The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

The Queen Elizabeth Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at The Queen Elizabeth Hospital

Requires Improvement 

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 The Queen Elizabeth Hospital.

We inspected the maternity service at The Queen Elizabeth 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.

The Queen Elizabeth Hospital provides maternity services to the population of west Norfolk, north Cambridgeshire and south Lincolnshire.

Maternity services include a maternal and fetal medicine, outpatient department, maternity assessment unit, combined antenatal and postnatal ward (Brancaster), central delivery suite / labour ward, midwifery led birthing centre (Waterlily), and two maternity theatres. Between April 2022 and January 2023, there were 1598 babies born at The Queen Elizabeth Hospital.

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

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

Our rating of this hospital stayed the same. We rated it as Requires Improvement because:

Our rating of Good for maternity services did not change ratings for the hospital overall. We rated safe as Requires Improvement and well-led as Good.

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited maternity assessment unit, maternity triage, delivery suite, the antenatal and postnatal ward and the antenatal clinic. We spoke with 22 people including the interim head of midwifery, an obstetrician, 3 doctors, an anaesthetic consultant, 13 midwives and two women and their families. We attended handover meetings and reviewed records.

We received 90 responses to our give feedback on care posters which were in place during the inspection.

Feedback received indicated 55% of women and birthing people had mostly positive views about their experience, although 45% had mixed or negative views. Feedback included concerns about communication, staffing numbers and support needed following birth.

Our findings

Following our onsite inspection, we spoke with senior leaders within the service. We also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

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

Good ↑

Our rating of this service improved. We rated it as good because:

- Staff worked well together for the benefit of women and birthing people. They understood how to protect women and birthing people from abuse, and managed safety well.
- The service managed infection risks well.
- Staff assessed most risks to women and birthing people, acted on them and kept good care records.
- The service had adequate staffing levels and a strategy in place to ensure staffing levels matched the planned numbers to ensure the safety of women, birthing people and babies.
- Since our last inspection there has been a significant improvement in the culture of the service.
- Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities.
- The service engaged with women and birthing people and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. Leaders understood how health inequalities affected treatment and outcomes for women and birthing people that accessed the service and worked with local partners to identify quality improvement to improve equity and equality.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent.

However:

- Staff did not always complete and document fresh eyes observations in line with national and trust guidance or escalate and document adverse baby observations. Not all women and birthing people were seen within appropriate timelines by medical staff when presenting to maternity triage. The maternity telephone triage monitoring did not allow for detailed data collection.
- Not all staff were up to date with maternity mandatory training modules or received training for out-of-scope events.
- Not all staff had access to appropriate appraisals to carry out their duties.
- There were a high number of overdue incidents that had not been investigated in a timely way.
- Not all controlled medicines were recorded in line with trust guidance.

Is the service safe?

Requires Improvement →←

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

Mandatory training

Maternity

The service provided mandatory training in key skills to all staff. However, staff did not always complete mandatory training to meet the trust's training compliance target in maternity services.

Staff were not all up-to-date with their mandatory training. Records showed that 66% of midwifery staff had completed the required maternity specific mandatory training courses against a trust target of 80%. Compliance in the midwife-led birthing unit scored above 80%. However, the overall mandatory training compliance rate for maternity support workers (MSW) was 70% and the overall maternity specific mandatory training compliance rate for medical staff was 68%. This was below the trust compliance target of 80%.

Records showed 61% of medical staff and 73% of midwives had completed adult resuscitation training and 85% of MSWs had completed this training. The trust informed us one reason for the lower than expected rate of training compliance by junior doctors was the change over of medical staff shortly before our inspection. Eighty-nine per cent of midwives and 61% of maternity support workers (MSWs) had received neonatal life support training.

The maternity specific mandatory training was comprehensive and met the needs of women and birthing people and staff. The service had a training guideline; it was in date and next due for review in June 2024. The guideline included a training needs analysis which outlined all training required to be completed by maternity staff. The training needs analysis linked to national recommendations and showed the compliance required to meet the recommended standards.

