Queen's Medical Centre

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Date of inspection visit: 14 October to 15 October 2020
Date of publication: 02/12/2020

Ratings

Overall rating for this hospital	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

Overall summary of services at Queen's Medical Centre

Requires improvement 

In rating this location, we took into account the current ratings of services not inspected at this time.

Our rating of Maternity services went down. We rated them as inadequate because:

Queen's Medical Centre is operated by Nottingham University Hospitals NHS Trust. The trust's maternity service sits within the division of family health and provides a range of services from pregnancy, birth and post-natal care and is based across two campuses and Nottinghamshire community. The trust provides inpatient antenatal, intrapartum and postnatal beds on Nottingham University Hospital (NUH) City campus and Queen's Medical Centre (QMC) campus for both high and low risk women. Both labour suites have alongside them midwifery led units and the trust provides a homebirth service. There are inpatient antenatal, intrapartum and postnatal beds available for women.

From January 2019 to December 2019 there were 8,265 deliveries at the trust.

Antenatal clinics are held across the whole of the service including community and the trust has day assessment units on both sites and ABC (triage service).

There is a fetal medicine service based on both sites, but this service is primarily delivered at the QMC campus.

Community services are provided by teams of midwives commissioned by Nottinghamshire CCG. They offer women a homebirth service and postnatal care.

The maternity unit at QMC is located over two floors in East block and includes:

- Ward B26 - an18 bedded antenatal ward (includes triage and induction of labour as additional beds in a separate area of the ward)
- Ward C29 – a 26 bedded postnatal ward which includes transitional care cots
- Labour suite – 10 beds plus two obstetric theatres with 24-hour anaesthetic cover, a bereavement suite and direct access to the neonatal unit.
- Sanctuary birth centre – 4 beds. A midwife led unit sometimes referred to as an Alongside Midwifery Unit (AMU)

We carried out a short notice, announced focused inspection at Queens Medical Centre on 15 October 2020. During this inspection we inspected maternity services which was in response to concerns raised from serious incidents, external investigations performed by Healthcare Safety Investigation Branch (HSIB) and coronial inquests.

We visited ward B26, ward C29, Labour suite and ABC triage assessment unit. We spoke with 22 staff, including service leads, matrons, midwives, medical staff, maternity care support workers and student midwives. We reviewed 18 sets of patient records (eight belonging to women and ten belonging to babies) and observed staff providing care and treatment to women.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of a regulation and issued a requirement notice or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we imposed conditions on the registration of the provider in respect to the regulated activity; Maternity and midwifery services. We took this urgent

Summary of findings

action as we believed a person would or may be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to the maternity units at the Queens Medical Centre and Nottingham City Hospital. We also issued a section 29a warning notice to the trust as we found significant improvement was required to the documentation for risk assessments and information technology systems. The section 29a notice has given the trust three months to rectify the significant improvements we identified.

Maternity

Inadequate 

Summary of this service

Our overall rating of this service went down. We rated it as inadequate because:

- Staff had not completed training in key skills and did not always understand how to keep women and babies safe. The service did not always have enough midwifery staff to keep women and babies safe and provide the right care and treatment. Staff did not always risk assess women appropriately and in line with national and local guidance, and records were not always well maintained. Incidents were not always reported due to the demand on staff and the ineffective feedback and escalation, and lessons were not being learnt.
- There was limited evidence of managers monitoring the effectiveness of care and treatment and driving improvement. Managers did not ensure all staff were competent for their role.
- Leaders did not have the skills and abilities to effectively lead the service. The service did not have an open culture where staff felt confident raising concerns without fear. Leaders did not operate an effective governance process to continually improve the quality of the service and safeguard the standards of care.

However:

- The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm.
- Staff were focused on the needs of women receiving care despite the challenges they faced. The service promoted equality and diversity in daily work.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- The service did not provide mandatory training in key skills to all staff; not everyone had completed it.
- Staff did not routinely complete and update risk assessments for all women in order to remove or minimise risks. Staff did not always identify and act quickly on babies at risk of deterioration.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always complete, up-to-date, or easily available to all staff providing care.
- There was not enough suitable equipment available to help staff safely care for women and babies.
- The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Although managers regularly reviewed staffing levels, they were not always able to adjust staffing levels to ensure safe numbers of staff in all areas due to staffing shortages.
- The service did not always manage patient safety incidents well. Staff recognised but did not always report incidents and near misses. Managers from the governance team investigated incidents but did not always shared lessons learned with the whole team and the wider service in a timely way.
- Staff collected safety information, but it was not routinely shared with staff, women and visitors.

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However:

- The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- The design, maintenance and use of facilities, premises and equipment kept people safe.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate because:

- Staff monitored the effectiveness of care and treatment. However, we did not see evidence that they used the findings to make improvements and achieve good outcomes for women and babies.
- The service did not make sure that all staff were competent for their roles. Managers appraised staff's work performance but did not routinely hold supervision meetings with them to provide support and development.
- Doctors, midwives and other healthcare professionals did not always work together as a multidisciplinary team to benefit patients. They supported each other to provide good care but did not always work together to provide joined up care.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- We were not assured the leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective in implementing meaningful changes that improved safety. Not all staff found leaders were visible and approachable in the service for patients and staff.
- The service did not have a positive, open culture where staff could raise concerns without fear. Not all staff felt respected or valued and rarely felt supported.
- Leaders did not operate effective governance processes, throughout the service to continually improve the quality of the service and safeguard standards of care. Not all staff had regular opportunities to meet, discuss and learn from the performance of the service.

However:

- Staff were focused on the needs of women receiving care despite the challenges they faced. The service promoted equality and diversity in daily work.

Maternity

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service did not provide mandatory training in key skills to all staff; not everyone had completed it.

Staff in the service did not all receive regular mandatory training. Training data for the Queens Medical Centre site showed that in October 2020, 61% of staff were compliant with mandatory training requirements. This did not meet the trust target for compliance, which was 80%. We identified concerns regarding aspects of training for emergency lifesaving of both women and babies as there had been no apparent risk assessment of the contingency plan put in place to ensure staff maintained their competency with this training. Managers told us that reduced compliance with mandatory training was largely due to face to face sessions being cancelled over the summer due to the Covid-19 pandemic. However, online training packages had been developed to replace some face to face sessions during the pandemic.

In addition to mandatory training, the service required midwives and medical obstetric staff to complete essential to role training. The service had been using 'Maternity Inter-professional Scenario Training' (MIST) to provide this emergency skills training. MIST was developed by a team of anaesthetists, obstetricians and midwives to provide staff working within the maternity units at Nottingham University Hospitals NHS Trust with meaningful emergency skills scenario training. The training took place on a closed ward at the City Hospital site where a realistic environment could be recreated to support training. The MIST timetable included topics such as post-partum haemorrhage, maternal collapse, sepsis, anaphylaxis, fetal bradycardia, shoulder dystocia, and neonatal life support.

Staff training compliance with MIST at the time of our inspection was 46% at the Queens Medical Centre site. Managers told us that poor compliance with MIST was due to the face to face MIST days having to be stopped during the Covid-19 pandemic due to the need for social distancing and the requirement for staff to work on the frontline. Although an attempt was made to restart the MIST days during August 2020, the courses did not work well due to the need to have much smaller groups and difficulty in maintaining social distancing.

The mandatory training available was comprehensive and met the needs of women and staff, however staff told us that it could be difficult to attend booked training sessions due to staffing demands. A ward manager explained that there was an approach to mandatory training called 'birth month training' which provided updates on all core training requirements. Staff completed the annual training in the month of their birth, and this was done as part of the off duty. However, it was not always possible for staff to be released to attend booked training if the unit was busy.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was monitored by the ward manager who reported figures to the matron and governance deputy head of midwifery (HOM) by email. This was done on an ad hoc basis. There was no routine system for reporting or monitoring mandatory training compliance to senior managers. The ward managers would highlight the need to update training with staff who were non-compliant. However, there was no system in place for addressing repeated noncompliance with mandatory training requirements with staff.

When we raised concerns about mandatory and essential to role training with the service following our inspection, managers told us that face to face sessions with social distancing and safety measures were in place from September 2020. The trust had placed an order for the on-line nationally recommended 'Practical Obstetric Multi-Professional Training' (PROMPT) emergency skills training to replace face to face MIST. The service was anticipating that access to the package would be available by the end of October 2020. Compliance with mandatory training and essential to role training was anticipated to be 90% by March 2021.

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Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. However, there was not enough suitable equipment available to help staff safely care for women and babies.

Staff carried out daily safety checks of specialist equipment, such as emergency resuscitation trolleys and resuscitaires (a warming therapy platform with the components needed for clinical emergencies and resuscitation of neonates). We checked neonatal and adult resuscitation trolleys as well as resuscitaires on the antenatal and postnatal wards and found that these had all been checked in accordance with policy and that these checks had been documented.

