Walsall Healthcare NHS Trust

Manor Hospital

Inspection report

Moat Road
Walsall
WS2 9PS
Tel: 01922721172
www.walsallhospitals.nhs.uk

Date of inspection visit: 28 July 2021
Date of publication: 01/10/2021

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Manor Hospital

Requires Improvement 

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas. The trust serves a population of around 270,000. Acute hospital services are provided from one site, Walsall Manor Hospital. Walsall Manor Hospital has 480 acute beds (July 2021).

The maternity service at Walsall Manor Hospital delivered 2115 babies between 1 January and 31 July 2021. The trust currently provides a choice of two birth settings: homebirth or the consultant led labour suite. (The separate low risk midwifery led birthing unit has closed since the inspection to release staff to support the main maternity unit)

The service is provided by a team of consultant obstetricians who provide consultant presence on labour suite, supported by training grade doctors and midwives who work across the inpatient areas. Community maternity services are provided by teams of midwives. The maternity service has specialist midwives including a midwife who leads on bereavement and offers ongoing support to women and partners who have suffered a pregnancy loss.

We carried out an unannounced focused inspection of the maternity service at Manor Hospital on the 28 July 2021, in response to concerns around safety and governance. At the time of our inspection the department was operating under COVID-19 infection, prevention and control measures. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry. we looked at the safe and well led domains and aspects of the effective domain. 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 acted under our enforcement powers. in these cases, the ratings will be limited to requires improvement or inadequate. The overall rating of the service remained requires improvement. The ratings for effective went down and safe and well led remained requires improvement. Please refer to the 'areas for improvement' section for more details.

Background

The service has 65 maternity beds across two sites: The Manor Hospital has 49 maternity beds; 20 on Primrose Ward, eight 8 on Foxglove Ward (includes four bedded transitional care), four Fetal assessment beds nine 9 delivery rooms including (enhanced maternity care), two maternity theatres, four induction beds, two bereavement beds, and three triage Beds

The freestanding midwifery led unit (MLU) has three maternity beds and was not inspected and has since closed.

How we carried out the inspection

This inspection was unannounced (This meant the service did not know we were going). It was a focused inspection of maternity services on 28 July 2021 following concerns identified about maternity staffing. We spoke with various members of staff, including, midwives, maternity care support workers, senior leadership team, doctors and domestic staff. We spoke with 16 staff and reviewed eight prescription charts and seven patient records. Following our inspection, a further nine midwifery staff contacted us to share their concerns about the service.

Our findings

We last inspected maternity services at Walsall Healthcare NHS Trust on 8 and 9 September 2020. We rated safe and well led as requires improvement and effective, as good (the caring and responsive domains were not inspected). The overall rating for the service was requires improvement. The trust was issued with two requirement notices in relation to breaches in Regulation 12 of the Health and Social Care Act (RA) Regulations 2014 and was told to improve. A range of data was requested from the service as part of this inspection.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection. Our rating of this service stayed the same. We rated it as requires improvement.

Maternity (inpatient services)

Requires Improvement  

Our rating of this service stayed the same. We rated it as requires improvement because:

- **The service did not control infection risk well. Staff did not always keep the premises or equipment and the premises clean.**
- **The design, maintenance and use of the premises was not suitable to meet the needs of women.**
- **Staff did not always complete and update risk assessments or identify all potential risks for each woman within triage.**
- **The service did not have enough maternity staff to keep women safe from avoidable harm and to provide the right care and treatment.**
- **Staff did not always keep detailed records of women's care and treatment and were not available to all staff providing care.**
- **The service did not always use systems and processes to safely store or administer medicines.**
- **The service did not always manage patient safety incidents well. There were delays in the investigations of incidents and lessons learned were not always shared amongst the whole team and the wider service.**
- **The service collected information for the safety thermometer but did not always use it to improve safety and findings were not shared with staff, women and visitors.**
- **The effectiveness of care and treatment was monitored but the timeliness of reviews and implementation of change was variable, which delayed improved outcomes for women.**
- **Leaders did not all have the skills and abilities to run the service. They understood but did not always manage the priorities and issues the service faced effectively. They were not visible and approachable in the service to all staff.**
- **Staff did not always feel supported and valued.**
- **Leaders did not operate effective governance processes. Arrangements to share findings with staff were not robust and valuable opportunities to improve performance, learn and make required improvements were lost.**
- **Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and but did not always identify actions to reduce their impact.**
- **The service collected, analysed and managed information. However, information was not widely shared across the service or always used effectively.**
- **Arrangements by leaders to engage with patients and staff were not effective. There was some collaboration with partner organisations to help improve services for patients.**

However:

- **The service provided mandatory training in key skills to staff and most staff had completed it**.
- **Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Maternity (inpatient services)

- **There were mostly appropriate arrangements in place for the use of equipment. Staff managed clinical waste well.**
- **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.**
- **Records were mostly stored securely.**
- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- **Doctors and midwives and other healthcare professionals mostly worked together as a team to benefit women.**
- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.**

Is the service safe?

