Care Quality Commission

Salisbury NHS Foundation Trust

Salisbury District Hospital

Inspection report

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Ratings

Overall rating for this service	Not inspected

Our findings

Overall summary of services at Salisbury District Hospital

Not inspected

We inspected maternity services at Salisbury District Hospital to review progress against concerns identified in a section 29A warning notice served to the trust in May 2021.

We carried out this short notice announced focused follow up inspection to look at parts of the service that did not meet legal requirements at the last inspection in March 2021.

We inspected the well-led key question in relation to leadership, culture, governance and risk management.

We did not rate this service at this inspection. The previous rating of requires improvement overall with good for responsive and effective, requires improvement for safe and inadequate for well-led remains.

How we carried out the inspection

We interviewed seven staff including the director of midwifery, the interim head of midwifery, the clinical director of the women and newborn division, the divisional director of operations, the obstetric clinical lead and the deputy head of midwifery.

We also had a staff focus group attended by 23 staff.

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

Maternity

Inspected but not rated

The trust had started to make progress to address our concerns. We judged the requirements in the warning notice had been met. However, further work was needed to embed the changes and ensure improvements were sustained. We did not rate the service at this focused follow up inspection.

We found:

- The service had improved divisional maternity leadership structures and started to invest in leadership training for staff.
- The leadership team acknowledged the challenges to improving the culture in the service and work to address this was in progress.
- Leaders were working to improve the effectiveness of governance processes in the service and division.
- Leaders were improving risk management processes to ensure risks were escalated and actions identified to reduce their impact.

However

- The divisional structure was temporary for one year which contributed to continued uncertainty in the service. While new leadership roles had been recruited to, as staff were only recently in post, it was too soon to assess the impact of the new leadership team.
- Staff morale was low and staff sickness and absence remained high.
- Governance processes were highly procedural and lacked the strategic view and level of scrutiny needed to make and sustain improvements that could make a difference at an operational level. Action plans were created in response to regulatory requirements in a narrow way which missed opportunities for wider learning. Leaders were working to improve the effectiveness of governance processes in the service and division. New governance structures had been recently implemented at the time of inspection and were not fully embedded.
- The leadership team had not identified all risks to the sustainability and quality of the service.

Is the service well-led?

Inspected but not rated

Leadership

The service had improved leadership structures since the last inspection and had started to invest in leadership training for staff.

At the last inspection there was not sufficient leadership capacity to drive forward improvements in safety culture necessary following the external clinical and cultural reviews. Since the last inspection the trust had created a 'women and newborn' division to manage maternity, gynaecology and neonatal services. At the time of inspection, this division

was led by a director of midwifery who came into post on 4 October 2021, an interim head of midwifery, a clinical director and a director of operations. The leadership were positive about the impact of the new division in terms of improving the maternity leadership team's access to support from the trust executive team and improving oversight from the trust board.

There was uncertainty around the future of the divisional structure as the women and newborn division was created on a temporary basis for one year. The trust planned to review the divisional structure at the end of 2021.There was a risk the continued uncertainty around the divisional structure would impact on the services ability to embed and sustain improvements. By not committing to the new divisional structure permanently the trust and executive team risked not giving maternity the level of resource, support and scrutiny needed commensurate with the risks to quality, safety and sustainability of the service.

The trust had restructured the maternity leadership to build leadership capacity. The trust had recruited a director of midwifery who started in October 2021. As the director of midwifery had been in post for three days at the time of inspection, we could not assess the impact of this role. The director of midwifery had three years' experience working as the head of midwifery at another district hospital in the South West. The interim head of midwifery was supported by an interim deputy head of midwifery. At the time of inspection there was a consultation ongoing around the future of this role. The service had recruited an outpatient matron and a quality and safety matron, but the quality safety matron had not yet started at the trust. The director of nursing was leading discussions with the local maternity and newborn system (LMNS) about the recruitment of a consultant midwife and these conversations were ongoing.

