

The Queen Elizabeth Hospital King's Lynn NHS
Foundation Trust

The Queen Elizabeth Hospital

Quality Report

Gayton Road
Kings Lynn
Norfolk
PE30 4ET
Tel: 01553 613613
Website: www.qehkl.nhs.uk

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Maternity (inpatient services)	
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Summary of findings

Letter from the Chief Inspector of Hospitals

The Queen Elizabeth Hospital Kings Lynn maternity service is operated by The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust. The hospital has 25 maternity beds within the antenatal/postnatal Castleacre ward, there is also a central delivery suite with eight birthing rooms and Waterlily birth centre which is a midwife led centre for low risk women and has three birthing rooms. The bereavement suite for the service is located in one room on the Waterlily birth centre.

The trust provides maternity services to the populations of West Norfolk, East Cambridgeshire and South Lincolnshire. Services are provided in the maternity unit and at clinics at a neighbouring hospital at Wisbech. Community midwifery teams provide care to low risk women choosing a home birth and outreach clinics are held across the three counties.

The maternity service includes an antenatal day assessment unit at the Queen Elizabeth Hospital and antenatal clinics at both the Queen Elizabeth Hospital and the neighbouring hospital at Wisbech; Waterlily Birth Centre, the delivery suite and a combined antenatal and post-natal ward at the Queen Elizabeth Hospital site.

The last inspection of maternity services took place on the 1 and 2 of May 2018. During the inspection we found several areas of concern including lack of leadership, dysfunctional culture and concerns around the safe care and treatment of high risk women and vulnerable women.

Following the inspection CQC undertook enforcement action and served a warning notice on 17 May 2018 under section 29A of the Health and Social Care Act 2009 in respect of Regulation 12 and Regulation 17.

We carried out an unannounced inspection at The Queen Elizabeth Hospital Kings Lynn on 4 December 2018. We carried out an unannounced inspection at North Cambridgeshire Hospital on 5 December to follow up specifically on compliance with the 10 points of concern within the Section 29A warning notice.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. As this was a focussed follow up there are no ratings attached to this inspection.

We found the following areas of improvement:

- The premises at North Cambridgeshire Hospital had been risk assessed and improvements had been made to mitigate the risk to service users and staff.
- Care planning for high risk and vulnerable women had improved. There were consultant leads in place and response times to see high risk women and consultant attendance at antenatal clinics were monitored.
- The management of incidents had improved. Staff recognised incidents and reported them appropriately. Managers and clinicians investigated incidents and shared lessons learned with the whole team and the wider service.
- The service took account of women's individual needs. Changes had been made to ensure women who miscarried before 16 weeks were cared for in a dedicated side room on the surgical ward. Alternative waiting areas were available for women on the Brancaster antenatal and gynaecology clinic outpatient unit should they require it.
- An electronic antenatal booking system was in place for women accessing maternity services. This had improved the process for the management of antenatal referrals.
- Leaders had been appointed to the service with the right skills and abilities to lead the service and deliver high quality care.

Summary of findings

- The culture in the service had improved. There was evidence of improved communication, engagement and multidisciplinary team working between midwives and obstetricians.
- There were improved governance processes in place to identify and manage risk. Some consultants were involved in the governance process. Risks were identified and monitored on the risk register.

However, we also found the following issues that the service provider needs to improve:

- The number of consultant vacancies meant that high risk and vulnerable women did not see the same consultant at each appointment to provide continuity of care.
- Although the leadership of the service had improved key leaders were interim appointments and we were concerned about the sustainability of improvements when they left the service.
- Staff felt that there was not effective, timely communication keeping them updated with plans and changes within the service.
- Staff reported that some consultants were still not on board with the cultural change and still displayed inappropriate and unprofessional behaviour.
- The service's audit programme was not fully embedded.
- There were 32 out of 64 guidelines still outstanding that required review and update.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals.

