been taken or followed up.

However:

- Leaders recognised that the instability of the senior leadership team had impacted on staff morale and the ability to implement and sustain improvements. A number of vacant posts had been recruited to, including the Director of Midwifery.
- The service engaged well with women and birthing people within the diverse community, particularly with regard to Female Genital Mutilation (FGM) as well as a specialist bereavement service.

Is the service safe?

Requires Improvement

We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff were up to date with all their mandatory training.

Staff did not always receive or kept up-to-date with their mandatory training. The trust target for mandatory training was 90%. Training records demonstrated that this target had not been achieved for practical manual handling training, level 2 infection control training or clinical life support (Level 2).

The service had birthing rooms with pools within their maternity led units and delivery suite. All staff within the Midwifery Led Unit (MLU) had been trained in pool evacuation via a ward based practical workshop and were provided with a video resource.

We reviewed the training data for manual handling and found these fell well below the trust's target of 90%. Training data showed only 52% of staff were compliant with this training. However, 99% of staff had completed manual handling theory training. Therefore, the service could not be assured that staff had the required skills in the event of sudden deterioration of women and the requirement for evacuation.

The trust provided level 1 and 2 Infection control training as part of mandatory training where 96% of staff had completed level 1 but only 63% had completed level 2. Therefore we could not be assured staff followed best practice guidelines for infection control.

The service provided clinical life support (Level 2) training. The rates at the service for both medical and nursing and midwifery staff compliance was 49%.This meant not all staff had training to provide lifesaving treatment to women and babies in their care.

The service had a weekly programme of multi-professional simulated obstetric emergency training (PROMPT). In addition to the annual PROMPT training. Records showed staff completed skills and drills training on a weekly basis with scenarios such as baby abduction or use of equipment. Records for January 2023 demonstrated all staff had met the trust target of 90% with the exception of anaesthetic trainees (86%) and support workers (84%).

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, safeguarding, skills and drills training and neo-natal life support. There was an emphasis on multidisciplinary training leading to better outcomes for woman, birthing people and babies.

Managers monitored mandatory training and rostered staff to attend when training days were organised. However, staff reported they were often pulled back on to the wards on these days due to staffing levels.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that 95% of staff had completed Level 3 safeguarding adults and 94% safeguarding children training at the level for their role, as set out in the trust's policy and in the intercollegiate guidelines.

The trust had a well-established safeguarding team. The team consisted of band 7 and 6 specialist trained midwives who had close links with 3 local authorities. The specialist team worked across all trust sites supporting midwives with specialist supervision and training. The team covered specialisms including children, female genital mutilation, substance misuse, domestic abuse, mental health, homelessness, asylum seekers and migrant women, and teenage pregnancy. The team had dedicated administrative support. The midwives had established relevant links with charitable groups associated with developing links within the local diverse community. These connections ensured appropriate birthing plans and discharge plans to support the women and their babies. The safeguard lead was chairing a pilot project ICON (Babies Cry, You Can Cope). There were 5 pilots across the country, looking at how to reduce the risk of babies being shaken and harmed. The project had a range of steps to provide information to professionals and women at different stages of their pregnancy and following the birth.

The service employed a midwife who specialised in female genital mutilation (FGM). Their role was to educate, raise awareness and support women affected by FGM. They had worked with interpreting services face to face due to the delicate and sensitive nature of the topic, as well as providing information in several different languages. The trust fairness task force team (who focus on equality and diversity) were very proud of how the midwife had engaged with the local community not only supporting pregnant women, but also others affected by FGM.

Maternity

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and recorded the details in the mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. Patient records detailed where safeguarding concerns had been escalated in line with local procedures. Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. The safeguarding team had worked on a new version of the abduction policy. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

When women had their babies taken into care at birth or shortly afterwards by social services the midwives ensured they received 'Hope' boxes which contained early memories of the baby and pregnancy journey. Early intervention was also being developed with social work teams to provide a support network through the birthing journey for the women.

The safeguard lead had been developing connections with CPIS (Child Protection - Information Sharing Service). This service provided a network across the country of women or their babies who could be at risk. The team were adding additional data for women 28 weeks plus to the register to provider a broader range of details.

The bereavement team was well versed in the diverse nature of the community and religious and cultural observances. The team worked closely with community groups to connect with women and their families. The team linked with the foetal medicine department and were aware in advance of those women and families who may need their support.

Cleanliness, infection control and hygiene

The service controlled infection risk. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. Not all areas of the premises and some equipment was not visibly clean.