The service provided training and competency-based assessments on the use of fetal surveillance, including Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Eighty-seven per cent of midwifery staff, 100% of consultants and 64% of middle grade doctors had completed this training. The service ran a multidisciplinary CTG review session every week, which staff could attend in person or through Teams. Staff told us they were required to attend at least 1 of these sessions to comply with training requirements and they received feedback by email.

Staff received multi-professional simulated obstetric emergency training. Multi-professional training ensures all grades of staff practice dealing with and managing emergency situations, such as post-partum haemorrhage, together. Eighty-nine per cent of midwives and 90% of consultant medical staff had received this training. However, only 73% of other medical staff and 38% of anaesthetic staff had received the training.

Managers were aware that not all staff had completed mandatory training and told us one reason for this was the impact of recent industrial action. They had a training trajectory to achieve 90% compliance by the end of December 2023 and had put extra sessions in place to catch up.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

The service had a team of specialist midwives across the hospital services, including practice development midwives, who monitored, supported and provided training for the maternity service. Staff were also supported by a team of 3 practice development midwives, a practice development MSW, a lead support worker and 2 clinical educators were led by the risk and governance lead midwife.

Safeguarding

Maternity

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 staff had completed both safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

The trust target for safeguarding training was 80%. Medical staff compliance with safeguarding training was 94%, nursing and midwifery staff was 96% and maternity support workers (MSW) was 97%. This met the trust target.

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 women and birthing people 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 this was a 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. The service had a safeguarding team who staff could turn to when they had concerns and staff told us who this team were. Staff submitted safeguarding concerns via the electronic records system, which detailed the safeguarding concerns had been escalated.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection. The service had systems in place to ensure visitors were known to and accepted by women and birthing people. Staff checked safeguarding lists each morning to ensure only those authorised to visit were allowed in.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. We saw areas such as corridors and patient rooms, were visibly clean and free from dust. Curtains and blinds were disposable and had been changed regularly. Temperature checks of the milk fridge and freezer had been completed, which showed the recommended temperature for safe storage.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning staff told us they recorded when they had cleaned each area, which provided information to other cleaning staff and assurance that areas that had not been cleaned were identified.

Maternity

The service generally performed well for cleanliness. Leaders completed regular infection prevention and control and hand hygiene audits. Cleaning scores showed staff consistently performed well for cleanliness. Where there were exceptions, the trust implemented a cleaning action plan to address identified concerns.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last year compliance was consistently above 95%.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use. They used 'I am clean' stickers to show this.

Environment and equipment

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

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored and locked entry and exit system to the different units and reception areas. There were ward clerks at reception desks during normal working hours.

The service had dedicated maternity theatre time in main theatres for elective caesarean sections and a dedicated emergency theatre in the delivery suite for emergency caesarean sections or other maternity related surgery.

Maternity triage consisted of a dedicated waiting area, one 2 bedded bay and a single room with a built-in scanner that enabled staff to relay information in a private setting. Although the triage unit was not next to delivery suite, the whole maternity unit was located on one floor and in the same part of the hospital.

The service's bereavement suite was developed in conjunction with the maternity voice's partnership and bereaved parents. It provided parents with a private entrance, the room was sound proofed, and beds and seating areas were large enough for both parents to be comfortable.

There were no high dependency beds for women or birthing people on the maternity unit. Women and birthing people that required a higher level of monitoring would be transferred to other units. Babies who needed a higher level of monitoring after delivery were cared for in transitional care cots/beds on the postnatal ward. Staff told us there was a dedicated maternity support worker for these babies with oversight from a midwife.

Staff usually completed safety checks of specialist equipment and we saw adult and newborn resuscitation equipment was mostly checked daily. However, there were 3 missed entries on one resuscitaire in a 2-month period. Records between April and September 2023 showed that resuscitation equipment outside maternity theatres was usually checked daily and complied with the trust target of 90%. Resuscitation equipment checks were above 90% until September 2023 however, when there was a drop in check compliance.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

Maternity

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. Refurbishment to the antenatal and postnatal ward included dedicated toilet and shower facilities for male partners who were staying with women and birthing people admitted to the ward. This provided privacy and security for women and birthing people.