The service did not have enough suitable equipment to help them to safely care for women and babies. Staff on the wards reported a shortage of equipment such as cardiotocography (CTG) machines, doppler fetal monitors and thermometers. They described staff from other areas coming to borrow equipment from wards which would then leave the ward area short of available equipment. Staff also reported that IT equipment used to access records, the incident reporting system, and online learning, was old and slow and that there was not enough of it. They described that it could be difficult to access IT equipment when they needed to.

Assessing and responding to patient risk

Staff did not routinely complete and update risk assessments for all women in order to remove or minimise risks. Staff did not always identify and act quickly on babies at risk of deterioration.

Staff did not always use a nationally recognised tool to identify women at risk of deterioration. We saw that the maternity early obstetric warning score system (MEOWS) were not used routinely in all areas. Although we saw that MEOWS were used appropriately on the postnatal and antenatal wards, they were not used in the high-risk triage area of the maternity unit. We raised our concerns with the service and following our inspection they told us that MEOWS had been implemented in the Triage area with immediate effect. The score would be recorded on handheld devices which would enable automatic alerts to be sent to the medical team when a woman had a raised MEOWS score. The service completed a retrospective review of patient observation data from January 2020 to September 2020. Within the maternity service staff used a combination of an electronic observation tool and paper MEOWS charts. The data was taken from the electronic observation tool only and showed overall compliance was just over 71%. The trust told us that going forward, compliance with documentation of patient observations was to be a metric that the service would monitor. There were no planned actions in response to the review findings at the time of writing the inspection report.

Staff used a nationally recognised tool the 'Newborn Early Warning Score' (NEWS) to identify newborn babies at risk of deterioration. Staff explained that not all babies would require NEWS recording, but those who were on antibiotics, or that were born more than 18 hours after rupture of membranes would have NEWS recorded. Staff recorded scores on a template chart which prompted them when there was a need to escalate scores through a colour coded RAG rating system. We saw four records of babies having NEWS recorded and saw that these were all completed and escalated where appropriate. In addition to NEWS scoring, all babies that were born pre-term (before 37 weeks of pregnancy) or who were receiving extra care, received a daily review by the neonatal medical team.

Staff did not routinely complete risk assessments for each woman on admission or at designated antenatal appointments using a recognised tool, nor review risk assessments regularly, including after any incident. We found poor compliance with risk assessments such as venous thromboembolism (VTE) risk assessments. In eight sets of records that we reviewed, we saw that although VTE was recorded in all but one record at booking, it was not recorded at the 28-week appointment in any of the records. VTE was not recorded at delivery in seven out of the eight records. We raised this concern with the service following our inspection and managers told us a message had been communicated immediately to staff about the importance of completing the VTE assessment.

We also found that mental health assessments were not consistently completed with women. Mental health assessments form part of the process for deciding if women are high or low risk pregnancies. In the eight records we reviewed we found that three mental health assessments had been completed at booking and three at 28 weeks. In four out of the eight records there was no evidence of a mental health assessment at any point during the women's pregnancy. This meant that it was not possible for staff to make a holistic decision on a woman's pregnancy risk status.

Staff did not always complete screening for specific risk issues. For example, we found that carbon monoxide screening, which is part of the 'saving babies lives 2016' initiative, was not always performed in line with guidance. We saw that carbon monoxide monitoring was only recorded in three out of the eight sets of records that we reviewed.

There was poor compliance with the completion of growth charts with this not being done in line with requirements for four out of the eight record sets we checked. This meant that there was a risk that babies that were small for gestational age (a term used to describe babies who are smaller than usual for the number of weeks of pregnancy) may not be identified. Babies that are small for gestational age are at increased risk of fetal demise during pregnancy and delivery. When we raised these concerns with the service following our inspection, managers told us a records audit programme would be developed and implemented together with a learning plan by 1 November 2020.

In preparation for our focused inspection, we reviewed serious incident investigation reports, a recent inquest report, and Healthcare Safety Investigation Branch (HSIB) reports. HSIB's maternity investigation programme is part of a national action plan to make maternity care safer. They investigate incidents that meet the 'Each Baby Counts' criteria and maternal deaths of women while pregnant or within 42 days of the end of pregnancy. We saw that there was a theme of concerns relating to staff competence to interpret, classify and escalate cardiotocography (CTG) traces appropriately. There were serious incidents where staff had failed to monitor CTGs or had misinterpreted CTG findings meaning concerns were not escalated in a timely way. The conclusions in some of these incidents was that the baby suffered severe harm or death as a direct result of failings in care, including misinterpretation of CTG findings and failure to escalate concerns.

Staff should use a buddy system to review CTG interpretation in line with national recommendations (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)). This is known as the 'fresh eyes' approach. This meant a second midwife was required to review the CTG recording hourly during the woman's labour, to ensure it had been interpreted and classified correctly and escalated when needed. In records we reviewed we saw evidence of 'fresh eyes'. The service included monitoring of two-hourly fresh eyes as part of their CTG documentation audit. Data provided for the September 2020 audit showed that 100% of two-hourly fresh eyes reviews had been completed by an appropriate midwife or obstetrician.

The CTG documentation audit reviewed 22 different indicators for compliance and the data provided for September 2020 showed that there were 16 out of 22 indicators where the compliance target was not met. In 13 of the indicators, compliance was less than 80% and was RAG rated red. During our inspection we saw evidence of multiple occasions when CTG categorisation tools were not used and CTG traces were not categorised correctly. Traces were not always reviewed by a senior member of the medical team when necessary meaning there were missed opportunities to identify risk to women and babies. We reviewed eight sets of records and found that there was no indication of why the CTG was being performed documented in four of these. In two sets of records we saw that there was no classification of the CTG trace documented at the end of the trace. We saw that in five of the records there was no Pinard auscultation before the CTG was commenced. Pinard auscultation is where a special type of stethoscope is used to listen to the heart rate of a fetus during pregnancy. The Royal College of Midwives currently recommend that the Pinard stethoscope should be used in the first instance to determine that there is a fetal heart before applying a CTG or when any concern arises (MHRA 2010). In addition, the maternal pulse must be palpated to differentiate between the sounds of the mother's and fetal heartbeats. In two of the eight records we checked this was not documented as having been completed. This meant that staff were not always following national guidance when performing a CTG.

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The service had identified the need to develop local guidelines for the use of CTG and its interpretation and findings following a quality and safety committee review of maternity and obstetric incidents in July 2020, however, at the time of our inspection these were not in place. When we raised our concerns following the inspection, managers told us that an immediate tea-trolley training programme led by the lead obstetrician and midwife had been commenced in clinical areas on 21 October 2020. Tea trolley training is a local term used to describe training delivered in the clinical area. It is designed to allow staff to attend training in their area of practice. This included education on the features and classification of an antenatal CTG and the importance of documentation in line with NICE guidelines. In addition, a senior member of the medical team (ST3 and above) would review all antenatal CTGs prior to final clinical decision making. There was also a planned audit of CTG classification and documentation for November 2020.

There was a triage assessment unit which was open from 8am to 8pm seven days a week. This was staffed by midwives and midwife support workers and had medical cover Monday to Friday 9am to 5pm with medical cover from the labour ward team after 5pm. The unit used a telephone triage system to assess women and to decide if they needed to go straight to labour suite or attend the triage unit for further assessment. There was no dedicated staff member to answer the telephone which meant that women may have to call on several occasions before the telephone was answered. This presented a risk of women not being able to access timely advice and support.

In the triage assessment unit, we saw that there was no standard approach to the triage assessment of women leading to inconsistent advice. There was no risk assessment of women on arrival to RAG rate their priority to be seen. RAG rating is the use of a Red, Amber, Green (RAG) traffic light system to colour code the level of risk, where red is high, amber is medium, and green is low. We saw that staff did not note the time that women arrived at the unit or the time that they were seen which meant that staff could not audit if women were breaching recommended waiting times.

Following our inspection, when we raised our concerns with the service, managers told us that they had taken some immediate actions. These included a new standard operating procedure which included assessment of level of risk with RAG rating for prioritisation. In addition new antenatal documentation and a new telephone triage risk assessment had been implemented and the triage guideline had been updated to reflect these changes.

Changes were to be implemented through an education programme which included handover safety huddles, the use of prompt sheets, social media updates through closed staff groups and daily support visits by managers to ensure that staff felt supported through the change. Monitoring of completion of the risk assessments would be included as part of an audit tool. A further action was that an additional midwifery shift had been allocated to the triage area to enable a midwife to be available to answer the telephone and avoid delay in responding to women who called the service for advice. The service told us this shift would initially be filled by bank staff or overtime and would be prioritised and permanent recruitment would form part of a wider business case for staffing. Additionally a business case for a locum consultant had been approved with aim of supporting the flow of women through the triage unit.