Maternity service areas had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The trust had not shared with us any audits or records in relation to the pool cleaning schedules. We saw pool cleaning schedules were available within the MLU and these were completed after use, to maintain infection control standards. However, we found that the pool in delivery suite was visibly unclean with tide marks and visible dirt.

The service audited cleaning checks every month. We looked at audits for the last 5 months and found the audits were not consistently completed for each ward on each month. The audits completed showed results over 90% compliance and reflected where areas needed additional cleaning or action. However, they did not identify who was responsible to complete these tasks or by a required date. Therefore, we could not be assured action was taken when improvements were required to ensure the safety of women and birthing people.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Leaders completed infection prevention and control (IPC) and hand hygiene audits. Data showed hand hygiene audits were completed every month in most maternity areas. For the delivery suite we only received a hand hygiene audit for December 2022 and January 2023 which showed compliance between 80% and 100% with hand washing. For the maternity led unit, audits were received for November 2022 and January 2023, with 100% compliance. Audits for November 2022, December 2022 and January 2023 for Ward 5 also showed 100% compliance with hand hygiene.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

Women and birthing people could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

Staff carried out daily safety checks of emergency equipment. However, we found that although the records indicated all equipment was present and in date, this was not the case. We saw on the emergency trolley on ward 5 and MLU, items were missing even though the checklist indicated they had been checked as available, out of date items including one item which was a year out of date, and some packaging was compromised. We raised this with ward staff and senior management, who addressed this issue during the inspection.

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

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

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

Assessing and responding to patient risk

Women and birthing people were at risk of harm. Staff completed and updated risk assessments for each woman but did not always take action to remove or minimise risks. Staff did not identify or act quickly when women and birthing people were at risk of deterioration.

Maternity

Staff used an evidence-based, standardised risk assessment tool for maternity triage. The tool was being run alongside the day assessment clinic and shared a notice board. During our inspection we noted it was difficult to distinguish the women attending through triage or women attending for a planned appointment. This posed a risk that some women may not always be seen in a timely manner in accordance with the triage tool or that there could be confusion of the risk levels for the women who presented to the triage department.

We saw that the risk assessment tool had been adapted and did not completely follow the standardised risk assessment tool. An additional risk rating (orange) had been added into the tool and the Red RAG rating was not used. We followed the journey of a birthing woman who attended triage and was assessed using the risk assessment tool. We saw the birthing woman had not been seen within the specified timescale and the process demonstrated a lack of understanding of the standardised risk assessment model.

The standardised risk assessment tool used required a doctor should be on site within the triage unit. Staff told us this was not always the case. This been recognised and was recorded on the trust's risk register. On the day of the inspection, medical cover for triage was being provided by the delivery suite doctor.

The service audited the use of the standardised risk assessment tool for triage by reviewing 20 care records every month. We looked at audits for the last 3 months and found the timeframes for the support required from a doctor where not always met. The audit showed 6 out of 20 women and birthing people had not been seen within the required timeframe during November 2022 and January 2023, and 7 women and birthing women during December 2022. This was due to the department not having an independent doctor associated with the triage assessment. This had been identified by the trust and action in relation to recruitment of a doctor was in progress. Midwives contacted doctors working elsewhere within the maternity unit to review women and birthing people when a designated doctor was not allocated to triage.

The triage unit was being run alongside the day assessment clinic and shared a notice board. During our inspection we noted it was difficult to distinguish the women attending through triage or women attending for a planned appointment. There was a risk some women may not be seen within the specified timescales in accordance with the standardised risk assessment tool for triage, there may be confusion over the risk levels for the women who presented to the triage department, or they may be completed overlooked as it is not clear whether they presented through triage or for a planned appointment.

The service used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) identify women and birthing people at risk of deterioration. The MEOWS chart was used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating. It was recognised that early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remained the key factors in providing high quality care to sick pregnant and postpartum women (MBRRACE 2016).

Leaders were not able to assure themselves that MEOWS were being completed in line with best practice or identify any learning or areas for improvement, as records were not audited. Leaders told us audits were not completed on the use of MEOWS and all records were directly inputted into the electronic record system.

Cardiotocography (CTG) was used during pregnancy to monitor foetal heart rate and uterine contractions. Best practice is to have a "fresh eyes" or buddy approach for regular review of CTGs during labour. We looked at the CTG and fresh eyes audits which covered January 2023, which demonstrated that fresh eyes had been completed as required.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists and outcomes of the audits were shared through Theatre Standards Group and Clinical Quality Monitoring Group (CQMG). The audits identified the sign out procedures were disorganised with lots of activity continuing, final counts were performed too early and not all staff engaged in the WHO process. Information from the audits were displayed on posters and shared in learning sets through the use of power point presentation of the audit details, including recommendations. There were also plans to increase the number of audits completed across all theatres.