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 with a pool and on the day assessment unit there were cardiotocograph machines and observation monitoring equipment. Most equipment was checked annually to ensure it could be safely used, although we did find 2 pieces of equipment where the re-test date had expired. The service had asset registers that showed when each piece of equipment was last checked and where they were located. Technicians then negotiated with staff for a convenient time to service the piece of equipment.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called. Call bells in some parts of the maternity unit also sounded in the closest other area, triage alarms sounded in the ante/postnatal ward and call bells from the midwifery led unit also sounded in delivery suite. This ensured support was available from other staff if needed.

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 risk

Staff completed and updated most risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration, but not always with babies.

Staff used a nationally recognised tool to identify women, birthing people and babies at risk of deterioration. They used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We were not able to review MEOWS records during our visit, so we asked the trust for information about how well staff completed them. Audits for July to October 2023 showed staff recorded MEOWS correctly 100% of the time. Staff also completed Newborn Early Warning Trigger and Track (NEWTT) scores for newborn babies who were at risk. An audit of score between July and September 2023 showed 100% compliance with accurate completion. Just over half of the NEWTT scores that required escalation, had been appropriately escalated. Of those that had not been escalated, half had no documentation to show whether any action had been taken at all. These findings were cascaded to ward staff and the practice development team to monitor and ongoing audits of NEWTTs were to begin.

Staff completed risk assessments for women and birthing people on arrival at maternity triage, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised electronic risk assessment and prioritisation tool for maternity triage. This had been fully implemented in a dedicated assessment area and included a RAG rating to identify women and birthing people at highest risk.

The service's policy for maternity triage was for midwives to assess women and birthing people within 15-30 minutes. An audit of maternity triage waiting time between September 2022 to September 2023 showed midwives reviewed 84% of women and birthing people within 15 minutes of arrival. Data showed the number of women seen within this timeframe had been improving since September 2022. For example, in September 2023, 91% of women were seen within 15 minutes by a midwife. However, only 60% of women who needed to be reviewed by a doctor saw one within the correct timeframe. The service told us that their analysis of these women or birthing people's records showed there had been no adverse effect experienced by the delay in being seen by a doctor.

Maternity

The service had introduced a telephone triage line in September 2022, available 24 hours a day, with a staff member specifically for this role. However, the staff member also supported staff in triage. The telephone line was not triage specific and therefore staff often received calls for other needs or from other professionals. Staff told us the phone line was very busy and they were not always able to respond in time. The service recognised there was an issue with the older analogue phone system as they were not able to easily gather data about calls to maternity triage. They had developed an action plan for a dedicated phone line and additional staff to work in maternity triage. The electronic records system automatically flagged to staff if the woman or birthing person had called before, and this helped staff recognise when there may be an ongoing issue.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks, such as the risk of developing blood clots, the risk of carbon monoxide poisoning or a reduction in the fetal growth. We reviewed the clinical documentation audit for October 2023 that showed most assessments had been completed at booking and at subsequent antenatal visits. The audit showed staff recorded the outcome of assessments in 90 to 100% of patient notes. However, the risk associated with developing a blood clot, known as venous thromboembolism (VTE), scored 88%. The service had taken action to escalate this with team leaders to encourage staff to accurately record all assessments they had completed.

Staff used the fresh eyes approach to carry out fetal monitoring. It is best practice to have a 'fresh eyes' or buddy approach for regular review of cardiotocography (CTGs) during labour. CTG is a continuous recording of the fetal heart rate obtained by an ultrasound transducer placed on the abdomen of the pregnant woman or birthing person. Leaders audited CTG records. We looked at the CTG and fresh eyes audit information for January to September 2023 and found fresh eyes were not completed often enough. Although this was improving, in September 2023 fresh eyes checks were only recorded as completed 53% of the time. Against a trust target of 90%

From May to June 2023, staff achieved 100% compliance in the World Health Organisation (WHO) surgical checklist audit.