There was continued instability in the maternity department leadership as not all the roles in the revised leadership structure were recruited to. Recruitment for a patient experience midwife was ongoing. While the service had been unable to recruit a digital midwife, a member of staff with digital expertise had been recruited to support digital developments in maternity.

At the last inspection clinical leads did not have enough time to dedicate to their roles. This had improved. The trust had re-organised clinical lead roles to ensure clinical leads had dedicated time for their roles. The new clinical lead structure had separate clinical leads for obstetrics, gynaecology and neonatal services. The obstetric lead was positive and allocated sufficient time for their clinical leadership role. While medical staff were consistently positive about the changes to leadership and governance, most midwifery staff we spoke with during a focus group attended by 23 staff had not noticed significant changes to the leadership of the service.

At the last inspection we raised concerns the trust had not invested in training and development for midwifery staff. The trust had started to invest in training and development for midwifery staff and all existing band 7 and 8 midwives had completed leadership training as part of a trust pilot in July 2021. The trust head of learning and the interim head of midwifery planned to evaluate the effectiveness of this leadership training in six months.

At the last two inspections we raised concerns about succession planning in maternity services. The service had started to improve succession planning and access to development opportunities for staff. They had created a checklist of skills and competencies for maternity staff at each band. The service had started offering a six-month development programme to band 6 midwives working towards band 7 labour ward coordinator roles. Once completed band 6 midwives had the opportunity to apply for a band 7 vacancy. At the time of inspection two midwives were completing the programme and the trust aimed to develop two staff every year on this programme.

Maternity

Culture

The leadership team acknowledged the challenges to improving the culture in the maternity service and work to address this was in progress. Midwifery staff morale was low and staff sickness was high.

The culture in the maternity department was poor. The maternity leadership team told us they were working with the trust organisational development team to create a behavioural framework based on the trust values. This work was in progress as the leadership team wanted to engage with staff to create this framework together to make it personal and relevant to the maternity service and the transformation project lead midwife had held virtual staff drop-in sessions in July 2021 to inform this work. However, it was not clear how these actions would lead to the anticipated improvements in culture as frontline staff were not yet sufficiently engaged with this work.

The 2020 staff survey for obstetrics and gynaecology showed a deterioration from the previous year on health and wellbeing, bullying and harassment and quality of care. The service was working to address these concerns with a new health and wellbeing strategy and a behavioural framework specific to maternity. These documents were in draft at the time of inspection, so we were unable to assess their effectiveness. The transformation lead midwife was supporting development of a health and wellbeing strategy. However, staff told us workload in the past six months had been 'relentless' and they struggled to be relieved for breaks due to pressures on the service. There was a perception from frontline staff that as midwives in senior leadership roles in the department did not work clinically on a regular basis , they were unable to relieve staff for breaks during times of high demand on the service and this created a level of resentment among frontline midwifery staff.

Staff sickness in the maternity department continued to be high and actions to address bullying and improve staff wellbeing were still in progress. The October 2021 trust board meeting minutes showed staff sickness in the women and newborn division had increased in September 2021 with stress and anxiety being the main reason for absence. Community midwifery and non-clinical staff in maternity were the areas most affected by staff absence.

Since the last inspection a lone worker policy had been reviewed and agreed at divisional management team meeting and was ready to be relaunched once it had been agreed at maternity governance meeting.

Actions to improve the safety culture by improving debriefs following incidents were delayed due to pressures on the service. The maternity risk action tracker noted that a debrief following an incident where a woman was transferred to the critical care unit was not organised due to pressures on the service. The clinical director escalated this to the trust organisational development team through the divisional management team meeting and was organising for the debrief to be facilitated by a clinician from a local trust.

The maternity team did not always take meaningful action in response to concerns raised by staff. Trust data showed between April and September 2021 two concerns had been raised from maternity services to the trust Freedom to Speak Up Guardians, of which one related to high workloads and another to a lack of compassion in the department. While the staff who had raised concerns were offered a conversation with the interim head of midwifery, it was not clear what the maternity leadership team had done to address these specific concerns raised by staff.