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

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The patient care record was on a secure electronic patient record system used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

We observed variations in the way handovers were conducted. Midwifery led handovers utilised computerised handover sheets and were clear and concise. They demonstrated good planning for the care and treatment for women and birthing people and babies. The handover used a format which described the situation, background, assessment, recommendation (SBAR) for each patient to share information. However, we observed that the medical handovers did not use the SBAR format to its full capacity. Staff had 2 safety huddles each shift to ensure all staff were up to date with key information, in addition to the midday multiagency safety huddle, attended by representatives from other NHS trusts within the locality.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. The newborn and infant physical examination (NIPE) screens babies for specific conditions, ideally within 72 hours of birth. The service audited completion of NIPE examinations, the audit we reviewed showed 99% compliance of the required timeframe. This meant they monitored that screening was completed in a timely way. The service also provided transitional care for babies who required additional care.

Staff completed risk assessments prior to discharging women and birthing people and pregnant people into the community and made sure third party organisations were informed of the discharge.

Midwifery Staffing

There was inadequate midwifery staff across the service. The service had issues with recruitment and retention and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Staff reported they were often short staffed and were frequently asked to move to other areas to provide support. Staff spoken with told us their main concern was around staff, as they were often short staffed. This impacted on their ability to care for women and birthing people, as well as their wellbeing, as they were unable to have their break.

Maternity

The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 ‘Safe midwifery staffing for maternity settings'. A red flag event is a warning sign that something may be wrong with midwifery staffing. We reviewed the data showing the red flags reported by the trust between September and December 2022, 66 in total. The most reported were ‘delayed or cancelled time critical activity’ and 'delay between admission for Induction and beginning of process’. The main reason noted for these red flags was staffing and bed availability on Delivery Suite. The action from these was to continue to review all planned admissions to consider forward planning. The introduction of the midday huddle enabled transparent conversations about activities within all units and to consider the workload.

‘Birth Rate Plus’ is an evidence-based methodology based on national standards for workforce planning. The service last completed a staffing and acuity review in June 2021. The staffing reflected in this acuity review included the services at Solihull and Willow the maternity lead unit, which at the time of the inspection were closed. Therefore this was not an accurate reflection of staffing requirements. The trust recognised in 2022 that they needed to complete a full staffing review. However, despite ‘red flag’ events continuing to warn of staffing issues, the decision had been made to delay the staffing review (‘Birth Rate Plus’) until the appointment of a permanent Director of Midwifery. This post had been recruited to and it was anticipated the assessment will be completed once this member of staff was in post.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. They were supported in this role by the safety co-ordinator between the hours of 9am and 5pm.

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

The service had high vacancy rates, sickness rates and high use of bank nurses. We saw that the service had a vacancy rate for midwives of approximately 15 whole time equivalents (WTE) for inpatient areas. Midwifery staffing fill rates across the trust for December 2022 was 69% of day shift and 75% for night shifts. The trust had a range of actions and controls to mitigate the risk. These included asking staff in specialist roles and managers at Band 7 and above to work clinically, relocate staff to ensure one to one care in labour and dedicated labour ward co-ordinator roles are maintained and manage and move capacity as required across sites. However, the service was still unable to fill all the required shifts.

Sickness levels across the trust for nursing and midwifery registered staff for December 2022 was 7%. Bank and agency usage varied from week to week. Information provided the trust demonstrated that on specific weeks between June 2022 and January 2023 for inpatient areas at the service bank fill rates ranged between 8% to 27%. For the trust as whole during this period bank fill rates ranged between 16% and 23%.

The service was unable to demonstrate that staff were fully competent for their roles. Not all staff had completed an annual appraisal or were fully up to date with their mandatory training.

The trust could not be assured staff had received the required support for their roles. Although there were systems and processes for managers to support staff to develop through yearly, constructive appraisals of their work, less than 60% of midwifery staff had received their annual appraisal. An audit undertaken in December 2022 identified that only 59% of nursing and midwifery registered staff within maternity services had a completed annual appraisal. Not all staff spoken with were up to date with their appraisal or had found it a useful exercise.