Where women and birthing people were admitted to other areas of the hospital due to their clinical needs, staff from the maternity service visited them every day to ensure their obstetric needs were met. Staff used a 4-bed bay on delivery suite for women who required enhanced maternity care, such as additional monitoring. Staff assured us women and birthing people who had invasive intravascular devices, such as central venous or arterial lines would be transferred to a high-dependency unit or critical care unit elsewhere in the hospital. However, the service guidance stated an arterial line may be needed in one severe condition and staff confirmed a woman or birthing person with this condition would remain on the maternity unit. There was guidance about oversight and management of this, and who had responsibility for the use and care of the arterial line. There was no information about possible risks or actions for the primary care giving staff to take in relation to the device in the event of an urgent issue. Therefore, there was a risk that staff may have to carry out some assessment of the device and take urgent action, without training or guidance.

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. The perinatal mental health midwife carried out weekly clinics in hubs outside the hospital to provide easier access for women and birthing people. 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 care record was on a secure electronic care record system used by all staff involved in the woman or birthing person's

intrapartum care. Each episode of care was recorded by health professionals and was used to share information between care givers. Staff used the situation, background, assessment and recommendation (SBAR) tool to handover patients to others. The communication tool prompted staff to record key information and recommendations about patients. An audit of SBAR records from July to September 2023 showed a 99% compliance rate.

Shift changes, handovers and safety huddles included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found that staff used SBAR and provided both verbal and an up-to-date handover sheet with all the key information needed to keep women, birthing people and babies safe.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge. Staff completed Newborn and Infant Physical Examination (NIPE) assessments of newborn babies before they could be discharged.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. We observed good access and flow in the service during inspection.

Midwifery Staffing

Staffing levels usually matched the planned numbers. Managers regularly reviewed and adjusted staffing levels and skill mix. The service did not make sure staff were competent for their roles as staff did not always receive support through supervision and appraisals.

Staffing levels usually matched the planned numbers to keep women, birthing people and babies safe. On the day of inspection midwifery staffing numbers were at the planned level. Staff told us they usually had enough staff unless there was sudden sick leave. In those instances, managers looked at the acuity in the area and moved staff if needed to ensure staffing was safe.

There were areas however, where optimum staffing was not always available. Maternity triage was staffed by one midwife and a maternity support worker, although recruitment was underway for additional staff. Staff were aware of the busier times in the unit and told us they would escalate issues or concerns to the labour ward coordinator. We saw in the afternoon of our visit that there were 8 women and birthing people in maternity triage, of which 4 were still to be seen. Staff had already escalated this as an issue and the labour ward coordinator visited the unit to assess staffing or whether any women or birthing people needed to be transferred to labour ward.

The midwife-led unit was staffed 24 hours a day by 2 community midwives. Staff there thought recruitment and retention at the service had improved and the unit had remained open throughout the pandemic and since.

The most recent assessment (August 2023) of the recommended safe staffing ratios for the maternity service compared favourably to whole time equivalent (WTE) in line with national recommendation. The overall ratio was 27.7 births to 1 WTE midwife, which was better than the national ratio.

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 midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. Between April and August 2023, the service reported 3 red flags, all due to different reasons. However, in September 2023 there were 4 red flag incidents.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. From 1 April to 31 August 2023, the compliance rate reported for one-to-one care was 100%. Rosters for labour wards were planned to always allow for one supernumerary coordinator.

The labour ward coordinator had 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.

The service had a sickness rate of 7.5% in September 2023, over the trust target of 4.5%, which had reduced from 9.5%. Senior managers had looked at reasons for this and developed some actions to try to reduce further the number of staff absences. This included regular welfare checks, clinical psychology referral and monthly monitoring. Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service had a clear escalation policy for management of staffing shortages and reduced bed capacity. The service used an evidence-based methodology for calculating midwifery staffing requirements based on the case mix of women, birthing people and babies accessing the service.

The service did not make sure all staff were competent for their roles. Managers did not appraise all staff's work performance or hold supervision meetings with them to provide support and development.

There was a system in place to support and develop staff through supervision and yearly, constructive appraisals of their work; however, not all staff were supported with supervision and annual appraisals in line with trust policy. Data showed 76% of midwifery staff had received an appraisal in the previous 12 months, against a trust target of 90%. A practice development team supported midwives in their day-to-day work.