The Queen Elizabeth Hospital

Detailed findings

Services we looked at

Maternity

Detailed findings

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Detailed findings from this inspection

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Background to The Queen Elizabeth Hospital

The Queen Elizabeth Hospital Kings Lynn maternity service is operated by The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust. The hospital has 25 maternity beds within the antenatal/postnatal care ward, there is also a central delivery suite with eight birthing rooms and Waterlily birth centre which is a midwife led centre for low risk women and has three birthing rooms. The bereavement suite for the service is located in one room on the Waterlily birth centre.

The trust provides maternity services to the populations of West Norfolk, East Cambridgeshire and South Lincolnshire. Services are provided in women's homes by the community midwifery team and outreach clinics are held across the three counties.

The provider is registered for the following regulated activities:

Maternity and midwifery services

Termination of pregnancies services

Treatment of disease, disorder or injury,

Surgical procedures.

During the inspection we visited the Central Delivery Suite, the Early Pregnancy Assessment Unit, Elm Ward and the antenatal clinics. We spoke with 39 members of staff including midwives, doctors, consultants, midwifery care assistants and senior managers. We reviewed 21 documents and supporting evidence provided in relation to areas of improvement required within the section 29A warning notice.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspection manager and two other CQC inspectors. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (inpatient services)	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Maternity (inpatient services)

Safe

Responsive

Well-led

Overall

Information about the service

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Summary of findings

We always ask the following five questions of each service:

Are services safe?

We did not rate safe. We found the following areas of improvement:

- Risk assessments had been carried out at the premises at North Cambridgeshire Hospital and changes had been made to mitigate the risk to service users and staff.
- Improvements had been made to the premises for the Early Pregnancy Assessment Unit. The area had been decluttered and could be accessed in case of an emergency. Emergency equipment was in place.
- Care planning for high risk and vulnerable women had improved. There were consultant leads in place and response times to see high risk women and consultant attendance at antenatal clinics were monitored.
- The management of incidents had improved. Staff recognised incidents and reported them appropriately. Managers and clinicians investigated incidents and shared lessons learned with the whole team and the wider service.

However, we also found the following issues that the service provider needs to improve:

- The reduced number of substantive consultant staff meant that high risk and vulnerable women did not see the same consultant.

Are services responsive?

We did not rate responsive. We found the following areas of improvement:

Maternity (inpatient services)

- The service took account of women's individual needs. Changes had been made to ensure women who miscarried before 16 weeks were cared for in a protected side room on the surgical ward.
- An alternative waiting area was available for women attending for a gynaecology appointment on the Brancaster unit should they require it.
- An electronic booking system was in place and the management of referrals had improved and were monitored.

Are services well-led?

We did not rate well-led. We found the following areas of improvement:

- Leaders had been appointed to the service with the right skills and abilities to lead the service.
- The culture in the service had improved. There was evidence of improved communication, engagement and multidisciplinary team working between midwives and obstetricians.
- There were improved governance processes in place to identify and manage risk. Some consultants were involved in the governance process. Risks were identified and monitored on the risk register.

However, we also found the following issues that the service provider needs to improve:

- Although the leadership of the service had improved key leaders were interim appointments and staff raised concerns about the sustainability of improvements when they leave the service.
- Staff felt that there was not effective, timely communication keeping them updated with plans and changes within the service.
- Staff reported that some consultants were still not on board with the cultural change and still displayed inappropriate and unprofessional behaviour.
- The service's audit programme was not fully embedded.
- There were 32 out of 64 guidelines outstanding that still required review and update.

Are Maternity (inpatient services) safe?

Environment and equipment

During our inspection in May 2018 we found that the maternity clinic facilities at North Cambridgeshire Hospital were not fit for purpose and risked the safety of service users. The facilities had only one combined entrance and exit which involved accessing the service through a narrow staircase with no lift access. Service-users could not be safely evacuated from this area in the event of a medical emergency or fire.