A practice development team supported midwives. The team included 2 practice development lead midwives, a clinical midwife trainer, 4 clinical preceptorship support midwifes, 3 professional midwifery advocates, a foetal surveillance midwife, 2 digital midwifes and an international recruitment midwife. Staff were positive about the support provided by the practice development lead midwives.

Managers made sure staff received any specialist training for their role. For example, 7 midwives had received funding for specialist training including a masters level course, leadership courses and 3rd trimester scanning training.

Medical staffing

The service did not have enough medical staff with the right qualifications, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment.

The service did not have enough medical staff to keep women and birthing people and babies safe.

The trust reported there were 4.25 whole time equivalents (WTE) consultant vacancies across all maternity services. A number of these posts had been recruited to, with staff due to commence employment in January and February 2023. However, in January 2023 it was reported that 2.25WTE consultant vacancies remained unfilled.

We could not be assured that women and birthing people were always seen and reviewed in a timely manner. Medical staffing rotas for 2022 indicated gaps in medical cover across the service. There were occasions when there was no medical cover for the Medical Assessment / Triage (MAC) on weekdays, either all day or for part of the day. We did not see any on call arrangements in triage for evening and weekends. Staff told us during these times medical staff covering other areas within the maternity unit would cover medical assessment / triage. Multiple staff told us that there were delays in women being seen for medical review in triage due to a lack of medical staff availability. This was in part due to gaps in rotas as well as medical staff attending ward rounds or carrying out other procedures. Staff told us they usually completed incident reports for any delays in care.

Women and birthing people were at risk of harm due to delays in medical review or in receiving care. There was in excess of 203 incidents reported within the maternity unit between 16 February 2022 and 31 January 2023. The accurate total number of women involved in the reported incidents was not known as some incidents were reported to have affected multiple women. Over 200 of these incidents were identified as being reported as ‘ delays in reviews and delays in care’. We saw 37 reported episodes of delays impacting on the care of women including lack of timely medical review and lack of ultrasound review. Several women were reported to have been left several hours without medical review and medical care. In addition, 10 of the incidents reviewed identified a lack of staff available to review women and birthing people.

The trust had a high usage of locum staff. We saw that between April 2022 and January 2023, locum consultant and junior doctor cover had been used every month, ranging from 11 consultant shifts in July 2022 through to 81 shifts in November 2022 and 99 junior doctors shifts in June 2022 to 1 junior doctor shift in January 2023. Additional junior doctors had been recruited via the international doctor recruitment scheme, which had reduced the reliance on locum staff. There was a written welcome pack for locum and agency clinical staff.

Junior medical staff told us that support from senior staff had improved although they felt this could be improved further. Junior doctors had a very intense rota that provided little or no learning/development opportunities, and the delivering the service took priority over training.

The service always had a consultant on call during evenings and weekends. The consultant attended twice daily ward rounds to review the care and treatment of women, birthing people and their babies. Junior medical staff told us due to the intensity of the rotas; they were rostered to work across all three maternity units within the trust. They said they would prefer to work blocks of shifts in one location as travel between the sites could be problematic.

Records

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

Women and birthing people's care records seen during the inspection were comprehensive and all staff could access them easily. The trust used a combination of paper and electronic records. The majority of information was recorded electronically although paper records were used for medicine charts. We reviewed 3 records and found records were clear and complete.

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

Records were stored securely. Staff locked computers when not in use.

The trust told us they did not routinely audit records, unless it is part of an investigation or to review complaints. They told us if any errors were identified during this process, these would be addressed with the midwife and support provided by the Professional Midwifery Advocates (PMAs). A lack of audit meant the trust were not consistently reviewing the completion of records to ensure they were in line with guidance or the trust policy. Therefore, the trust could not be assured all records were correctly completed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines although they were not always used effectively.

The service did not have systems in place to check staff competency when using medicines was in line with trust policy and national guidelines. The trust told us competency tests were currently completed on the wards. A new package of training was being developed; however this was not in place at this inspection. This meant the trust could not always be assured of the training competencies of staff in relation to medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission.

Staff reviewed medicines regularly and provided advice to woman, birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed.

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

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services.

Maternity

Incidents

The service managed safety incidents although there were delays in reviewing incidents. Staff recognised but did always reported incidents and near misses due to time constraints. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support.

The service was not aware of, investigating or learning from all incidents and near misses as staff did not always report them. Staff knew what incidents to report and how to report them in line with trust policy. However, staff told us they did not always report incidents due to time constraints. Staff could describe what incidents were reportable and how to use the electronic reporting system. Leaders could not be assured they had full oversight of all risks within the service due to inconsistent reporting.