Managers made sure staff received any specialist training for their role.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service always had a consultant on call during evenings and weekends. The consultants including the anaesthetists were available on site 8am to 8.30pm. There was off site on-call consultants cover from 8pm to 8.30am and registrars were available on site out of hours. There was adequate medical cover across the maternity unit including triage, day assessment unit and maternity wards.

The service had some vacancies for medical staff. Trust data showed there were 3 vacancies for obstetric consultants at the service, 2 of which were filled by locum consultants. There had been some turnover of consultants in the year prior to our inspection. However, staff told us there were 12 consultants working at the service and this provided a consultant either on shift or on call 24 hours a day. The service had one senior registrar vacancy, which they had filled with a locum registrar who had been in post for a year.

Maternity

The service did not separate sickness rates for midwifery and medical staff. They had a sickness rate of 7.5% in September 2023, over the trust target of 4.5%, which had reduced from 9.5%. This was a combination of long and short term sickness. Senior managers had looked at reasons for this and developed some actions to try to reduce further the number of staff absences, including regular welfare checks, clinical psychology referral and monthly monitoring.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Compliance rates for medical supervision was more than 91%, which was greater than the trust target of 90%.

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 notes were comprehensive, and all staff could access them easily. The service had used an electronic records system since March 2017, and they were able to audit these records each month to assess compliance. We were not able to review the electronic records onsite, so asked the trust for information about how well staff completed records. Information sent to us showed most areas of the electronic record, such as antenatal booking and blood tests, and risk assessments were completed between 85% and 100% of the time. They showed intrapartum risk assessments were completed 88% of the time between July and September 2023.

After every 3 monthly audit the service produced a report identifying key success and concerns in each area (antenatally, intrapartum and postnatally), made recommendations and developed an action plan. The actions were clear, identified individual responsibility for completion and updates, date for completion and RAG rated how quickly this should happen.

When women and birthing people transferred to a new team, there were no delays in maternity staff in the trust accessing their records. When women transferred to other hospitals staff sent records by secure email. Women and birthing people were also able to access their records through an app and share them directly. Senior managers told us there were no delays in accessing women and birthing people's maternity records.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets. Staff told us they had enough mobile computers, which were used to document patient records by the bedside.

Medicines

The service used systems and processes to safely prescribe, administer and store medicines, but not all medicines were recorded correctly.

Staff completed most medicines records accurately and kept them up-to-date. Most medicines records were clear and up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit. However, staff did not always maintain accurate records of controlled drugs that were not given in full. This did not follow the trust policy and increased the risk of substance misuse.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 5 prescription charts and found staff had correctly completed all but one prescription, where the person had been given the prescribed medicine orally instead of intravenously.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

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 checked controlled drug stocks daily. 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. Medicines recorded on the digital systems for the 5 sets of records we looked at were mostly completed, accurate and up-to-date. Where VTE scores or patient allergy status had not been entered, the system automatically prevented prescription of some medicines until these details were added.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed multiple incidents reported in the 9 months before inspection, all occurring in the first 5 months of the year, and found not all were reported correctly. Incidents, such as post-partum haemorrhage (PPH) were sometimes recorded and rated as being no or low harm, even when there had been significant intervention, including intravenous medicines, blood transfusions or transfer to theatre for further treatment.

However, since our inspection senior managers provided evidence to show a thematic review of PPH was completed in April 2023 and identified whether appropriate actions had been taken, the reasons why accurate assessment had not been made and recommendations for improvement. We noted the service had changed the way it reports incidents to

align with patient safety incident response framework (PSIRF), so it would inform learning to better manage PPH and improve outcomes and experiences for women and birthing people. A process was set up to review all PPH incidents by a multidisciplinary team using the NHS England System Engineering Initiative for Patient Safety (SEIPS) and to be discussed at the trust weekly safety incident review forum.

The service had no 'never' events in the 12 months prior to our inspection. 'Never events' are serious clinical incidents that are wholly preventable because of guidance and safety recommendations that should be implemented by all healthcare providers.