Staff shared key information to keep women safe when handing over their care to others. On the post-natal ward staff told us about a process that had been developed following recommendations from the healthcare safety investigation branch (HSIB) to improve provision of information to women when they were discharged from the ward. A checklist sticker had been developed to use on a woman's record to ensure that all required and appropriate information had been provided prior to them leaving the ward. Managers told us about a project that was underway to develop podcasts for women to watch prior to discharge to ensure information about was provided in a consistent and timely way. For example information and advice about feeding, smoking, and common health concerns. Discharge summary records were provided to the community team to communicate any key information about the care a woman received during her hospital stay. However, the information technology (IT) systems used in the community were different to those used in the hospital and information could not be shared between the two systems.

Shift changes and handovers did not consistently include all necessary key information to keep women and babies safe. We saw that handover on the labour suite took place in the central reception area which was not confidential and was a

noisy environment. Although the handover was multidisciplinary and included anaesthetics, the midwife coordinator and the medical day and night team, there were no introductions. This meant that not all staff may know who they were speaking with, particularly if they did not usually work in that clinical area. The process was registrar led but needed prompting from the midwife to discuss higher risk cases, such as history of previous caesarean section.

A recent inquest report found failings in the information handed over between midwives during shift change meaning that staff were not always fully informed about the woman's history. On the labour suite staff did not use the situation, background, assessment, recommendations (SBAR) tool which had recently been implemented across the service. SBAR is a tool used to facilitate prompt and appropriate communication between wards/services. The tool was introduced following recommendations from a HSIB investigation to improve sharing of any incident learning or changes within the service. The handover did, however, identify women with any additional support needs and we saw that a woman with a learning disability was highlighted as requiring communication charts.

On the antenatal and postnatal wards, all women were discussed in a whole ward handover in the staff room and any risks were identified. The key handover information was shared with new staff on shift in a handover sheet. In addition any key ward or service wide messages were shared verbally and the SBAR tool was read out to staff and signed as read out by the coordinator at each handover. The SBAR was used at each handover for a one-week period and a new SBAR was used each week. Following the whole ward handover there was an individual handover midwife to midwife completed in the bays for the women they had been allocated to look after by the coordinator.

Midwifery Staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Although managers regularly reviewed staffing levels, they were not always able to adjust staffing levels to ensure safe numbers of staff in all areas due to staffing shortages.

The service did not have enough nursing and midwifery staff to keep women and babies safe. All staff we spoke with across the service, told us that there were not enough staff to provide safe care. Staff told us that staffing numbers did not enable them to provide high quality care.

Midwives described not having enough time to care for women properly. Staff told us they were not always able to raise patient safety incidents appropriately as there was not the time to complete the incident reporting process. However, at the Queens Medical Centre site, there had been had 30 occasions when staffing concerns had been reported as incidents from April 2020 to September 2020.

At times, staff reported that they had been unable to attend mandatory and/or essential training sessions as there were insufficient staff on duty to enable them to be released for training. Staff said they frequently missed breaks and worked over their hours due to the low staffing levels. We were told by midwives and ward managers that actual staffing levels often did not meet planned staffing levels. Staff were often pulled to different areas to cover, leaving the other areas without adequate staffing support.

The labour suite took priority for staffing and the antenatal and postnatal wards found it difficult to manage on the reduced staffing. This meant that staff did not always identify and respond appropriately to changing risks and may expose babies and women to the risk of harm.

Each ward had a shift coordinator who should be supernumerary, but we found that this was not always the case, meaning that they were not able to facilitate communication between professionals and oversee risk and appropriate use of resources. On the labour suite this was not in line with 'Safer Childbirth recommendations, October 2007' which states that each delivery suite must have a rota of experienced senior midwives as delivery suite shift coordinators, supernumerary to the staffing numbers required for one-to-one care.

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National guidance from the Royal College of Obstetricians and Gynaecologists and the National Institute for Health and Care Excellence recommends that mothers, in established labour, in labour suites should receive one to one care. We found that staffing levels at the time of our inspection did not allow for one to one care on labour suite. The planned staffing numbers meant that there would never be 10 staff to cover the 10 labour suite beds as there was only a maximum of nine staff rostered on a shift.

Data provided by the service following our inspection suggested that one to one care was achieved during delivery on average in 92% of cases from October 2019 to September 2020 at the Queen's Medical Centre maternity unit. This meant that the unit did not meet the national guidance requirement for all women in established labour to receive one to one care. Although staff on the labour suite told us there was often staffing support provided during the day, overnight they could be four staff short, meaning the coordinator had to make several calls to escalate acuity and staffing concerns which would take them away from their coordinating role.

Although managers regularly reviewed staffing levels, they were not always able to adjust staffing levels to ensure safe numbers of staff in all areas due to staffing shortages. Ward coordinators completed the safer staffing app at each shift handover and at any point during the shift when staffing levels and acuity were felt to be unsafe. Concerns were escalated to other ward coordinators and the matron on call, but staff told us they did not always receive a response or that no action was taken. Staff on the antenatal and postnatal wards told us that the priority area was always labour suite and that ward areas were often left short staffed. The impact of this was that jobs were missed, and standard of care was poor. Staff reported frequently missing breaks and described the work environment as very stressful. We were told of occasions when unsafe staffing had been declared and this was challenged, and staff had been asked to change it back to safe by senior managers.

Staff told us that on the wards, staffing overnight was a real concern as often only two qualified staff were on shift on the post-natal ward looking after 14 women plus babies which staff said felt unsafe. Following our inspection, the trust provided example data from their intrapartum acuity tool. This showed that on the 10 occasions that acuity data was recorded, staffing levels did not meet acuity on nine of these occasions. The main reason documented for this was vacant shifts. Fill rates for shifts provided by the trust showed that at the Queen's Medical Centre maternity unit, from April 2020 to September 2020, there was an average fill rate of 97% across the unit. However, an average of 11.4% of all available shifts in the unit were covered by internal bank staff. Managers only offered unfilled shifts to internal bank staff who worked within the trust and were familiar with the service. They did not use agency staff.

Managers had not accurately calculated and reviewed the number and grade of midwives and midwife support workers needed for each shift in accordance with national guidance. At the time of our inspection, senior managers told us that there were eight whole time equivalent (WTE) midwife staff vacancies across the trust. Data provided following our inspection showed that in September 2020 there was a gap between the number of budgeted midwife staff and the contracted number of midwife staff. However, senior managers told us that the service was staffed up to the establishment which had been budgeted for.

Across the whole maternity service in the trust, there were 24.4 WTE less contracted staff than were budgeted to be in post. However, these figures did not include new starters. The trust told us that all vacancies were being recruited to and 18 new starters had commenced on rotational contracts on or before 19 October 2020.

Senior managers told us that a birth rate plus review had been undertaken in July 2020 and this had identified a significant shortage of staff with an additional 73 WTE staff being required across the maternity units at both sites to ensure safe staffing. (Birth rate plus is a national tool that calculates the number of clinically active midwives required to deliver a safe high-quality service). These findings had not been communicated with staff at the time of our inspection. We raised this as a concern with senior managers who, following our inspection, told us that a staff feedback session was being arranged to ensure that staff were aware of the review findings and the plans to action the staffing gap.

Following our inspection, managers told us that actions had been put in place to address staffing concerns. These included removing all pay restrictions on bank and overtime shifts, a twice daily review of staffing numbers and acuity by the deputy head of midwifery and the release of non-clinical time into practice as required. There would be daily oversight of staffing by the director of midwifery with a twice daily assurance report provided to the chief nurse on the safety and acuity of the maternity units. A business case for additional staffing was under development and was awaiting approval from the finance committee.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service generally had enough medical staff to keep women and babies safe. There was one junior doctor gap, no junior registrar gaps and one senior registrar gaps on the obstetric rota. Ward staff we spoke with described good availability to medical staff support. However, there were some concerns that in the triage unit, patient flow was impacted by the availability of consultant staff. Following our inspection, managers told us that a business case for appointment of a locum consultant had been approved to improve patient flow. An increased consultant presence in the triage unit had been incorporated into the modelling and business case to increase consultant staffing. In addition, an urgent business case was in development to fund a separate junior doctor rota for gynaecology cover to preserve junior doctor cover for labour suite.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always complete, up-to-date, or easily available to all staff providing care.