There appeared to be a disconnect between how staff and senior management described how incidents are managed and responded to. Some staff told us they felt there was little point reporting incidents as it took too long to get a response and no action was taken as a consequence. They said senior management did not share what action they were taking, or take on board what staff were saying, which had an emotional impact on staff.

We spoke with members of the Clinical Governance and Patient Safety team. Weekly risk meeting reviewed incidents from across the maternity service to identify any themes or trends. Incidents were reviewed using the Perinatal Mortality Review Tool (PRMT) and any learning shared, through presentations which took place four times a year. There was a dedicated email which staff can use to raise issues with the safety board anonymously. Support for midwives was available through the PMAs, or through the Preceptee Clinical Support Midwife team for band 5 and 6 staff. The Clinical Governance and Patient Safety team were aware of the criteria for reporting incidents to the Healthcare Safety Investigation Branch (HSIB) for investigation and that any still births or neonatal deaths required a 72-hour review.

The trust had one 'never' event, which was identified by staff postnatally. We saw that this event had been investigated and the findings shared at board level. However, we did not see any learning from the event shared with staff.

Incidents were not investigated and responded to in a timely way; there were 38 incidents open over 60 days. This was against national guidance put in place to support learning and prevent events reoccurring.

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

Is the service well-led?

Inadequate

We rated it as inadequate.

Leadership

Maternity

Due to period of instability there had been a lack of consistent leadership within the service and a number of senior posts remained vacant, leading to delays in improvements being implemented. New and interim leaders had started to support staff to develop their skills and take on more senior roles. However, they were not always visible and approachable in the service for woman, birthing people and staff. Executive leaders did understand the priorities and issues the service faced, although these were not always managed effectively.

There had been a period of instability within the leadership structure across the trust. A number of senior posts were either filled with interim staff or vacant. The Director of Midwifery (DoM) post had been recruited to, with a planned start date of June 2023. This post was currently filled with an experienced interim DoM. There were two Head of Midwifery (HoM) posts. An existing member of staff had been recruited to the HoM for Birmingham Heartlands Hospital. The HoM for Good Hope Hospital and Community remained vacant and would be advertised in the near future.

Maternity services were part of Division 6 within the trust. The designated board member for maternity was the Chief Nurse, who was also the safety champion. There was a clear organisation structure for the division and below that, the senior midwifery team. The DoM was supported by the HoMs, in addition to matrons for inpatient care, intrapartum care, community, maternity governance and screening (including foetal medicine and antenatal clinic), as well the named midwife for safeguarding and lead midwives for bereavement and service and practice development. There was a clear line of reporting into the executive directors and board.

Following the inspection the Trust provided an updated structure for Division 6. This indicated separate General Manager and Operational Manager roles had been created for Maternity and Gynaecology. The Operational Manager roles had been recruited to, and the General Manager for Obstetrics was due to commence in post during May 2023. The General Manager for Gynaecology was already in post and covering for Maternity in the interim.

Leaders understood the priorities and issues the service faced. However, due to a period of instability there had been a lack of consistent leadership within the service and a number of senior posts remained vacant, leading to delays in improvements being implemented.

Although matrons and ward managers were visible and supported staff, not all staff felt that more senior leaders were visible in the service for women and birthing people and staff. They felt that the executive team did not visit the service on a regular basis.

The service was supported by maternity safety champions and non-executive directors, although some safety champions were new to the post.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action, however leaders had plans in place to develop one.

There was an overarching vision and values for the trust, in addition to the implementation plan. There was an expectation that each division would develop their own service strategy. We were told there were plans to redevelop the maternity and neonatal strategy. Staff engagement was due to take place in March 2023, ensuring staff had input into the new vision and strategy. The engagement team were supporting the process, with plans for an away day in April 2023 to deliver the final vision and strategy.

Maternity

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations.

Staff told us that the trust vision and strategy used to be displayed on the home screen of all computers, but this was no longer the case, meaning staff no longer knew where the trust was with their vision and strategy.

Culture

Staff did not always feel respected, supported, and valued due to workload and staffing levels. Staff tried to focus on the needs of women and birthing people receiving care. The service did not always promote equality and diversity in daily work.

Staff did not feel respected, supported, and valued**.** Staff we spoke with said they could speak up about concerns but they did not always feel they were listened to, or action taken.