Managers reviewed incidents so that they could identify potential immediate actions. Moderate and serious incidents were reported to the board level maternity safety champions and the Local Maternity and Neonatal System (LMNS) monthly. However, incidents were not always reviewed promptly. Data from the maternity service showed that in September and October 2023 there were 226 open incidents, of which 140 had been open for more than 60 days, 19 of these were rated as moderate and 16 had an action impact of immediate. Two incidents had been reported to the Health and Safety Investigation Branch (HSIB) for investigation. The service was aware of these outstanding incidents and had developed an action plan to reduce the backlog so staff could learn from incidents in a more timely way.

Staff told us they were encouraged to complete electronic reporting and were able to receive feedback electronically or from a professional midwifery advisor who oversaw incidents. Debrief was arranged following serious incidents and staff said there was a focus on learning from incidents.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations. We reviewed 4 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 4 investigations, managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'lessons learnt library' that staff could access using a QR code, which provided information about incidents across the division. Staff told us there was also an email bulletin on current risks/incidents/actions which they could read.

Staff reported serious incidents clearly and in line with trust policy. 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.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback on electronic reporting and were emailed with actions and the outcome of investigations.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Maternity

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. Leaders had a good understanding of the issues, challenges and priorities in the service, and beyond. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture.

The service had undergone a significant change in maternity leadership in the last year, with an Acting Head of Midwifery and Nursing in post from May 2023. A new appointment to the role of general manager was expected and the head of midwifery substantive post was to be advertised. Leaders advised that despite this potential for an adverse impact to the service they continued to operate at normal activity levels.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service was supported by maternity safety champions and non-executive directors. The interim head of midwifery met with the non-executive maternity safety champion every month. Both the non-executive maternity board safety champion and the head of midwifery were aware of issues relating to the quality and safety of the service and acted as advocates for the service at board level. We reviewed information of the safety champion ‘walkabouts’ for June 2022. These showed a clear structure which covered relevant safety areas. Information from these ‘walkabouts’ was reported back to staff in the maternity safety dashboard.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy to cover a 3 year period from 2022 to 2025. Staff could explain the vision and what it meant for women, birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and included these as part of their vision. There were 7 essential safety recommendations made, including recording twice daily ward rounds, embedding standard operating procedures, engaging with the maternity voices partnership (MVP), and improving personalised care and support plans. Delivery of the service's Ockenden action plan was regularly mentioned as part of monitoring and governance processes. These showed the service had met all but one of their targets and were on track to meet the remaining target.

Maternity

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders and staff understood and knew how to apply them and monitor progress.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued. The service had a condition on their registration in relation to culture from a previous inspection. The 2022 NHS Staff Survey showed the maternity service responses were all below the trust average and reflective of previous culture issues. The service developed an action plan for improvement, which was on track for completion. We found there had been improvement in the culture of the service. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

All staff we spoke with, from ward clerks to nursing managers and medical staff told us they were part of a good team, they felt valued and supported. Senior staff were approachable, staff were able to ask questions and question decisions and relationships were respectful. They spoke positively about most current working relationships with other colleagues and told us these had improved following a change in leadership. We received a few comments, however, that showed these changes were new and there was still work to do to fully embed such a significant cultural adaptation.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect towards women and birthing people were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. Over half of the responses, we received from women and birthing people showed a positive experience.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or a disadvantaged background affected treatment and outcomes, which they shared with teams to help improve care. They also incorporated a training programme to educate all staff on how to identify and reduce health inequalities.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. From July to October 2023, the service

received 4 complaints, which were mainly related to staff attitude, treatment and care received. Three of these complaints had been investigated, lessons had been identified and had actions taken to reduce the risk of reoccurrence. The fourth complaint was withdrawn by the person involved and no action was taken to look into the concerns. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. 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.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a clearly defined governance structure that supported the flow of information from frontline staff to senior managers and the trust board. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

Governance meetings were well attended by a multidisciplinary team and discussion included areas that covered performance data, audits and training, feedback, guidelines and research updates. The head of midwifery was responsible for leading on and reporting on this and other national outcomes to these agencies and to the trust board; they acted as an intermediary to keep staff and others updated.