Women's notes were not comprehensive and not all staff could access them easily. We found that there was a combination of paper and electronic records in use across the unit. The main electronic records system was only accessed by midwives and was not able to be accessed in the community by GPs or community midwives. On the wards there were two sets of paper records in use; one for midwives and a separate one for medical staff. In addition, midwives used a software system on a tablet device to record women's routine observations. This meant that it could be difficult for staff to easily access all information about women and babies.

During our inspection we reviewed eight sets of records during our inspection and found that not all risk assessments were completed, and most antenatal record entries were not timed, although they were dated and signed. This meant that records did not meet the requirements of the Nursing and Midwifery Council (NMC). We raised our concerns with the service following our inspection and managers told us that a rapid record audit had identified gaps in the overall standard of documentation. As a result a patient safety bulletin had been developed and circulated to highlight key findings to staff. In addition, a record keeping audit had been registered as a local audit requirement and an electronic audit form would be completed for antenatal, intrapartum and postnatal record audits from November 2020.

When women transferred to a new team in the community, staff were unable to access their hospital records as there was no shared record keeping system. Managers told us that plans were already in place to replace the current community records system with the same electronic system used in the hospital. This was planned to be implemented by the end of November 2020.

Incidents

The service did not always manage patient safety incidents well. Staff recognised but did not always report incidents and near misses. Managers from the governance team investigated incidents but did not always shared lessons learned with the whole team and the wider service in a timely way.

Staff knew what incidents to report and how to report them. All staff we spoke with were aware of the incident reporting system and confirmed they had access to this. From July 2020 to September 2020 there were 488 incidents reported through the National Reporting and Learning System (NRLS) across the trust relating to obstetrics. Three of these were classified as severe harm, six as moderate harm, and 477 as low or no harm. A further two incidents were classed as serious incidents meeting the criteria for reporting through the Serious Incident to the Strategic Executive Information System (STEIS).

We reviewed the NRLS data submitted by the trust from July to September 2020, and we observed that a number of incidents were inappropriately graded. For example but not limited to; babies transferred to the neonatal intensive care unit for admission were graded as no harm or low harm, a maternal death was graded as low harm and a woman admitted to the intensive care unit was graded as low harm. Therefore, we were not assured that incidents were being graded appropriately. This meant that incidents may not be investigated fully, nor duty of candour be applied correctly. People would be at risk of harm as lessons could not be learnt.

Staff did not always raise concerns or report incidents and near misses in line with trust policy. Staff told us they did not always report incidents or concerns as they did not have time due to staffing pressures. However, from April 2020 to September 2020, staff at QMC had reported staffing concerns as incidents on 30 occasions. Ward managers recognised that there was under reporting of incidents since staff did not have time and felt that incident reporting was further limited as staff had a lack of confidence that actions would be taken.

Never Events

The service had no never events on any wards.

Breakdown of serious incidents reported to STEIS

There were two STEIS incidents reported from July 2020 to September 2020 across the trust relating to obstetric incidents. One of these incidents happened in the labour suite at the Queens Medical Centre site. This involved the delivery of a baby in poor condition who required transfer to the neonatal unit. A specialty case review by the service identified areas where different management may have changed the outcome. The case met the reporting criteria for referral to the Healthcare Safety Investigation Branch (HSIB) for independent investigation.

Staff reported serious incidents clearly and in line with trust policy. Managers told us staff were supported with serious incident reporting by the midwifery governance team. This team reviewed all incidents reported by the service daily and discussed any potential serious incidents with the ward manager and matron. All serious incidents were discussed at divisional level and board and were categorised into levels. Level three incidents received external support for investigation, level two were investigated internally by a trust incident support facility and level one were investigated at ward level.

We had concerns before our inspection that there may be a delay in the reporting of serious incidents through STEIS. We, therefore asked the service to provide data relating to the number of days taken to report serious incidents through STEIS. At the Queens Medical Centre site we saw that from October 2019 to September 2020, five maternity incidents were reported to STEIS. Three of these were reported through STEIS within 14 days, however one of these took 76 days to report and another took 180 days to report. The service told us that these incidents had been reported as incidents immediately and were discussed at an incident review meeting in line with local policy. However, the initial recommendations had been for a local investigation, but the cases were later presented for reconsideration following escalation of concerns following local investigation findings by the panel. This meant that there was a delay in some serious incidents being reported through STEIS. We were concerned that not all incidents were, therefore, being investigated appropriately and that there were missed opportunities to identify learning in a timely way.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. For example, if incidents were referred to HSIB there was no trust investigation of the incident. Managers would wait to

receive the findings and recommendations of HSIB investigations before reviewing them and sharing any learning with staff. managers reviewed the findings to identify any learning with staff. However, staff told us that debriefs after serious incidents were not routine and were ad hoc. The situation background, assessment recommendation (SBAR) tool had recently been introduced at handover within the service to improve information sharing, but this was not yet embedded across all areas. When we raised this with the trust following our inspection, they told us the way learning was shared was changing as part of the maternity transformation programme work. Learning from the learning review group and from HSIB recommendations would be shared regularly though safety bulletins.

Managers did not routinely debrief or support staff after any serious incident. Staff told us that senior managers rarely visited wards following serious incidents in order to support staff. Staff reported that when they did visit it was to identify staff failings and staff felt there was a blame culture rather than a supportive approach. Following a recent coroner's case, staff described a lack of support from the senior leadership team for the service. A letter was sent to staff following the outcome highlighting guidance and changes required but no support was provided in how to achieve the changes. Staff described feeling overwhelmed at the impact of such cases.

Managers told us that they did support individual staff in high profile cases and communicated with all staff in the service through posters, email, meetings. Managers told us that staff wellbeing support was available at the trust and debrief was offered to staff involved in high profile cases. However, there was a disconnect between how supported staff felt and the level of support managers said was available. Senior managers did, however, recognise the need to work more closely with the trust legal team in preparing staff who were required to attend coroners court and inquest hearings.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. We saw evidence in the 72-hour incident reports that were reviewed by the maternity matters group that duty of candour was understood and applied appropriately in line with trust policy.

From November 2018 there had been 33 referrals to the HSIB maternity investigation branch and that 24 of these had progressed to full investigations. Data provided showed that these investigations had identified 53 findings of failures in care and 24 recommendation themes for action. When we reviewed some of the HSIB investigation findings, we saw that many of the recommendations identified had not been acted upon. For example, the theme most often identified was cardiotocography (CTG) issues (14 instances), yet in a recent inquest report and in the latest STEIS report, CTG concerns were identified as causative factors.

Staff did not meet to discuss the feedback from serious incidents and look at improvements to women's care. There was no evidence of a structured process for regular feedback from serious incidents. There was a lack of audit and learning from repeated themes in incidents meaning there were missed opportunities to make improvements in women's care.

Managers from the governance team had a process to investigate incidents, however, clinical staff, women and their families were not routinely involved in these investigations. There was a team of governance midwives who reviewed all incidents. This arrangement was set up as it was recognised that some ward managers and matrons were new in post and were inexperienced, hence they would need additional support. The process was that the midwife governance team led incident reviews and fed back numbers and themes of incidents to ward managers following initial investigation. Staff explained that this meant that clinical leaders did not have ownership of incidents in their area. The governance team transferred management of incidents to ward managers once any themes or areas of high concern had been identified. However, ward managers told us that they did not have the capacity or support to investigate themes and take actions. The senior midwife on the ward did not have protected time for incident management as they were required to work clinically. Some managers told us that this approach to incident management meant they not always have oversight of their area's incidents and were not always involved in decisions about actions. They described a disconnect between the governance team and operational teams and felt that autonomy and accountability had been

taken away from clinical leaders. They explained that there was little clinical involvement in the 72-hour incident reports completed by the governance team and that actions were agreed and allocated to ward managers without their involvement in agreeing the decisions. When we raised our concerns following our inspection, senior leaders told us that the operational team had been involved in managing and responding to incidents since September 2020

We saw that there were 616 open incidents for the service across both maternity units awaiting review. At the Queens Medical Centre site, there were 199 open incidents; 77 of these had been open for over 45 days and 65 of these had been open for 60 days or more. The longest of these had been open for 830 working days. Most of these open incidents were graded as no harm or low harm incidents. It was unclear why the incidents remained open and had not been closed in a timely way. This meant there was a significant number of incident investigations that had not been completed. There was a risk to any learning identified not being shared with staff at the earliest opportunity in order to prevent further similar incidents. We were not assured that the service was aware of all of their safety concerns in a timely manner due to the number of incidents awaiting a review.

Safety thermometer

Staff collected safety information, but it was not routinely shared with staff, women and visitors.

Safety thermometer data was not displayed on wards for staff and women to see; managers told us that they did not use the safety thermometer as the metrics contained within it were part of an internal dashboard which was used for monitoring. We saw evidence that following a maternity risk review meeting, the clinical commissioning group informed the service that they were no longer required to undertake the monthly Maternity Safety Thermometer data collection audit from April 2018. The safety thermometer is designed to support improvements in women's care and experience and records any harms associated with maternity care.