Governance

Governance processes were highly procedural and lacked the strategic view and level of scrutiny needed to make and sustain improvements that could make a difference at an operational level. Action plans were created in response to regulatory requirements in a narrow way which missed opportunities for wider learning. Leaders were working to improve the effectiveness of governance processes in the service and division. New governance structures had been recently implemented at the time of inspection and were not fully embedded.

Maternity

Trust board oversight of the maternity service had started to improve. The clinical director and interim head of midwifery had monthly meetings with the Director of Nursing and maternity safety champion. We reviewed the meeting minutes for the July 2021 safety champion meeting and found the trust response to the Ockenden report, the NHS resolution scheme and continuity of carer were discussed. The service had reviewed maternity staffing using a nationally recognised acuity tool in June 2021 and presented this to the trust board in September 2021. The staffing review showed a variance between the budgeted vs actual staffing levels needed as 13.34 whole time equivalent (wte) (with 20.51wte needed including maternity leave.)

A maternity dashboard was included in trust board papers since August 2021. The September 2021 public board meeting minutes reported that a quarterly maternity report would go to the trust wide clinical governance committee which would include review of the maternity clinical negligence scheme for trusts (CNST). At the time of inspection, the trust was compliant with only four out of the ten safety measures for the three year reporting period (December 2019 – July 2021) measures. The CNST was reviewed in detail at the June 2021 clinical governance committee and presented at public board in July 2021. However, continued oversight, challenge and monitoring of the CNST at board level needed to improve. The conclusion of the CNST review identified the trust had recently discovered a gap in evidence available to demonstrate compliance with the remaining six safety actions the trust was not compliant with due to a lack of understanding of what was required and gaps in senior leadership positions in the maternity service. Actions to address non-compliance with the six actions were in progress at the time of inspection and at the time of inspection actions plans for safety measures six (Saving Babies Lives care bundle 2) , eight (multiprofessional training and newborn life support training) and nine (board safety champions) and not yet been produced.

The service was working to improve the quality of the maternity dashboard to ensure effective benchmarking data was included. The clinical director was working with informatics colleagues in the trust to plot the data to show trends over time rather than using red, amber, green ratings. The clinical director acknowledged the challenges of ensuring data to monitor performance was accurate in a department using paper records. The accuracy of the vaginal birth after caesarean (VBAC) data was discussed in the July 2021 maternity governance meeting as it was reported as being consistently 100%.

Maternity governance forum meetings had started to improve. The service had reviewed governance structures and meeting agendas since the last inspection and maternity governance meetings had standard agendas and an action tracker. The standard agenda included: audit, guidelines, risk, staffing and patient experience.

While the service had started to make improvements, staffing challenges had impacted on its ability to complete actions due to increased demands on the service in August and September 2021. The impact of staffing pressures on reducing capacity to complete audits was escalated to the divisional management team at the September 2021 maternity governance meeting.

Improvements to the service were overseen by a maternity transformation board that met monthly. The meeting was chaired by the transformation lead midwife and any issues for escalation were reported up to the executive performance review meeting.

Action to improve the perinatal mortality meetings was in progress but underdeveloped. There had only been one ‘new style’ perinatal mortality meeting since the last inspection. The perinatal mortality review tool was being used in more detail and as a multidisciplinary review for learning rather than as an investigation. The clinical lead for obstetrics was working with the neonatal clinical lead to chair the meetings.

Maternity

At the last inspection we raised concerns that the service did not have a local audit programme. Since the last inspection, the service had a local audit programme organised to address local and national safety priorities and learning from serious incidents. However, the maternity leadership team acknowledged strengthening the link between audit and improvement was a challenge. Progress to improve the quality of governance processes was slowed down by lack of administrative support and this was acknowledged as a challenge in the August 2021 maternity governance meeting. High acuity and staffing also impacted on staff ability to complete actions for the August 2021 meeting. The maternity leadership team agreed compliant audits would be communicated to staff in the monthly safety and quality newsletter and non-compliant audits would be discussed at maternity governance to manage learning from the audits.