The service worked with external agencies to ensure compliance with national reports and incentives, such as the NHS Resolution Maternity Incentive Scheme (MIS). The maternity service was on track with all measures outlined within the year 5 MIS and held regular meetings to discuss other areas, such as fetal and neonatal mortality reviews. Parental views and feedback were included for all cases and questions that parents had regarding care were included in the review to ensure they received timely and full feedback.

Maternity services participated in both national and local audits, including the National Maternity and Perinatal Audit. This looked at statistical information about birth, such as the number of caesarean sections performed, whether an episiotomy (deliberate cut to avoid a tear during birth) was performed or the number of women and birthing people who had given up smoking while pregnant. Data showed the service’s statistics between May 2022 and April 2023 for the number of women and birthing people who were smokers at the time of booking, were higher than the national average but had reduced by approximately 5% at the time of delivery. Statistics for postpartum haemorrhage show the service was in line with the national average.

Learning from incidents and Healthcare Safety Investigation Branch (HSIB) recommendations were shared across the service. There were good processes in place and the Board was updated monthly through the quality committee report about all maternity and neonatal serious incidents. The findings of incident reviews and investigations were discussed at the clinical governance meeting. However, there was a missed opportunity to report on triage times and delays to induction of labour as these can pose significant risks.

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. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Staff followed policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years. Senior staff told us 8 guidelines were out of date according to their guideline tracker but 5 of these were awaiting trust ratification.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. The service reported outcomes to the NHS Digital Maternity dashboard, the National Neonatal Audit Programme, the National Maternity and Perinatal Audit and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiry).

Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards. These showed the service was better or at the national average for clinical audits, including 3rd and 4th degree tears and postpartum haemorrhage (PPH) of more than 1500ml. Managers monitored outcomes on the maternity scorecard, which provided statistical information monthly. When these statistical figures were outside national standards, these were discussed at risk meetings to ensure appropriate actions were taken to improve. Senior staff were aware of the high number of women and birthing people who smoked at booking and developed strategies to encourage them to stop. Similarly, staff recording of fetal growth risk (FGR) was inconsistent and falling short of the trust target until November 2022. There had since been a significant improvement, with FGR identification at booking at 95% or above. The corresponding risk of women and birthing people having a small for gestational age baby had also reduced from 10.9% at its highest to 0.6% in the 2 months prior to our inspection.

Data supplied by the trust showed fetal monitoring (CTG) was recorded all the time, although tasks associated with ‘fresh eyes’ monitoring was not. Appropriate escalation of concerning CTG recordings was escalated. Managers and staff used the results to improve women and birthing people's outcomes.

Managers and staff carried out a programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits. Managers developed a maternity safety dashboard each month that provided staff with an overview of incidents and risks identified during the previous month.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The service had a risk register and included risks such as staffing, nitrous oxide levels in delivery suite and the culture of the service. The risk register had control measures, actions to mitigate risks, progress made and the risk status. The leadership team took action to make changes where risks were identified and relayed this to staff, who were able to tell us clearly about the changes made around culture and nitrous oxide levels.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

Information Management

The service collected reliable data and analysed it. Staff 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 reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. Key information from the dashboard, score cards, audits and performance data were displayed across the service for staff, women, birthing people and public to access.

Data or notifications were consistently submitted to external organisations as required. The service submitted data to external bodies such as the National Neonatal Audit Programme, maternity dashboard, friends and family test (FFT) results and MBRRACE-UK. The service also worked closely with other local providers of maternity services, which enabled them to benchmark performance against other providers and national outcomes.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff used electronic patient records to access all the information they needed, including screening results and safeguarding information.

The information systems were integrated and secure**.** Electronic patient records systems were password protected to prevent unauthorised access.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local maternity voices partnership (MVP) to help make sure women's and birthing people's views were represented and maternity services were designed to meet local needs. They worked together to determine how accessible information was and what was needed to improve care and choice for all women and birthing people.

Although the MVP lead had only been in post for a few months at the time of our inspection, they worked closely with hospital staff to introduce themselves and develop relationships. The MVP lead had written a training programme for other new MVP leads across the local maternity and neonatal services (LMNS) and a process for new staff and specific roles to follow for their positions.