Trainees in an approved training post in the UK complete the General Medical Council National Trainee Survey (GMC NTS) regarding the quality of training received, support and wellbeing. In the 2022 survey, scores at the Good Hope Hospital were significantly below (ie worse) than the national average for 14 indicators. This was a deterioration from the 2021 scores where 12 indicators had scored significantly below the national average. Scores for 14 of the 2022 indicators were lower than in 2021, including overall satisfaction which had dropped from 45 in 2021 to 34 in 2022. The trust had been working with Health Education England, who had imposed conditions on the trust in response to the survey results. The clinical lead told us action was being taken and they met regularly with the junior doctors and improvements had been made. However, this was not supported by comments from junior medical staff.

All grades of doctors but in particular junior doctors described episodes of racism, and some cited the involvement of midwives. This had been reported to educational supervisors, but action had not been taken until the concerns had been escalated to the local deanery. Doctors told us some individuals were offered more training opportunities than others, creating an imbalance.

Health Education England (HEE) undertook a further visit on 30 March 2023 and shared their findings with us. HEE had requested an urgent response from the Trust in relation to the findings.

Junior doctors told us there was a discrepancy in support provided by senior medical staff at the different locations. They told us they felt the consultants did not provide an adequate level of support to junior doctors, resulting in low morale at Good Hope Hospital. Midwifery staff also commented on the lack of support for junior doctors and that some consultants did not always carry their bleeps, meaning staff were unable to contact them. This potentially caused delays in women and birthing people being seen.

Staff engagement and morale had declined in the NHS Staff Survey 2021 when compared to the 2020 scores.

The trust shared with us their staff survey from 2021. All the questions had been RAG rated using a traffic light system and any red items had an action plan with related timescales. While we saw evidence of completed actions relating to the 2021 survey, the trust did not share the most recent survey results from 2022 and we were therefore unable to assess whether these actions had an impact on the responses from staff. Therefore, we cannot be assured that action had been taken in response to the staff survey.

Women, relatives and carers knew how to complain or raise concerns. The service received 8 complaints in the 3 months before the inspection. Themes identified included delays in care and treatment and attitude of staff. Complaints were reported to the board on monthly basis.

We looked at the results of the Maternity Survey 2022. To summarise, many women praised the general quality of care at the trust. However, many of them felt they had mixed experiences: at some stage they had negative interactions with individual members of staff (mainly midwives and MSW) who did not treat them with dignity and respect. Examples included women's concerns about birth choices, pain, and labour progress were not respected, such as "Not listened to" and "didn't believe me" were repeatedly mentioned, as well as staff perceived as being rude and unhelpful. Women commented about the poor care they perceived they had received postnatally.

The Maternity Voices Partnership (MVP) told us they had been asked to raise concerns with the trust about the care provided to women. This included delays in care, lack of consideration of medical conditions unrelated to pregnancy and inappropriate comments about women who did not have English as their first language. The MVP told us the trust had responded positively to concerns raised on behalf of a person who had used the service.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

Leaders did not operate effective governance processes, throughout the service and with partner organisations. The service did not have a strong governance structure that supported the flow of information from frontline staff to senior managers. Although there was a comprehensive series of well-structured governance meetings, leaders did not always monitor key safety and performance metrics due to the lack of audits. For example, use of SBAR for handovers, audit of care records and the decision to delay the review of 'Birth Rate Plus'.

We found several safety concerns on the management of equipment, records, cleanliness and infection prevention and control (IPC). There was a lack of oversight of these issues and some cases, there had been no recent audits carried out to monitor compliance or improvements.

Maternity services sought assurance through various governance meetings in the service divisional meetings and trust board meetings. We saw the reports submitted for discussion were detailed and comprehensive. We reviewed the minutes of various meetings and saw that issues were escalated from the ward to board. Actions were clearly documented but not reviewed at the next meeting to evidence that they had been implemented. Therefore, we were not assured action had taken place. Additionally, we did not see evidence of how discussions and learning was fed back to the staff team. Therefore, the trust could not be assured that their governance processes were effective.

Oversight of safety in maternity services was reported to the board monthly. We reviewed the last 2 reports and found appropriate risks and issues and key challenges were escalated, and they were reflected in other reports we reviewed.

Managers did not always investigate and close incidents in a timely manner. NHS Patient Safety Incident Response Framework 2022 was put in place to ensure effective investigation of incidents and for continuous learning and

improvement. The framework outlines proportionate response timeframes for trusts to follow. The trust had a backlog of 98 incidents that had been open over 60 days. As of February 2023 due to staff capacity it was not clear what the service was doing to close the open incidents or how long the incidents had been open. This may result in incidents being repeated due to the delay in identifying learning and implementing any required changes.