Whilst the service did not use the maternity safety thermometer, it did collect data for the internal maternity dashboard. The maternity dashboard is recommended good practice from the Royal College of Obstetricians and Gynaecologists (RCOG) 2008 to plan and improve maternity services. It serves as a clinical performance and governance score card to monitor and help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure a woman-centred, high-quality, safe maternity care. The tool uses a Red, Amber, Green (RAG) traffic light system to measure performance against agreed parameters. It should cover categories such as clinical activity, workforce, clinical outcomes, and risk incidents or complaints.

We saw that the service had a RAG rated dashboard which identified compliance with safety performance indicators and clinical outcomes by site or ward. However, although we saw that key performance indicator data was collected, the results were not displayed, and ward staff did not have access to the dashboard. Managers told us that dashboard data was managed by the maternity governance team rather than ward managers, who also did not have access to the dashboard system. Information from the dashboard was shared by the governance team at divisional and board level. There were plans to develop an intranet page so that performance information could be shared widely with all staff.

The service had identified maternity safety champions at trust and service level. The trust maternity safety champions were the chief nurse and a non-executive director with responsibility for quality assurance and risk management. At a local level, the deputy head of midwifery (HOM) and a consultant obstetrician were the service safety champions.

Is the service effective?

Patient outcomes

Staff monitored the effectiveness of care and treatment. However, we did not see evidence that they used the findings to make improvements and achieve good outcomes for women and babies.

Maternity

The service used the maternity dashboard to monitor a range of performance indicators. This included the number of births and type of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma), maternal admissions to intensive care unit, shoulder dystocia, and neonatal concerns (including meconium aspiration, hypoxic encephalopathy and deaths). There was also data relating to unit closures and diversions, percentage of women who underwent induction of labour and antenatal bookings. Parameters were set for each indicator and the indicators were RAG rated. Data was collated over a rolling 13-month period to enable review of change over time.

We saw from the dashboard that there were some indicators where performance was not in line with the target set. For example, for eight out of 11 months where data was recorded from August 2019 to June 2020, the percentage of maternity bookings that were booked by 12 weeks and six days gestation did not achieve a green RAG rating and was amber. In addition, there were eight out of 13 months from August 2019 to August 2020 when maternal admissions to intensive care were higher than the target and achieved amber or red RAG ratings. Some of the data in the dashboard was cross site data for both sites and some was site specific, enabling a comparison of performance between sites. Although dashboard activity summary graphs were produced for some indicators, there was no benchmarking of performance against national data. Improvement was checked and monitored; however, it was unclear how managers used the information in the dashboard to make changes and improvements to service delivery.

Information requested from the service showed that there were 27 unexpected admissions to the Neonatal unit at the Queens Medical Centre Maternity unit from April 2020 to September 2020.

The service participated in relevant national clinical audits.

The service had contributed to the National Neonatal Audit Programme, MBRRACE (mother and baby: reducing risk through audits and confidential enquiries) maternal, newborn and infant clinical outcome review programme, National Maternity and Perinatal Audit and ATAIN (avoiding term admissions into neonatal unit) since the previous inspection. We saw that the service had a national audit plan for 2020/2021 with leads identified for each audit. Details of national audits were discussed at various clinical governance and effectiveness meetings where actions were identified for improvement.

National Neonatal Audit Programme

In the 2018 National Neonatal Audit Queen's Medical Centre performance in the two measures relevant to maternity services was as follows:

- Are mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 135 eligible cases identified for inclusion, 87.1% of mothers were given a complete or incomplete course of antenatal steroids. This was lower than the national average (89.1%) but was higher than the national standard of 85%.

- Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 25 eligible cases identified for inclusion, 64.7% of mothers were given magnesium sulphate in the 24 hours prior to delivery. This was slightly lower than the national average (65.07%)

Standardised Caesarean section rates and modes of birth

Data provided by the trust on the maternity dashboard showed that from June 2019 to June 2020, between 25% and 32% of all births were by planned or elective caesarean section. For the same date period, between 55% and 62% of all births were normal deliveries, and between 11% and 16% of all births required ventouse or forceps assistance. There were no target parameters for RAG rating these performance indicators, so it was unclear if the trust were actively monitoring this data and taking appropriate action over any concerns.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

Maternity

At the time of this inspection the MBRRACE report had not yet been published.

National Maternity and Perinatal Audit

This audit is conducted by the Royal College of Obstetricians and Gynaecologists (RCOG). The service submitted data to this audit based on births in their NHS maternity service from 1 April 2016 to 31 March 2017 and a report was produced in 2018. This was the latest data available. The service was identified as an outlier for post-partum haemorrhage (PPH) of more than 1500ml blood loss. The incidence of PPH for the service was 4.8% compared to a national average of 2.9%. This meant that they were performing worse than the national average.

The trust had responded to RCOG in July 2019 with a list of actions to address performance in this audit, which included changed practice, amended intrapartum guidelines, improved measurement of blood loss, and a focus on staff education. The trust reported that data from their maternity dashboard up to June 2019 had shown a downward trend in the incidence of PPH of more than 1500mls. There were other indicators in the audit where the service performed worse than expected but not to a point where they were classed as an outlier. The service had a higher than the national average incidence rate of 3rd and 4th degree tears, induction of labour and birth without intervention except for augmentation. The service performed better than expected in some other indicators and was a lower than the national average incidence rate for episiotomies and emergency caesarean births. For all other indicators, the service performed similar to the national average.

Outcomes for women were mixed and did not always meet expectations, such as national standards.

The national audit data reviewed demonstrated the service was not performing consistently and ensuring good outcomes for women and babies. Local audit data also showed mixed performance. For example, in September 2018 the service benchmarked itself against the 'Each Baby Counts – themed report on anaesthetic care' and this showed there were outstanding actions required against seven of the 12 recommendations in order for the service to be fully compliant.

The service participated in the NHS Resolution 10 safety standards, year three. Divisional leadership team meeting minutes from September 2020 demonstrated there was only limited assurance given for compliance with these standards. It was acknowledged that assurance had been impacted by the COVID-19 pandemic, however, it was also discussed that standards still needed to be met. The minutes stated that the safety standards should be embedded into clinical care. However, during our inspection we saw evidence that standard five (demonstration of an effective system of midwifery workforce planning to the required standard) and standard eight (at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year) were not met. We were not assured that national standards were able to be consistently met.

The service submitted key performance indicator data for the antenatal NHS screening programme to Public Health England. The data for quarter one in 2020/21 showed generally good performance with six out of nine indicators achieving the acceptable threshold for performance.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. We requested a local audit plan from the service, and they provided a list of audits which had been completed or were planned. We saw that 12 of the 21 audits were listed to be 'on track' for completion in the audit plan document but had overrun their proposed end date, some by as much as 14 months. We were not, therefore, assured that there was a robust programme of audit embedded across the service.

Managers did not always share and make sure staff understood information from audits. Staff were unable to discuss recent audits with us which had been shared with them and had resulted in improvements being made to the service. Information submitted after the inspection showed some limited evidence of audits being discussed within targeted audiences. For example, there were minutes of meetings from the intrapartum care group meeting which had evidence

of audits and their outcomes being discussed, however these were only attended by a small core group of staff and did not demonstrate wider distribution of information. We were not assured that managers and staff used audit results to improve women's outcomes as findings were not widely shared. Managers could not demonstrate that they were routinely using information from audits to improve care and treatment.

Competent staff

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

Staff did not have the right skills and knowledge to meet the needs of women. We saw from Healthcare Safety Investigation Branch (HSIB) reports that themes of findings and recommendations had been made. From November 2018 there had been 24 recommendation themes and the theme which was more often identified was CTG issues (14 instances). In the latest HSIB report from October 2020 a recommendation was made to ensure that staff used a consistent categorisation tool and a systematic approach to cardiotocography (CTG) interpretation in line with local and national guidance.

During our inspection we found evidence that staff were not always interpreting, categorising or escalating CTG traces appropriately and a CTG audit completed by the service identified areas where improvement was required. Staff we spoke with told us that they had completed CTG training through an online system and trust data showed that 98% of midwives and 90% of obstetricians across the service had completed this training within the last year. However, although there was an online test at the end of the training, no additional competency assessments were required. The CTG training did not include classification of traces and there was no competency assessment relating to CTG classification.