The service and MVP collaborated with other organisations to help improve services for women and birthing people. They developed specific incentives, such as listening events in soft play centres each month, to more effectively engage with women and birthing people from deprived communities in the area. There were also listening events at baby fairs and at weekends, which were a joint venture between hospital staff and the MVP. These provided women and birthing people with the opportunity to speak with midwifery and medical staff as well as MVP staff. Although there had only been a few women and birthing people attend these meeting, the service had received positive feedback about a 'feedback Friday' meeting that aimed to clarify information about pregnancy and childbirth.

Maternity

Both the maternity service and the MVP used social media platforms to connect with and obtain the views of women and birthing people. They provided information directly and links to more detailed information, and held a 'Thankful Thursday' session, which published positive feedback from women and birthing people. There was a 'meet the maternity staff' day every month where staff engaged with women and birthing people to build a relationship with them. Staff told us having access to information and responses in this way had increased their ability to relay information and had made information more accessible to women and birthing people.

The service had systems in place to engage with staff. There were staff and student information boards in clinical areas that provided contact details for Freedom to Speak Up Guardians and others where staff could get support.

The service made available interpreting services for women and pregnant people and collected data on ethnicity. The trust used a telephone interpreting service when needed and staff also used an electronic system that was able to be read or spoken out loud.

Leaders understood the needs of the local population. One of the service's identified priorities was in relation to the anticipated increase of women and birthing people from an ethnic minority from one area in the trust's geographical catchment area. Managers identified they needed to increase their understanding of the risks and the impact pregnancy and childbirth would have for them.

We received 90 give feedback on care forms through our website. Feedback received indicated women and birthing people had mixed views about their experience. Negative feedback included concerns about communication and staffing numbers. Many women and birthing people were unhappy their partners were not able to stay on the maternity ward overnight and did not feel they received the support they required following the birth of their babies. Since our inspection visit senior managers advised that partners had been able to stay with women and birthing people since January 2023. Forty women and birthing people gave negative feedback about their experience. Fifty women and birthing people told us they had a positive experience and described how supportive midwifery and medical staff had been.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had an understanding of quality improvement methods, but systems were not embedded to look at quality improvement.

Staff were committed to continually learning and improving services. They had an understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted change. Staff contributed to programmes, such as the patient safety incident response framework (PSIRF) and multidisciplinary review meetings, that provided reflection and learning. Meeting minutes for June to September 2023 showed overall continuing improvement in outcomes for women, birthing people and babies.

The service, however, did not have a quality improvement programme or specific meetings that looked solely at this subject. Quality Improvement was instead embedded within existing meetings, although minutes we received following this inspection showed improvement with existing national programmes in general or the maternity improvement plan only. Although there was improvement within the service, we saw no focus on how to encourage improvement.

The service collaborated with regional organisations, such as the Integrated Care Board and Local Maternity & Neonatal System, where these organisations supported research ideas.

Maternity

Areas for improvement

Action the service 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 service must ensure staff complete and document fresh eyes observations in line with national and trust guidance. Regulation 12(1)(2)(a)(b)
- The service must ensure staff escalate and document adverse baby observations. Regulation 12(1)(2)(a)(b)
- The service must ensure women and birthing people are seen within appropriate timelines by medical staff when presenting to maternity triage. Regulation 12(1)(2)[MA1] (a)(b)
- The service should ensure staff are up to date with maternity mandatory training modules. Regulation 18(1)(2)(a)
- The service should ensure all staff are supported through supervision and appraisals to carry out their duties. Regulation 18(1)(2)(a)

Action the trust SHOULD take to improve:

Maternity and midwifery service

- The service should ensure staff who may have to provide care for out-of-scope events are giving training to do so.
- The service should ensure all incidents are investigated in a timely way.
- The service should ensure maternity telephone triage monitoring allows for detailed data collection.
- The service should ensure discarded controlled medicines are recorded in line with trust guidance.
- The service should ensure emergency equipment is checked daily in line with their procedures.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 1 other CQC inspector, 2 midwife specialist advisors and an obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.

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 18 HSCA (RA) Regulations 2014 Staffing