We were not assured that all staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. We saw and were told not all staff had received an annual appraisal, feedback from incidents either wasn't given or took a long time to be received and not all staff had completed mandatory training. The triumvirate met monthly. We looked at meeting minutes for the last 3 months. The agenda had a clear process to cover operational issues, financial, procurement, matrons, guidelines and consultants. These areas identified any issues and the actions required for them to be addressed. However, the action plan list at the end of each meeting was not always completed and not reviewed at the following meeting to see if the issue or action had been addressed. This meant we could not be assured that issues which had been identified were consistently being addressed to an agreed outcome.

The safety champion visited the maternity service at least once a month to speak with staff and observe the environment and feed safety concerns up to the board. We reviewed records of these meetings. The safety champion had introduced a 'you said we did' section, and we saw evidence of this displayed in some areas. For January 2023 the record included 'assurance that midweek messages are being circulated at GHH as some staff have highlighted they were not aware of the safety email – being shared through multiple platforms and printed'.

Not all policies we reviewed were up to date. We reviewed 13 policies and found that 4 had not been reviewed in line with the review date. The out of date policies ranged from one month to 30 months. Leaders told us they experience delays in approval of new or revised policies by the Clinical Guidelines Group. Therefore the trust could not be assured that they were always following the mot up to date or national guidance.

Management of risk, issues and performance

Systems to manage performance were not always used effectively. Where identified, leaders escalated relevant risks and issues and identified actions to reduce their impact. However, it was not always clear if action had been taken or followed up.

Maternity performance measures were reported using the maternity dashboard.

The service did not have effective systems and processes in place to identify risk in the first instance. The maternity service had a risk register and included risks such as mandatory training, non-compliance with Ockenden, delays in caesarean sections due to theatre capacity and the lack of an allocated senior obstetrician in the Maternity Assessment Centre. We found all risks on the risk register did not have a risk owner for reviewing and monitoring them. There was mitigation, action and due date, although there were still actions on the risk register where the due date had passed and no further update on progress or current status. In addition, staff did not always report incidents so leaders could not be assured they had full oversight of all risks within the service due to inconsistent reporting.

We were advised due to capacity women and birthing people were not booked for elective caesarean sections at Good Hope Hospital. However, we were told and evidence supported that a number of non-life threatening caesarean sections had taken place at Good Hope Hospital. Data we reviewed identified these decisions were made on a clinical basis when it was not recommended to transfer to another hospital.

We saw that risks were discussed at trust wide meetings, including via the monthly Maternity Safety report. The purpose of the report was to provide an update on key maternity safety initiatives which would support UHB achieve the national ambition. It also provided evidence for NHS Resolutions Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. The information in the report was detailed and provided sufficient detail for board members to understand the identified risks and any mitigating actions.

The service participated in relevant national clinical audits such as National Neonatal Audit Programme, National Maternity Dashboard audit and MBBRACE. Outcomes for women were a combination of positive, negative and partially met on some national standards.

The hospital participated in the MBBRACE 2020 audit. The result showed the stabilised and adjusted perinatal mortality rate at the trust was more than 5% higher than the comparator group average for all births and for births excluding congenital anomalies.

Clinical Quality Improvement Metrics (CQIMS) are a set of 12 metrics derived from the Maternity Services Dataset for the purpose of identifying areas that may require local clinical quality improvement. The November 2022 result showed that the rate of Babies who were born preterm at the trust was in the middle 50% of all trusts nationally.

The service had a comprehensive programme of audits to check improvement over time, however, the implementation of the programme was inconsistent. Although they audited performance and identified where improvements were needed, it was not always clear what action had been taken to bring about these improvements, or repeat audits completed. Managers did not always share and make sure staff understood information from the audits. We saw little evidence of feedback from managers to staff. As a consequence, this risked events reoccurring, staff not being up to date with best practice and poor staff morale. Where identified, leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. When reported, risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. However, it was not always clear that action the leadership team had taken to make change where risks were identified.

Information Management

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

The service collected data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Managers could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated and secure.

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

Engagement

Leaders and staff recognised the need for improvement in engaging with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They had started to collaborate with partner organisations to help improve services for women and birthing people.