The environment in the Early Pregnancy Assessment Unit (EPAU) was not fit for purpose and put people who visited the premises at risk. There was a wall between the scan room and the door, which meant that women could not be safely transferred in the event of an emergency.

- **Although the premises at North Cambridgeshire Hospital were not ideal due to the clinic being located on the first-floor appropriate risk assessments had been completed and improvements had been made to mitigate the risk to service users and staff.**
- The antenatal clinic at North Cambridgeshire hospital had clear signage displayed on the wall above the door and a sign informing women not to leave pushchairs in the lobby area. We observed the lobby area at the bottom of the stairs had clear access and was not obstructed. Pushchairs and prams were stored appropriately and were not blocking the stairs and exits.
- A fire risk assessment had been completed by an independent specialist. We reviewed the report and saw that it concluded that the fire safety provision including plans for evacuation were reasonable and were deemed to be safe.
- There was a robust evacuation plan in place. We saw that a fire drill had been carried out in June 2018. The report completed by the trust fire safety officer following the drill stated that "the evacuation was performed to a high standard" and there were no areas of concern.
- There was an evacuation chair in place to assist the evacuation of women. Data provided by the trust

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showed that five members of staff out of six had completed evacuation chair training. This was confirmed by staff on site, five of the six members of staff we met at the clinic had completed the training.

- Only low risk women were seen at the clinic in North Cambridgeshire Hospital. There was a standard operating procedure in place which included an inclusion and exclusion criteria for women seen at the clinic. Women deemed to be high risk were seen at The Queen Elizabeth Hospital antenatal clinic. Staff informed us that some women who could not afford to travel to Kings Lynn or chose not to go had a risk assessment completed and were seen at home or in the ground floor outpatient department at North Cambridge Hospital.
- Staff at the clinic told us that there had been no incidents in the previous 12 months where women had been seen at the clinic who did not comply with the inclusion criteria. Data provided by the trust following the inspection confirmed this.
- The maternity clinic was due to be relocated to newly built clinic facilities at the North Cambridgeshire site in early 2019.
- Although the premises for the EPAU were not ideal, improvements had been made. The area had been cleared of clutter. The filing cabinet had been removed and this allowed easier access in and out of the area. There was space to care for a woman if their condition deteriorated or there was an emergency.
- Emergency resus equipment was located on the EPAU. Weekly checks of this equipment were scheduled to be carried out but had only started the week before our inspection. Therefore, we were only able to confirm that one check had been completed.
- The wall between the scan room and the door was still in place. However, this was in place to protect the privacy and dignity of women. Staff explained that the wall was there to prevent women who had received bad news having to exit the clinic room through the waiting room. However, the removal of the filing cabinet made access to the area easier and a member of staff confirmed that the area was accessible if a patient needed to be transferred in an emergency.

- We reviewed a business case with plans to extend the current area to create an EPAU with improved facilities to care for women. This business case received final ratification at the Maternity Risk & Oversight Group (MROG) on 21 December 2018.

Assessing and responding to patient risk

During our inspection in May 2018 we found that there was a lack of ownership for care planning for high-risk service-users by consultants. Service-users with high-risk care pathways, such as twin pregnancies, did not routinely see the same consultant and experienced delays in care planning.

Vulnerable service users were not prioritised by the service. The service ran a limited number of vulnerable service-user antenatal clinics and the demand exceeded the number of appointments available. There was not an effective system in place for women who could not be offered an appointment at vulnerable women clinics.