Weekly CTG meetings were held where CTGs and outcomes for interesting cases were discussed. The meeting was multidisciplinary for obstetricians, obstetricians in training and midwives. Midwives and obstetricians in training were expected to attend 12 meetings a year but midwives rarely attended as staffing issues made it difficult for them to be released from the ward. Medical staff told us for cases that were discussed, learning points were highlighted and documented. We were told that learning points were relayed to all staff and requested evidence of how this was achieved, but the trust did not provide it. When we spoke with managers about the lack of midwife attendance at the weekly CTG meetings, they told us the meeting was currently medically led and currently no agendas or minutes to include a record of attendance were kept. The trust planned that these meetings would have minutes going forward, commencing 19 October 2020. They accepted that attendance was primarily medical, and the service was looking at how midwifery attendance could be achieved without impacting on front-line staffing. A plan was being developed to address this by December 2020.

We saw evidence that the Dawes Redman CTG machine was used for monitoring in premature pregnancy, staff said they had no formal training to use this type of CTG machine. We also found there had been no review of CTG training despite the serious concerns identified through investigations of serious incidents or by HSIB.

Following our inspection we raised our concerns with the senior leadership team who told us they did not think that the current CTG training package and online testing system was sufficient to ensure staff competence. They described the system as not being fit for purpose, however, they told us this had not been identified on the service risk register. The trust submitted an action plan to address the concerns raised which included a fresh approach to training and competency assessment, review of traces and audit of CTG documentation. However we still had concerns around the ability of the trust to implement these actions within the timescales suggested on the plan and therefore were not assured that their actions would mitigate the immediate risk of harm to women and their babies. We took urgent enforcement action to impose conditions on the service to ensure all possible actions were taken to mitigate the risk to women and babies.

Maternity

Staff in the labour suite provided care and treatment for women who required more specialist care and treatment which would usually be found within a high dependency unit. Staff told us they had received some in-house training provided by consultant anaesthetists to enable them to provide care and treatment for unwell women. However, most felt additional training would be required. Information submitted following the inspection showed midwives caring for an acutely unwell woman were required to have completed the advanced maternity care (AMC) training. Managers told us that all labour suite shifts had a member of staff rostered on who had completed the AMC training module. The training covered common maternal emergencies (obstetric haemorrhages, eclampsia/pre-eclampsia), arterial blood gas analysis and chest/breathing concerns. The trust told us that this training was attendance only with no requirements for competency assessments. The training was for band seven midwives although some band six midwives had also completed this training. Data submitted by the trust showed there were eight midwives (five band seven and three band six midwives) who were in date with this training out of an eligible 65 staff (12%). In addition there was a maternal critical care training day which provided refresher training for staff. This was last held in December 2019, but the trust did not provide details of numbers who had attended or how regularly this training was provided to staff.

Managers did not make sure staff received specialist training for their role. Staff were required to complete training in skills essential to their role in addition to mandatory training. This was delivered through the 'Maternity Inter-professional Scenario Training' (MIST) and provided emergency skills training. Staff training compliance with MIST at the time of our inspection was 46% at the Queens Medical Centre site. Managers told us that compliance with MIST was impacted due to the Covid-19 pandemic. However, there had been no alternative training put in place to mitigate the risk of staff not being up to date with emergency skills training. Although the trust had sourced an alternative online training programme, this was not in place at the time of our inspection and we were concerned that large numbers of staff were not up to date with this training.

Ward staff and senior managers told us that many of the operational leadership posts (ward manager and matron posts) were filled by new and relatively inexperienced staff. There was concern that these staff had not received adequate training and support to develop into the role. As a result the midwifery governance team were taking ownership of tasks such as incident review and risk management, rather than these being clinically led. We were not assured that ward managers and matrons that were new in post were given adequate opportunities and support to develop the required skills.

Managers gave all new staff a full induction tailored to their role before they started work. Induction included an orientation to the clinical area and attendance at mandatory training. New midwives were supernumerary for two weeks at the start of their contract to enable them to complete their induction requirements.

The clinical educators supported the learning and development needs of staff. All newly qualified (band five) midwives received support and advice from the coordinator on each shift and were part of a preceptorship programme. This was delivered by a dedicated preceptorship team over a 12 to 18 month period and included a competency sign off process. There was a midwifery clinical education team who worked across both maternity unit sites to deliver update training and ad hoc training as required. However, staff told us that this team was small and under resourced.

All student midwives working on the ward had named mentors who supported their learning and development. However, staff that were mentors told us that they did not have time to adequately mentor students or complete their assessment paperwork resulting in a poor experience for students.

Managers did not routinely hold supervision meetings with staff to provide support and development. Outside of the appraisal process there was no regular formal meeting of clinical staff with their line managers in order to review their development or support needs. However, ward managers told us that they had regular one to one meetings with the matron which were documented on a standard template.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with told us they had all received appraisals in the last year. Ward managers confirmed that they completed appraisals with all their staff and that they themselves had an annual appraisal from the deputy head of midwifery. The trust provided appraisal completion rates but told us these were not collected or reported as site specific data; they were instead reported by speciality. Data for September 2020 showed that compliance for obstetrics and gynaecology nursing and midwifery together was 85%. The trust target for appraisal compliance was 90%. Medical staff appraisal data was not collected in the same way and was managed through individual job plans. The Obstetric head of service confirmed that there were no appraisals outstanding among obstetricians for the appraisal year 1 April 2019 to 31 March 2020 and that all obstetricians with the exception of one were currently compliant for the year 2020-2021.

Team meetings were not consistent across the areas within the service. However, where meetings did occur managers encouraged staff attendance or ensured staff had access to full notes when they could not attend. Not all staff were aware of formal team meetings and were unable to tell us about the last team meeting they attended. Some ward managers told us that there were no regular formal meetings at ward level. Within some areas, staff relied on daily handovers or '10@10' gatherings for updates or important information. The 10@10 sessions were an opportunity for ward staff to meet together over tea and biscuits to share information. However, these gatherings were not recorded and did not have attendance lists completed. The service was not able to provide any minutes or regular meetings with set agendas that were held at ward level at the Queens Medical Centre maternity unit. There were regular meetings held at a senior level (band seven and above), however, there was no evidence of this information being cascaded at a team/ward/unit level.

Managers identified any training needs their staff had but staff were not always given the time and opportunity to develop their skills and knowledge. When training requirements had been identified, staff told us there were often obstructions with staffing requirements and funding which meant they were unable to attend. This was for both mandatory training and additional training identified as part of their appraisal. In addition, staff described that the removal of the rotation for band five staff across different areas of the unit had resulted in staff feeling de-skilled in some areas of care, such as labour suite. Some staff told us that it had been over a year since they had regularly worked shifts on labour suite, but they could still be called to provide cover to the area when there were staffing concerns. They told us that this felt unsafe as they did not feel their skills were up to date.

Multidisciplinary working

Doctors, midwives and other healthcare professionals did not always work together as a multidisciplinary team to benefit patients. They supported each other to provide good care but did not always work together to provide joined up care.

Information reviewed prior to the inspection from serious incidents and HSIB investigation reports identified concerns with multidisciplinary team working, especially around communication between professionals and the challenge staff gave each other. During our inspection we observed staff working well together. Staff described positive working relationships between all members of the obstetric team. Midwives told us they felt able to approach the medical team and were confident to contact registrars and consultants for advice and support when necessary.

Staff held multidisciplinary handover meetings in some areas of the maternity unit to discuss women and improve their care. On labour suite we observed that the handover included obstetric and anaesthetic staff, as well as the shift coordinators and medical day and night team. The handover was led by the registrar. However, it was held at the central reception desk which was a noisy and disruptive environment as staff were answering the telephone and moving in and out of the area. Not all staff stayed for the whole duration of the handover as they were attending to women. We were, therefore, not assured that the handover process was effective. Handover meetings held in other areas of the maternity unit were for midwives and support staff only and did not include medical staff.

Maternity

Ward rounds were generally completed by the medical team without the support of midwives. This was since midwives did not have the capacity to accompany the medical team as there were several different consultant teams who completed ward rounds. Midwives told us they would make a list of women who needed reviewing by the medical teams each day. The medical team wrote in a separate set of paper notes and would communicate any necessary information back to midwives in an ad hoc way; there was no process for formal communication between the medical team and midwives following a ward round.

Staff worked well with other healthcare professionals across the service. Midwives were supported by midwife support workers and transitional care workers who were trained to provide care to babies of early gestation, of a low birth weight, or who required naso-gastric (NG) feeding.

Doctors from the neonatal team worked alongside obstetricians and midwives. They visited the postnatal ward daily and reviewed all babies for newborn and infant physical examination (NIPE) screening. The neonatal team also reviewed all extra care and transitional care babies.

Physiotherapy staff visited the postnatal ward to provide information and advice to women who required it, for example women who had undergone a caesarean section procedure. Staff told us they had previously required assistance from specialist nurses including cardiac specialist nurses and diabetic specialist nurses from across the trust when providing holistic care for women.