Requires Improvement 

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

Mandatory training

The service provided mandatory training in key skills to staff and most staff had completed it.

Staff we spoke with during the inspection told us they had completed their mandatory training. Local data showed that mandatory training compliance for midwives was above the trust target of 90% for all subjects, apart from fire safety, which was at 86.7% compliance for the community midwives and 60.0% for the midwives on delivery suite.

Medical staff received and kept up to date with their mandatory training. Medical staff compliance was recorded as part of the obstetrics and gynaecology staff data. Obstetrics and gynaecology staff compliance was above the trust target of 90% for all topics, apart from fire safety, where compliance was at 80%.

The mandatory training was comprehensive and met the needs of women and staff. Topics covered clinical and risk based subject matter and were completed either online or by face to face classroom training.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Staff we spoke with had a good understanding of these conditions and knew how to access additional support as necessary.

Managers monitored mandatory training and reported on compliance monthly. Staff were alerted to the need to complete training by the practice development midwife.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Safeguarding training compliance was above the target of 90% for all staff. As of June 2021, safeguarding children level 2 was 100% and safeguarding children level 3 was 96.8%.

The staff were required to complete safeguarding adults' level 3, compliance for June 2021 was 99.1%.

Training compliance had improved since the last inspection in 2019.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

We saw staff discussing women at risk and action that had been taken in response to concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were knowledgeable about safeguarding and we saw this in practice during the inspection and was discussed at the handover. There were detailed management plans in patient records.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a named midwife for safeguarding and named contacts across the trust for escalation purposes. We saw that incidents reported reflected any concerns regarding women and children's safeguarding. Effective arrangements were in place to safeguard women from a range of risks including female genital mutilation, diabetes and epilepsy. Effective systems were in place to address areas such as child protection, asylum seekers, travellers and migrants, safeguarding unborn babies and baby abductions.

Staff followed the baby abduction policy and undertook baby abduction drills. Baby abduction drills were carried out regularly on delivery suite and the wards, all staff were involved, and different scenarios were used. The last drill was carried out in early July 2021.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff did not always keep the premises or equipment and the premises clean.

Ward areas were not always visibly clean, and furnishings were not always well-maintained. We were not assured of cleaning undertaken. We observed some dusty equipment which included, two cardiotocography (CTG) machines, an intravenous fluid stand and tubing to portable ventilation machine. Staff cleaned the equipment when this was highlighted to them. We found when areas were occupied by patients, they were not able to be fully cleaned. For example, the staff told us the floors would not be cleaned regularly if beds were occupied. We spoke with domestic staff who told us there should be two domestic staff; one member of staff would cover kitchen duties and the second to undertake cleaning on the ward. Because of staff shortages one member of domestic staff was undertaking both roles. This had been highlighted as a concern by the infection control team. We were told it was impossible due to time constraints to do high cleaning and domestic staff struggled to undertake basic cleaning.

We saw aspects of décor was chipped such as door to delivery room doors and cabinets in the rooms, which meant they could not be effectively cleaned. The trust were aware of the backlog of maintenance and were working to address this.

Maternity (inpatient services)

Information provided by the trust included the infection prevention environmental audit for June 2021 and identified Primrose ward scored 84% which was below the trust target of 90%. Foxglove and delivery suite were compliant at 91% and 95% respectively.

In October 2020 managers reported to the trust board that a recent NHSEI maternity infection control audit had identified insufficient assurance on infection control standards on the delivery suite. NHSEI returned to carry out a re audit in June 2021. They documented that they were pleased that all concerns identified in 2020 had been rectified. This was contrary to what we found during our inspection, so improvements had not been sustained.

There had been one incident of a surgical site infection post caesarean section since January 2021. This was classified as 'low' impact and had been investigated with lessons learnt.

Cleaning records were not kept up-to-date and did not demonstrate that all areas were cleaned regularly. During the inspection we saw that the cleaning checklists for daily cleaning of the rooms and equipment were not always completed.

On Primrose ward there was a cleaning checklist. The records reviewed showed there were ten gaps for July 2021 at the time of the inspection. The support worker and the midwife's tasks were seldomly signed as being completed. We were told this was due to reduced staffing levels and not staff always having the time. This meant that managers and patients would not know when some rooms or equipment were last cleaned.

The service used disposable curtains. Four sets of curtains had no date recorded on them, so there was no way of knowing how long they had been used for.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff to comply with uniform policy. Medical and midwifery staff were always 'arms bare below the elbow'. We observed staff washing their hands and using hand sanitiser when going in and out of rooms of women's rooms. All staff during the inspection wore face masks, when needed.

Service data showed that hand hygiene audits generally confirmed good practice.

Environment and equipment

The design, maintenance and use of the premise did not always meet the needs of women. There were mostly appropriate arrangements in place for the use of equipment. Staff managed clinical waste well.