- **Staff completed and updated risk assessments for each woman. They kept clear records and asked for support when necessary.**
- The interim director of midwifery told us that the referral processes for high risk women had been in place since July 2018. They told us that there had been a recent review of this process and the service were assured that high risk women with an identified obstetric clinical need were being given appointments to be seen by the consultant led medical teams.
- A dedicated consultant led team had been established to look after high risk women.
- There was a dedicated weekly clinic each Wednesday with a named consultant present for women with significant high risk clinical factors. This clinic had been set up to ensure that the women with significant high-risk factors were seen appropriately. Two consultants led the service and worked alternate weeks to ensure continuity for women attending the service. The consultant job plans had been organised so that neither consultant was on leave at the same time, this ensured that the clinic took place weekly. We reviewed the clinic rota for October 2018 and saw that a high risk

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antenatal clinic had taken place every week. Staff we spoke with in the antenatal clinic also confirmed that the clinic for women with significant high-risks took place weekly.

- A senior staff member told us that not all high-risk women needed to attend this dedicated 'significant high risk' clinic. They told us that of the majority of high risk women, dependent on clinical need attended the specialised and generic obstetric led clinics. Women could be transferred to the significant high-risk clinic at any time should a clinical need be identified during the pregnancy.
- Two consultants confirmed that high risk clinical pathways were currently under development. Obstetric and midwifery staff were developing clinical pathways for each pregnancy related condition, for all staff to follow and refer to and share with women in their pregnancy.
- The final clinic schedules were still awaiting completion and ratification. This was anticipated to be completed by March 2019. The director of midwifery told us that once in practice regular audit would be undertaken to ensure clinics ran in line with the schedule and to provide assurance that all high-risk women were referred to the correct pathway and reviewed by the obstetric team.
- There were improved processes in place to identify and support vulnerable women. The social and vulnerable woman risk assessment was completed at the time of booking by the community midwives. A flow chart to identify which specialist services to refer to had been developed and was due to be ratified in January 2019. Referral was either to consultant led care and review in the vulnerable women's antenatal clinic or a referral to specialist service for further support. Vulnerability concerns included mental health concerns, teenage pregnancies, substance misuse, domestic abuse, migrant, asylum or residency status, learning disabilities and female genital mutilation (FGM). Where a vulnerability was identified the midwives referred women to the appropriate pathway.
- We tracked two patient records. We saw that a risk was identified and the women were referred to the appropriate clinic. However, we found that there was inconsistent consultant contact with one woman seeing two different consultants and two different middle grade doctors at their antenatal appointments. Leaders acknowledged that this inconsistency was still an issue. They told us that it was because there were vacancies for obstetric consultants. However, there had been two recent appointments and interviews were scheduled to recruit three more substantive consultants.
- There was a named consultant for vulnerable women who ran weekly clinics alternating between The Queen Elizabeth Hospital and North Cambridgeshire Hospital. All women identified as vulnerable at booking were referred to this clinic for an appointment. The midwifery advisor told us that women who developed vulnerable needs in pregnancy were switched to this clinic when needed.
- Clinic capacity was flexible to ensure all women who needed to see a consultant obstetrician could do so. The clinic had 11 appointment slots, with one always kept free for occasions where an urgent referral was needed. The trust told us that there had been no incidents reported where a vulnerable woman had not been seen as requested in the antenatal clinic since the commencement of the new referral pathways in July 2018. The service had conducted a snap shot review and were assured that all vulnerable women identified at booking were allocated clinic appointments in the vulnerable women clinic.
- An assessment of safeguarding was carried out at the home visit conducted at 16-20 weeks. Staff told us that it was not always possible to ask women questions relating to domestic abuse if their partner was present. They told us that they would often take the opportunity to address this issue when they accompanied the woman to the bathroom. They told us that from January the 16-week appointment would be a woman only appointment to ensure that domestic abuse was discussed.
- There service had two midwives for vulnerable women. There was an additional specialist midwife for perinatal mental health. However, at the time of our inspection this person was on leave. Their work load was being managed by the two vulnerable women's midwives with strong support from the mental health team.

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- We observed a multi-disciplinary team hand over and saw that safeguarding concerns were identified and an update was provided re actions taken and next steps.
- The vulnerable women midwifery team held a meeting with neonatal intensive care unit (NICU) weekly. The NICU lead told us that communication between neonatal and maternity services had improved. NICU were informed about high risk women that were due to deliver their babies so that care could be planned accordingly.