Staff worked across health care disciplines and with other agencies where appropriate to care for women. Staff told us they provided combined diabetic and perinatal mental health clinics for women who required this input. There was also a specialist drug and alcohol midwife who was able to work with other agencies to provide specialised care for women who required support with these issues during pregnancy. Midwives provided discharge information to community staff such as GPs and community midwives.

Is the service well-led?

Leadership

We were not assured the leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective in implementing meaningful changes that improved safety. Not all staff found leaders were visible and approachable in the service for patients and staff.

Maternity services were provided as part of the family health division which also included neonatal service, paediatrics, gynaecology, clinical genetics, integrated sexual health and fertility. The division was led by a divisional director, a divisional general manager, a divisional lead nurse and a director of midwifery (DoM).

The DoM was a strategic role and would usually be supported by a head of midwifery (HoM) along with three deputy HoMs who were more operational. There was one deputy HoM at each of the two sites and a further deputy HoM for governance. However, the HoM post was vacant at the time of our inspection and had been for 20 months which meant the DoM was also taking on more operational responsibility. This was identified as a significant issue due to the demand on the DoM as well as the support required by the matrons and ward managers which would usually be provided by the HoM.

Concerns were raised during our inspection over how the midwifery service was represented at board level. Staff told us there was not a strong or clear voice at board level to escalate concerns about the maternity service. We found that the DoM did not always have opportunity to present to the board and that the service was often represented by the chief nurse. We requested information following the inspection for evidence of where the DoM had presented to the board. Minutes from the quality assurance committee were submitted which demonstrated maternity issues were presented to trust board, but not always by the DoM. The chief nurse presented some papers including the proposal for the maternity

transformation programme. We were concerned about the lack of interaction between the DoM and trust board and the challenges this presented. In light of the concerns raised during inspection and lack of evidence to support continuous involvement of the DoM at these meetings, we were not assured that all concerns were being escalated to the board in a timely manner or that the trust board had oversight of the significant concerns within the maternity services.

Following the inspection in November 2018, the maternity services were issued with nine 'shoulds' in relation to improvements which were required although no breaches of regulation were identified at the time. In addition to this, there were 33 referrals to the healthcare safety investigation branch (HSIB) with 24 cases proceeding to full investigation. At the time of our inspection, HSIB had made 24 recommendations to the trust with a further 53 areas of concern identified. We found the senior leadership team (SLT) had made little progress with any of the areas identified for improvement, and in some areas, found further concern. Where the SLT had tried to implement improvements, we found these were not embedded and the risk to women and babies continued.

We wrote to the trust following our inspection to inform them of our concerns in relation to the slow progress against the findings and recommendations from both CQC and HSIB. The trust submitted an action plan of how they planned to address these concerns however there was a lack of assurance over the immediate actions we required the trust, and more specifically the maternity SLT to take. We were not assured therefore the leadership of the maternity services gave the concerns sufficient consideration on how they would address them to reduce the immediate risk of harm to women and babies.

Most staff we spoke with raised concerns about the lack of visibility of senior leaders of the maternity service. However, midwives described being generally well supported by ward managers and ward managers described good working relationships with the matron. We were told that the SLT only visited the wards on rare occasions, such as following an inquest or coroners court conclusion.

Staff said the SLT were not approachable or supportive. They did not feel they fully understood the challenges facing staff on the wards. Staff reported that when the SLT did visit the wards it was to feedback some learning themes highlighted in serious incidents and coroners court cases, but no direction or support was provided on how to embed actions and achieve improvements. Staff told us that feedback around learning points was delivered in a negative way and often came across as criticism. They also said that they received no support from SLT when safety concerns about staffing had been raised and they did not see evidence of appropriate action taken when concerns were escalated. This led to concerns that the SLT did not fully comprehend the impact of the operational issues on the staff and staff not feeling listened to or valued. This in turn led to staff being reluctant to raise operational issues and report incidents. Members of the SLT did not appear to recognise that this was how staff felt which led to further concerns around a disconnect between the SLT and the operational staff. This disconnect between the SLT and staff meant there was an increased likelihood of a lack of oversight of the service by the SLT, placing women and babies at risk of significant harm.

Evidence of the disconnect between the SLT and operation staff was evidence in the findings of the latest staff 'temperature test' survey undertaken in August 2020. Staff were asked to comment on the support their managers and service leads provided during the COVID-19 pandemic. Despite 45.8% feeling very supported and 33.6% somewhat supported, the additional comments added by those who participated, identified the support had mainly come from their immediate managers and not the SLT. Comments highlighting the lack of leadership, support and visibility of the SLT were noted, with one comment highlighting a member of the SLT causing chaos rather than supporting staff at a challenging time.

Further concerns around the disconnect between the leadership team and the operational staff was raised in relation to the recent Birth Rate Plus review which had occurred. The results of this review had been discussed amongst the leadership team when they had received the formal outcome of the review in July 2020. However, this had not been communicated with operational staff at the time of our inspection. The leadership team told us they had not communicated the results with the operational staff due to wanting to manage the message which came out in relation to staffing and not wanting to cause hysteria. We did not feel it was acceptable for the extent of the staffing gap to be

withheld from staff who were feeling under significant pressure due to the staffing issues they were facing on a daily basis. This demonstrated a lack of respect for staff and a lack of willingness for the SLT to engage with staff on the ward. When we raised this concern with the trust following our inspection, they told us that a staff feedback session had been arranged to ensure staff were aware of the review findings, gaps and plans to address these.

When we raised our concerns about leadership in the service with the trust, they provided an action plan following our inspection which identified several actions. They told us a maternity transformation programme had been established which was being overseen by the chief executive officer (CEO). One of the four focus areas of the programme was 'People' which encompassed culture, leadership and teamwork and it was anticipated this would pick up the issues identified. The transformation plan would build on work already undertaken in the service by an organisational development project lead for maternity who has been working in the service. A project plan for this workstream was in development at the time of our inspection.

Culture

The service did not have a positive, open culture where staff could raise concerns without fear. Not all staff felt respected or valued and rarely felt supported. However, staff were focused on the needs of the patients receiving care, and the service promoted equality and diversity in daily work.

During our inspection in November 2018, we identified there were concerns around the unsupportive culture and the historical (but on-going) negative behaviours of a small group of staff. We issued the trust with a 'should' in relation to this as there was no evidence at the time of direct harm to women and babies. During this inspection, we found that the majority of staff still told us they felt unsupported by the leadership team. Staff told us when concerns had been raised previously, these were often ignored or not addressed completely. This had disengaged staff from further raising concerns.

The trust participated in the annual NHS National Staff Survey and the latest results for the division of family health in 2019 endorsed the disconnect felt between ward staff and the senior leadership team (SLT). The survey identified that only 30% of staff responded positively to the statement that 'communication between senior management and staff was effective' and only 25% of staff responded positively to the statement 'senior managers act on staff feedback'.

The lasting impact from the cultural problems was evident. We were particularly concerned that for some staff the slowness of the trust to respond to concerns and the delay in instigating any improvements had been detrimental to their career, health and emotional wellbeing. During this inspection we spoke with staff who described the culture as one of low staff morale where midwives felt stressed and fatigued. Some staff told us that as a result of the poor culture in the service they feared for their professional registration, as the lack of support or understanding from the SLT was putting them in difficult situations where the care they were able to provide was sub-standard and at times, unsafe. Some midwives on the wards described a bullying approach from senior staff on the labour suite. They described a failure of senior midwives on labour suite to understand the pressures in other areas resulting in support not being provided when staffing issues were escalated to them. They told us they felt unable to say no to any requests made from senior midwives on labour suite for support stating that it felt more like a demand for staff to be reallocated to that area.

Following our inspection, we received calls from a number of staff, on this hospital site, who wanted to escalate their concerns to us directly. Staff who spoke to us appeared fragile and told us they felt unsupported and unable to raise concerns despite actions taken by CQC immediately following this inspection. Some of the issues raised related to the leadership's response to the verbal outcome of our inspection and the continued unsupportive nature of the leadership team which provided further evidence of the deep-rooted cultural problems the service faced. We escalated our concerns over these calls immediately to the CEO of the trust who was equally as concerned as we were over the issues raised with us. They informed us they would be personally overseeing the improvement process required within the maternity services, which included the cultural concerns escalated.

Staff were complimentary about the support they received from their colleagues. This was also evident within the recent 'temperature test' survey conducted by service leads in August 2020. In response to a question asking staff how well supported they felt from their colleagues, 76% of staff responded very well supported with an additional 23.1% stating somewhat supported. Staff who had been involved in serious incidents described an exceptional level of support from staff they worked, although they found support from senior leaders less forthcoming.