Maternity

During the inspection we spoke with the Maternity Voices Partnership (MVP) chair for the Local Maternity and Neonatal System (LMNS) and a representative for the host organisation. The MVP was being redesigned and there had been a period of 6 to 12 months without an MVP link person for the services. Each hospital within the LMNS (5 in total) will have a designated chair. These posts had been recruited to and staff would be attending for their induction in the near future. The MVP told us that the trust had not worked well or engaged with them in the past, but the relationship had improved following the appointment of the interim DoM. The MVP shared an example where the trust had responded positively to concerns raised on behalf of a person who had used the service.

The service made available interpreting services for women and birthing people and pregnant people. However, there were inconsistencies across clinical areas in the use of interpreting services and availability of information in different languages. Ward staff regularly used telephone translation services, however face to face translation services tended to be used more by the specialist midwifes. We noted that face to face translation services could be used more proactively in areas such as clinics.

Leaders and staff were aware of the needs of the local population. Despite the multicultural population the trust did not have a lead person for equality and diversity within maternity services. Specialist midwives worked in innovative ways to engage with the diverse population. However, we saw a lack of signage / information in different languages within the trust buildings or clear directions to the maternity units.

Learning, continuous improvement and innovation

Staff wanted to be committed to continually learning and improving services. However, factors such as staffing levels and vacancies within the leadership team had impacted on the effectiveness of learning and improvement at the service. Quality improvements were in place but completion timescales had been delayed by factors outside the control of the service. There was some evidence to innovation and participation in research.

Staff wanted to be committed to continually learning and improving services. However, the instability within the senior leadership team had impacted on the ability to implement and sustain any required improvements. The trust had a quality improvement programme that was reviewed at least quarterly. However, we saw that the planned timescales for completion had not always been maintained.

The service aimed to improve services by learning when things went well or not so well and promoted training and innovation. We saw the process for staff identifying and reporting concerns, although this was not always used effectively. Some training packages identified learning from incidents. However, we did not see the feedback and learning from incidents was shared across the wider staff team.

We saw some evidence of innovation and participation in research. The service collaborated with regional universities and charities to support research studies. The safeguard lead was chairing a pilot project ICON (Babies Cry, You Can Cope). There are 5 pilots across the country, looking at how to reduce the risk of babies being shaken and harmed. The project has a range of steps to provide information to professionals and women at different stages of their pregnancy and following the birth.

Outstanding practice

We found the following outstanding practice:

Maternity

- The trust had a well-established safeguarding team. The midwives had established relevant links with charitable groups associated which developing links within the local diverse community. These connections ensured appropriate birthing plans and discharge plans to support the women and their babies. The safeguard lead was chairing a pilot project ICON (Babies Cry, You Can Cope). There were 5 pilots across the country, looking at how to reduce the risk of babies being shaken and harmed. The project had a range of steps to provide information to professionals and women at different stages of their pregnancy and following the birth. The bereavement team was well versed in the diverse nature of the community and religious and cultural observances. The team worked closely with community groups to connect with women and their families. The team linked with the foetal medicine department and were aware in advance of those women and families who may need their support.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Maternity

- The trust must ensure staff are up to date with mandatory training modules. Regulation 12(1)(2)(c)
- The trust must ensure staffing for maternity is sufficient to deliver the service in line with national guidance. Regulation 18 (1))
- The trust must ensure staff act to remove or minimise risks following risk assessment for each woman. (Regulation 12(1)(2))
- The trust must ensure incidents are investigated without delay in line with trust policy. (Regulation 17(1)(2))
- The trust must ensure effective risk and governance systems are implemented which supports safe, quality care. (Regulation 17(1)(2))
- The trust must ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform in line with the Trust’s own target. (Regulation 18(1)(2))
- The trust ensure that policies are up to date and reviewed in accordance with the review date. Regulation 17(1)(2)

Action the trust SHOULD take to improve:

- The trust should ensure staff adhere to assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12(1)(2)
- The trust should ensure staff check thoroughly when completing daily checks of emergency equipment. Regulation 17(1)(2)
- The trust should consider using the situation, background, assessment and recommendation (SBAR) for all handovers between clinical staff.
- The trust should continue to act on staff surveys, investigate concerns regarding bullying and racism and ensure equal opportunities for all staff.

Maternity

- The trust should consider ways in which to strengthen and support the senior leadership team.
- The trust should ensure the vision and strategy is shared with all staff once developed. Regulation 17(1)(2)
- The trust should ensure all learning from incidents is shared across the wider staff team. Regulation 17(1)(2)

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 7 other CQC inspectors, and one CQC inspection manager. There were 3 specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.