Incidents

During our inspection in May 2018 we were not assured that incidents were being investigated or graded to the appropriate level.

- **The service had improved since our last inspection and managed safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**
- The service had a risk and governance matron. They confirmed that they reviewed the incidents reported daily and had good oversight
- There was a process in place for incident investigation to ensure that incidents were investigated and graded to the appropriate level. The panel for the investigation of a serious incident consisted of two consultants, two midwives and the risk and governance matron. One person on the team was required to have root cause analysis (RCA) training. Root cause analysis is a method of investigation used for identifying the root causes of incidents. . Midwives and doctors could investigate incidents initially graded as moderate. These staff members had received additional training in investigating incidents but had not had RCA training. The risk and governance matron told us that there were plans in place to deliver further training to staff investigating incidents to further continue to improve the incident investigation process.
- The interim project lead for risk and governance confirmed that all incidents graded as moderate and above go through a check and challenge process at the weekly trust incident review panel.

- We reviewed three serious incident investigations. The investigation reports were completed by a team of medical and midwifery staff. A minimum of one team member had received RCA training. The investigation report showed evidence of a thorough investigation, root cause and lessons learnt. The action plans included the issue being addressed and the cause of the issue. A red, amber or green (RAG) system was used to monitor progress against actions. The investigation reports were reviewed and signed off by the report review panel.

Are Maternity (inpatient services) responsive to people's needs? (for example, to feedback?)

Meeting people's individual needs

During our inspection in May 2018 we found that the arrangements for women who miscarried up to 16 weeks were unsuitable. Women who miscarried up to 16 weeks of pregnancy were placed on Elm ward which is a surgical ward.

The waiting area arrangements for antenatal clinics on Brancaster unit were unsuitable. The waiting room was shared with gynaecology which meant that gynaecological patients with fertility concerns were seated with pregnant women attending antenatal clinics.

- **The service took account of patient's individual needs.**
- The service had a guideline in place for "the Management of Pregnancy Complications and Loss up to 16 Weeks Gestation in Adults and/ or Children". This obtained final approval in August 2018. The guideline contained an emergency speciality pathway for women admitted to the emergency department at 16 weeks gestation and below. The guideline improved the care of these women ensuring that they were cared for in a safe and private environment.
- A side room on the surgical ward had been dedicated for women who miscarried up to 16 weeks of pregnancy. Staff confirmed that the status of the dedicated room was checked daily and the appropriate use of the room was recorded on the ward daily dashboard. This was also reviewed by the clinical site management team.

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- There was an escalation process in place to the site leadership team if the side room was not available. There were three incidents reported where the dedicated side room was occupied by a non-gynaecological patient in the six months prior to our inspection. We reviewed the incidents and found that in each case the dedicated side room was made available for the woman requiring it as per the guideline.
- The waiting area for antenatal clinics and the Brancaster unit were still shared. However, the service had put a system in place where by women who may feel uncomfortable in the shared waiting area could request to wait in a separate area. The appointment letter sent to women stated the waiting area was a shared area for antenatal and gynaecology women and advised women if they did not feel comfortable with this the women could request to wait in a separate area. This was reiterated with laminated posters in the waiting area. Reception staff stated this had been accommodated for one woman when requested.
- There were laminated notices displayed which also advised women that the waiting area was a shared area and that if they did not feel comfortable then they should let a member of staff know and an alternative waiting area would be found for them.
- Reception staff were aware that women could request to wait in an alternative area. One member of staff told us that one woman had requested not to wait in the waiting area and alternative space in an unoccupied clinic room had been found.

Access and flow

During our inspection in May 2018 we found that the booking process for consultant-led antenatal clinics was not effective; there was no tracking or monitoring of referrals. Referrals were regularly lost resulting in high-risk service-users experiencing delayed or missed appointments.