Despite the challenges faced by staff, all staff we spoke with told us the needs and experiences of women was paramount and they continued to focus on providing a positive experience for women and babies. Staff who spoke with us told us they loved their job despite the challenges they faced and they were clearly passionate about trying to deliver high quality care. Midwives described how they described how they worked together to support each other and that working relationships within midwife teams were positive.

Staff were unaware of the trusts provision of Freedom to Speak Up (FTSU) guardians and therefore had not thought to seek assistance from them when situations had arisen where their input would have been useful. Staff spoke about situations where independent support would have been useful, but said they were unaware of any of the guardians within the immediate location or trust wide. Staff had accessed professional midwifery advocates (PMAs) at times when they required support, however they were unsure if this was an element of their role to support staff when speaking out about concerns within the service. Minutes from a recent divisional leadership meeting dated 7 October 2020 had identified the usefulness in promoting the FTSU guardians available in the trust due to the lack of awareness within the maternity services. There was an action documented following this meeting for a member of the senior leadership team to follow up on this.

Governance

Leaders did not operate effective governance processes, throughout the service to continually improve the quality of the service and safeguard standards of care. Not all staff had regular opportunities to meet, discuss and learn from the performance of the service.

We found there was a lack of robust governance systems and processes. There were low numbers of audits conducted by the service. There was a lack of routine audits across the service. Although there was an audit plan, we saw that many audits had overrun their planned completion date. There was no established process for monitoring the audit plan and no systematic process for sharing findings with staff in order to drive improvement. Staff including the senior leaders of the service acknowledged that audit practice was not embedded throughout the service and was ineffective. A risk around audit practice had been added to the risk register in June 2020, however this was waiting for speciality approval.

There was a maternity governance team who had taken the responsibility on for investigating patient safety incidents. This did not involve any operational staff and meant the ward managers did not have oversight or ownership of the incidents in their area. In addition to this, we found arrangements for reviewing and investigating safety incidents were not robust. Data provided by the trust showed there were 199 open incidents for the service at the Queens Medical Centre site. Of these, 65 had been open for 60 days or more. The longest of these had been open for 830 working days. In addition, a review of incidents reported through the National Reporting and Learning System, showed that incidents were not always graded appropriately. This raised concerns about the lack of identifying significant learning outcomes in a timely manner; outcomes which may be vital to reducing the risk of harm to women and babies.

Intelligence gathered prior to the focused inspection showed there were a large proportion of incidents which had been escalated to healthcare safety investigation branch (HSIB) for investigation. Of the 33 cases which were referred, 24 proceeded to a full investigation. At the time of our inspection, we found that there had been little progress made against the 24 recommendations made and the 53 significant findings.

The trust had recently proposed to implement a maternity transformation programme which had four focus areas. Senior leaders told us that a project plan for this work stream was in development and that an organisational development lead was due to commence in post. They also told us that the maternity transformation programme has

been expanded to include a work stream on governance of the service. This would be led by the director of corporate governance who would provide oversight and support to the maternity governance team. We requested information following our inspection to update us on the progress made by the maternity transformation programme. However, all the trust was able to provide was an update of all the current workstreams for maternity services but no specific update on the maternity transformation programme itself. We were therefore not assured the maternity transformation programme had been fully implemented.

During an interview with the senior leadership team (SLT), we discussed the concerns we had around the training for cardiotocography (CTG) and related competency assessment. We raised concerns that staff were not always following national guidance for documenting, reviewing and escalating CTG traces appropriately. We were concerned that there was no competency assessment for interpretation of CTGs and that the SLT told us they were aware that the current training process was not fit for purpose. The concerns we had identified were similar to the concerns identified in the HSIB investigations conducted, which had not been actioned by the service. The SLT had little overview of CTG performance and the issues identified due to the minimal audit process. We noted that the SLT had not escalated their own concerns about CTG competence by adding it to the risk register but, when challenged, agreed this should be on the service risk register. Since an alternative training package and method for competency assessment had not been identified by the service, we escalated this as an urgent concern after the inspection and requested an action plan on urgent actions they were taking to mitigate this risk. We were not assured the actions contained within the action plan provided sufficiently mitigated the risk posed to women and babies. We therefore took urgent action to impose conditions on them to ensure urgent action was taken.

We reviewed the service risk register and saw that it contained 52 risks which the service leads had identified, 19 of which were still awaiting approval. We saw that five of the risks identified had been on the register since 2011 but had not yet been sufficiently mitigated for the risk to be removed. There were a further two risks which did not have initial assessment dates and were documented as still in development. These risks were both scoring 20, which was the maximum risk score and a rating of extreme risk. The risks related to a failure to embed learning from incidents and unsafe and ineffective fetal monitoring. We did not see any evidence on the risk register of what actions had been put in place to mitigate these risks.

We reviewed minutes of the divisional leadership team meeting and senior midwifery team meetings but found no evidence of regular discussion of the risk register. We also reviewed divisional leadership team meeting minutes and found that there was no fixed agenda and risk was not discussed at these meetings as a standing agenda item. We did, however, see evidence of the risk register being discussed at clinical governance meetings. Any new risks being considered for addition to the risk register which scored 10 or above were referred to the divisional risk meeting for further discussion and agreement for addition to the service risk register. We had concerns around the local monitoring of risks by the service and how risks were identified and escalated under the current governance processes. We were not assured that all risks had been identified on the risk register or that there was a robust process for regular review and mitigation of risk.

We found that there was not a consistent approach to information sharing across the service. There was a lack of regular meetings between midwives and ward managers / matrons. There were regular clinical governance meetings and divisional leadership team (DLT) meetings, but these did not involve midwives working on the wards. The clinical governance meeting followed a set agenda including items such as clinical effectiveness, incident reporting, health and safety and complaints, but the DLT meeting only used a matters arising and any other business approach to discussion items. We saw that there were also regular meetings that happened at a senior midwife level (between ward managers and matrons) and these did follow a set agenda which included an action log. Although we asked for minutes from unit meetings, most areas did not submit evidence of local team meetings. In addition, where meetings did happen, there was no evidence of items being escalated up or information being cascaded down. We had concerns over how the current governance processes ensured all staff were kept up to date with relevant information from senior meetings such as the clinical governance meeting.

Maternity

There was a maternity dashboard in place for the service which maintained clinical outcome indicators including those recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) 2008. Although the data provided the SLT with oversight of the activity and specific outcomes for the service, this was not accessible to all staff and information from the dashboard was not displayed within the clinical areas. When we raised this with senior managers, they told us that the governance team regularly shared information from the dashboard with ward managers to enable them to share it with ward staff. In addition, there was an intranet page under development for staff to be able to view performance going forwards. We were not assured that the dashboard information was shared consistently or used to ensure all staff understood the service performance in order to drive improvement.

Managers told us that policies were based on national guidance and were reviewed centrally on a regular basis to ensure staff were presented with the most current information. These were available on the intranet for staff to access as required. We reviewed four policies relating to clinical care and found that these did not all have multidisciplinary authorship and not all policies were in date review. Only one of the four policies reviewed had multidisciplinary authors (obstetrician and midwife involvement). The policy for obstetric early warning score guidelines was overdue for review since December 2019. The policy relating to guidelines for antepartum fetal heart rate monitoring was overdue for review since July 2020. We were not assured that the governance process around managing policies relating to clinical guidelines was effective.

Areas for improvement

Musts:

- The trust must implement an effective system to ensure that staffing is actively assessed, reviewed and escalated appropriately to maintain safe staffing in the maternity unit in line with national guidance. **Regulation 18 Staffing.**
- The trust must implement an effective system to ensure that medical and midwifery staff are suitably qualified, skilled and competent to care for and meet the needs of women and babies within all areas of the Maternity Service including any area where women are waiting to be seen. **Regulation 18 Staffing.**
- The trust must implement an effective governance system which ensures that there are effective quality assurance systems in place to support safe and quality care. **Regulation 17 Good governance.**
- The trust must ensure risk assessments and risk management plans are completed in accordance with national guidance and local trust policy and documented appropriately. **Regulation 12 Safe care and treatment.**
- The trust must ensure information technology systems are used effectively to monitor and improve the quality of care provided to women and babies. **Regulation 12 Safe care and treatment.**

Our inspection team

Michelle Dunna, Inspection Manager led this inspection. Fiona Allinson, Head of Hospital Inspection, supported our inspection. The inspection team included one inspection manager and two inspectors.

This section is primarily information for the provider

Enforcement actions

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	Section 31 HSCA Urgent procedure for suspension, variation etc.

Regulated activity	Regulation
Maternity and midwifery services	S29A Warning Notice: quality of healthcare