At the last inspection we raised concerns about low compliance with fluid balance audits and this had not improved. Actions to improve compliance with completion of fluid balance charts had not led to sustained improvements. Maternity audit data showed a decline in compliance over the previous six months. At this inspection performance in the fluid balance audit for quarter 1 was 53%. Actions to improve compliance with recording of fluid balance charts included teaching on fluid balance as part of induction of new midwives, 'tea trolley training' on the unit and learning posters displayed on noticeboards. A new bladder care guideline was due to be relaunched at the time of inspection.

At the last inspection we raised concerns about low compliance with maternity early obstetric warning score (MEOWS) audits and this had not improved. The service was continuing to work on improving compliance MEOWS audits. The August 2021 transformation meeting agreed to focus on post-operative MEOWS for audit timings and repeat in three months.

Management of risk, issues and performance

Leaders were improving risk management processes to ensure risks were escalated and actions identified to reduce their impact. However, the leadership team had not identified all risks to the sustainability and quality of the service.

At the last inspection we found the risk register was not regularly reviewed. This had improved. The maternity leadership team had completed two 'deep dive' sessions in July and August 2021 to review the risk register. Historic risks had been reviewed and removed from the risk register and all risks included risk owners, deadlines for mitigating actions and review dates.

Top risks included: maternity leadership capacity, lack of capacity in the quality and safety team, and babies not being entered into the electronic patient record system in a timely way. Staffing risks, for example, were mitigated by rolling recruitment of band 6 midwives, over recruitment of band 5 midwives, submitting a bid to recruit overseas midwives.

The maternity leadership team had reviewed the risk meeting governance structure. The monthly risk meeting had a new agenda and action tracker since the last inspection. The standard agenda included: review of the maternity dashboard, risk register, serious incidents, incidents reported and summary from case reviews.

The maternity leadership team had not identified all risks to the sustainability and quality of the maternity service. The risk of not being able to open the alongside midwifery unit until midwifery staffing levels improved was not included on the risk register. There was a reputational risk that the service would not be able to offer women a full range of birth choices and a potential operational risk that the lack of a full range of birth environment choices could lead to increased pressure on the community teams to provide home birth services while the alongside midwifery-led unit was not open. A staffing options paper for the two room, alongside midwifery unit had been written in September 2021. At the time of inspection this had not progressed through the maternity governance processes. The labour ward manager's role was

being reviewed to include the alongside midwifery unit. Likewise, the risks relating to the culture in the service with low staff morale and increased staff sickness and the potential impact on staff retention was not explicitly included on the risk register. There was a risk that actions to mitigate the risks relating to poor culture would not be effectively mitigated.

The service did not have a continuity of carer team at the time of inspection. The continuity of carer model means women will have a named midwife and be supported by a small team of midwives who work together to provide care throughout the pregnancy, birth and after the baby is born. The maternity leadership team had drafted a paper on continuity of carer, including modelling of staffing requirements. The service was awaiting further guidance from NHSE and working with the local maternity and neonatal system.

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:

- Ensure staff complete fluid balance charts. (Regulation 12 (2)(a))
- Ensure learning from serious incidents is embedded to sustain improvements in the quality and safety of services. (Regulation 17(2)(a))

Action the trust SHOULD take to improve:

- Consider how staff wellbeing, including prioritising the need for clinical staff get required breaks, can be improved at pace.
- The team should work to evidence action taken when staff raise concerns.
- Review availability of debriefs for staff following serious or distressing incidents.
- Consider the impact of midwifery staffing challenges on resourcing the quality and safety agenda in maternity.
- Review the effectiveness of ongoing board oversight and monitoring of the NHS resolution scheme.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and a midwifery specialist advisor. The inspection team was overseen by Cath Campbell, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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