- **People could access the service when they needed it.**
- An electronic booking system had been in place since July 2018. This had improved the processes for the management of referrals. There was an electronic high-risk pathway referral process in place. Following

the pathway, booking referrals were completed by community midwives and risk factors were identified. Obstetric referral forms were completed by the community midwives on the electronic system. The system allowed midwives to specify the dates that appointments were required to ensure women were reviewed appropriately.

- The referral was automatically emailed to a generic in-box. Staff told us that the emails were checked daily Monday to Friday. The referrals were checked to ensure they were completed correctly and all the appropriate information was present. The referral was then forwarded onto the appointment booking team.
- There was an escalation process in place if the booking team were unable to book an appointment for women within the indicated dates. This included the escalation to the antenatal clinic midwife so that an appointment could be prioritised dependent on the clinical need of the woman.
- An audit was performed in November 2018 reviewing all women booked in August 2018 who were identified as high risk at booking and needed an appointment with the obstetric team. Results showed that of the 112 women who had obstetric referrals in August six did not have an appointment booked with the obstetric team. A further review of these six women showed that four women were referred but were found to not meet the high-risk referral criteria and remained on the low risk care pathway. One woman required a referral to a specialist clinic and an appointment was made with the midwife led specialist clinic rather than the obstetrician led specialist clinic. One woman was referred to the high-risk clinic but an appointment with an obstetrician was not made. However, this had been picked up by the team and a consultant appointment had subsequently been actioned and an appropriate care plan was in place.
- Any referral with incomplete information was forwarded to antenatal 'Day Assessment Unit (DAU) or ante natal clinic to be completed. This gave an opportunity for staff to review the reason for referral to ensure that the woman was risk assessed onto the appropriate care pathway.

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- The director of midwifery told us that antenatal clinic staff were developing an audit tool to provide on-going assurance that the referral process was effective. The audit programme was due to commence in January 2019.

Are Maternity (inpatient services) well-led?

Leadership

During our inspection in May 2018 we found that the leadership of the maternity service had broken down. This breakdown meant that the service was no longer providing safe, effective, or responsive care and treatment to women.

- **Managers at all levels in the service had the right skills and abilities to undertake their roles. However, some of the leaders were appointed on an interim basis which meant that the leadership team lacked long term stability. This created uncertainty amongst the workforce.**
- New appointments had been made to the service leadership team. These included a consultant clinical lead for obstetrics and gynaecology, a locum consultant lead for risk and governance, interim midwifery advisor and an interim director of midwifery. A consultant lead for the central delivery suite had been appointed and was due to join the trust in January 2019.
- An interim clinical director had been appointed in May 2018 from another speciality within the hospital. They had become more established and staff reported that they offered clear leadership, were approachable and addressed issues and concerns.
- Staff reported that the maternity and obstetric senior leadership team were visible and approachable.
- Midwives told us that they felt supported by the matrons in the service. One staff member described them as excellent and told us that they were always accessible.
- There was increased consultant presence on the delivery suite providing leadership and support in the clinical environment.
- Junior doctors we spoke with told us that they felt supported by senior clinicians. One doctor told us that the senior doctors were approachable and supportive.

There was always a consultant or middle grade doctor available to support them if required. The service had re-introduced a cardiotocography (CTG) review meeting. CTG is used during pregnancy to monitor the fetal heart and contractions of the uterus. We attended a review meeting and observed a presentation from a registrar which included a review of the CTG and a discussion around actions taken and learning. The rota also had a maternity briefing and a teaching session.

- Monthly multidisciplinary departmental meetings were held. We reviewed the meeting minutes for August, September, November and December 2018 and saw that these were well attended with representatives from the midwifery and medical teams. There was a representative from the service senior leadership team in attendance at each meeting. The meeting followed a set agenda which included an update of the action log, mandatory training, recruitment, appraisals, review of the maternity dashboard including incidents, an action plan update and trainee updates.
- Staff raised concerns that the midwifery leadership was interim and the interim director of midwifery was due to leave in January 2019. Staff were worried about the continuity of the progress made and there had been no communication from the trust senior leadership regarding the plan for leading the service following the current interim director of midwifery's departure. We fed this back to the chief nurse at the time of the inspection and they told us that they would provide staff with an update regarding the ongoing leadership of the service. We received confirmation and a copy of an email sent to staff that confirmed the interim midwifery advisor would continue to work with the service to provide continuity of leadership.
- Staff raised concerns that communication was not timely or effective. For example, they told us that recent changes to introduce elective lower segment caesarean section (LSCS) list to the central delivery suite (CDS) was not effectively communicated and some staff felt that they had not been consulted. The director of midwifery told us that the management team had subsequently sent out an email to update staff. We received a copy of the email and saw that it contained details of the planned changes, an update of progress so far and confirmed that part of the plan would be put on hold to allow further staff consultation.

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Culture

During our inspection in May 2018 we found that the culture of the maternity service was poor. The relationship between midwifery and obstetrics staff was challenged and contributed to unacceptable working practices. Medical staff were not engaged in the safe provision of obstetric care and treatment.

- **New leaders within the service promoted a positive culture that supported and valued staff. The culture of the service had improved and leaders and staff were working towards creating a sense of common purpose based on shared values.**
- All staff we spoke with told us that the culture within the service had improved. All staff were much more positive and told us that their personal morale had improved.
- We observed a morning hand over on the central delivery suite. This was attended by consultants, junior doctors, matrons, lead midwives and representatives from the theatre team. All staff members were engaged in the process and interacted well together.
- Staff had attended an Advancing Change through Transformation (ACT) working together workshop in November 2018 facilitated by NHS improvement (NHSi). Staff reported that this was very positive and those that attended were engaged in the process. They felt that it had improved relationships between staff groups.
- Staff reported that the medical team were much more engaged and regularly attended departmental meetings. We reviewed four sets of departmental meeting minutes and saw that these were well attended by all staff groups including consultants and junior doctors.
- Staff told us that they felt able to challenge unacceptable behaviour and obtain the support of senior clinicians. We saw that the service had a guideline in place to support this. The clinical guideline for referral to medical staff, calling for help and escalating concerns was approved in July 2018. The guidance stated that a midwife had a duty to contact a consultant if it was not possible to get other help or if the performance of the doctor or midwife jeopardised the health and safety of mother or baby. This guideline supported midwives to get clinical support from consultants when required.

- There was an increased presence of medical staff on the delivery suite. A consultant was present on the delivery suite between 9am and 7pm daily. Staff told us that this had improved the culture and the multi-disciplinary (MDT) working relationship between staff groups. Midwives and doctors told us that staff were working well together and felt supported by each other. However, six midwives told us that a small number of the senior medical staff did not always behave professionally towards them and could be obstructive and rude.

Managing risks, issues and performance

During our inspection in May 2018 we were concerned that systems and processes for identifying and managing risk were neither properly established nor operated effectively.

- **There were processes in place to identify and manage risk but these were not fully embedded.**
- The maternity service was part of clinical business unit four (CBU4). We reviewed the CBU4 risk register and saw that maternity risks identified by managers at the inspection were on the risk register. They were rated red, amber and green (RAG). Each risk had actions with an owner. For example, the lack of consistent leadership and engagement on the central delivery suite by the consultant team and high reliance on locum staff was rated red. We saw that it had been recorded that a substantive clinical lead was in post and the clinical governance lead was filled by a locum and that the clinical director post was advertised and the risk was to be reviewed in one month.
- The service held a monthly risk and governance meetings. We reviewed eight sets of meeting minutes for the obstetrics and gynaecology clinical governance group and the maternity risk and governance oversight group from August to November 2018 and saw that the risk register review and review of incidents was a standing agenda item.
- The service held a monthly multi-disciplinary obstetrics and gynaecology department / business meeting which was attended by representatives from the medical team, the midwifery team, nurses, allied health professionals and operational support staff. Governance formed part of the agenda including a review of the maternity dashboard. A standing agenda item was feedback from team meetings. We reviewed meeting minutes from

Maternity (inpatient services)

August, September, October and November 2018 and saw that feedback from the departmental teams was inconsistent. For example, in August 2018 there were updates from the screening team, central delivery suite, ante-natal clinic, Castleacre ward and community midwives. In September 2018 there was no update from Castleacre ward. Minutes from October 2018 did not contain any update from any area. We noted in these minutes that the director of midwifery requested that a summary from the departmental teams be presented. There was an action to request a summary from the team managers for the next meeting. However, minutes from November 2018 contained updates from Castleacre ward and the screening team. The central delivery suite and the community midwives team meetings were cancelled and there was no update from Brancaster day assessment unit and antenatal clinics. Therefore, we were not assured that the governance process was embedded and that information was being cascaded throughout the service.

- There was improved consultant involvement in clinical governance. A locum consultant had been appointed to the role of clinical governance lead. There was an obstetrics and gynaecology clinical governance group. There was improved consultant attendance at departmental and governance meetings. We reviewed four sets of meeting minutes from the obstetrics and gynaecology departmental / business meeting from August to November 2018 and saw that they were attended by doctors and consultants. However, staff told us that some of the consultants were still not engaged in the governance process.
- The risk and governance midwife reviewed all maternity incidents. A local governance report was reviewed at departmental meetings to share learning and outcomes. There was a lesson learnt page on the clinical business unit four (CBU4) intranet page. The learning was linked

to the electronic incident report and consisted of a six-slide presentation highlighting key points. This was also emailed out to staff. The risk and governance matron told us that every two months they took two cases to present at a monthly meeting with risk leads from two local trusts to share learning.

- The service had started to review clinical guidelines. In May 2018 there were 64 guidelines that were out of date and required a review and ratification. At the time of our inspection this number had been reduced to 32 guidelines remaining out of date. The service had a plan to ensure that the 32 guidelines still out of date would be reviewed and ratified by March 2019. There was a programme being implemented to schedule forthcoming guideline updates, to ensure that guidelines were reviewed and updated before they became out of date.
- There was an audit programme to monitor the delivery of care but this was not embedded due to guidelines and pathways still being developed and updated. We saw evidence that spot checks had taken place to monitor recent changes in pathways and guidelines. However, the service had 32 guidelines that were out of date therefore we were not assured that national best practice was being followed by staff.
- All moderate incidents were reviewed at the trust incident review panel. This meant that rating of incidents was open to external check and challenge to provide assurance that incidents were rated correctly and duty of candour had been carried out where required.
- The maternity risk management strategy was under review at the time of inspection so that it was aligned to the trust's risk management strategy. There was a maternity governance improvement plan in development

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- The provider must continue to improve governance process and quality assurance measures and ensure that these become embedded in practice.
- The provider must ensure that all clinical guidelines are reviewed and up to date in line with national guidelines and best practice.
- The provider must ensure that the audit programme is embedded and delivered.

- The provider must ensure that work continues to improve culture within the service and support multi-disciplinary team working.

Action the hospital **SHOULD** take to improve

- The provider should continue to work towards establishing a substantive leadership team.
- The provider should ensure that there is timely effective communication between senior leaders in the trust and staff in the service.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);</p> <p>(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs</p> <p>(a) Governance and quality assurance processes, including the risk management strategy, were under review and not yet embedded.</p> <p>The provider had 32 guidelines that were out of date.</p> <p>We were not assured that staff had access to the most up to date national best practice guidance.</p> <p>Audit of guidance was not yet embedded which meant that the service could not evaluate and improve their practice.</p> <p>Culture and multidisciplinary working needed to continue to improve.</p>