The design of the environment did not always follow national guidance. Whilst the service mostly had suitable facilities to meet the needs of women's and their families this was not always the situation.

The clinical areas were largely suitable and appropriate for the service which was being managed in them. However clinical rooms where medicines and intravenous fluids were stored did not have suitable arrangements in place to ensure they could be locked.

The triage area had three assessment trolleys, across two rooms, and a separate waiting area. Women would be asked to wait in a seating area by the entrance to the ward if the triage room was occupied or in use, to meet social distancing requirements. There was an increase in the number of women waiting when the foetal assessment unit (FAU) was closed.

Maternity (inpatient services)

Some of the rooms on the wards and delivery suite were old and showed wear and tear. Five rooms we looked at all had chipped doors and bedroom cabinets. The ensuite bathroom floors were stained and needed updating. Service leads told us there was a review of the service planned in terms of pathways and location of services, which included an estates review.

Two rooms used for bereaved women and families within the delivery suite were situated on the main corridor, next to the induction bay and the main entrance into the unit. The sound of baby's heartbeats when using ultrasound was clearly audible both within these rooms, adjacent rooms and in the corridor outside them. The décor of the environment was tired and there were no facilities to aid their comfort at a deeply distressing time.

We spoke with the bereavement specialist midwife, who was aware of this issue and had spoken with the Still birth and Neonatal death Society (SANDS) about where they could possibly have a separate suite. (SANDS support anyone affected by the death of a baby and improve the care bereaved parents).

All clinical areas were secure with access permitted by a staff member. Visitors to all departments were required to inform staff of who they were and were then directed to the relevant area. We did not see tailgate access and saw staff challenge people they did not recognise.

Women could reach call bells, but staff did not always respond quickly when called. Staff reported on Primrose and Foxglove wards that there could be delays in attending a woman due to staffing levels and activity. Staff told us women often commented that they knew they were busy, and they apologised for the calls. However, during inspection most calls were managed in a timely manner and no women were kept waiting for any assistance.

Staff carried out daily safety checks of specialist equipment. All equipment had been electrical tested within the specified timeframe.

The adult resuscitation trolley records were checked daily and the trolley contents were fully checked either weekly or after use. Expiry dates were recorded, and any issues were escalated to the ward manager. The neonatal resuscitation trolley records were missing for May and June 2021 and there was no record of checks for three days in July 2021. Information provided by the trust following our inspection identified the records were available and had been filed.

The service had enough suitable equipment to help them to safely care for women and babies. Staff reported that equipment was readily available and suitable for the needs of the women and their babies.

The birthing pool was tested regularly for water borne infections. Data showed that there were no reported cases of legionella in the twelve months preceding the inspection.

A room was also available for women who required enhanced care in relation to their pregnancy and birth. There were also two emergency theatres providing with around the clock access and a separate theatre for planned caesarean sections ('C-sections').

A range of birthing aids were available on the delivery suite including a birthing cube (complete with a foam mattress that allowed freedom of positioning in labour), birthing pool, a specialised pole with slings/support to enable women support in labour and beanbags to aid positioning and comfort in labour.

Staff disposed of clinical waste safely. Clinical waste was segregated from domestic waste and disposed of and collected regularly.

Maternity (inpatient services)

Assessing and responding to patient risk

Staff did not always complete and update risk assessments or identify all potential risks for each woman within triage.

The trust used a locally adapted tool to identify women at risk of deterioration, but it was not always completed. Staff were not consistently taking all observations and scoring correctly on the Modified Early Obstetric Warning Score (MEOWS) charts. Staff told us they did not routinely carry out MEOWS when short staffed. Triage staff told us they would carry out a basic set of observations, including a blood pressure and pulse. If these were 'normal', then they would not carry out a full assessment according to the MEOWS chart when short staffed. Records we looked at during the inspection showed three of the seven women had no MEOWS recorded.

The service undertook audits of MEOWS with target compliance for escalating women to an obstetrician being 100%. The latest audit (April 2021) showed that 87.5% of women who should have been escalated according to their score were, and 12.5% were not escalated at all. Out of the 87.5%, 58% were escalated immediately, and 14% had a delay in escalation. There were actions detailed in the audit for staff. These included, to include the MEOWS escalation policy in the weekly team email and team leader to disseminate the findings at each handover.

Staff did not complete risk assessments for each woman on admission / arrival, using a recognised tool. We were told staff were too busy to record and assess risk formally. Instead they would use their own clinical judgement, this meant there was a risk woman would not be safely or appropriately assessed. The trust used a tool which identified a RAG (red, amber and green) rating for assessing women's triage priority. Women identified as being rated red required an immediate midwife and medical review.

We requested information following our inspection in relation to waiting times within triage aligned to women's RAG rating for July 2021. The information received was not complete but identified 867 women had been seen in triage in July 2021. A review of 100 sets of notes identified the most common attendance was for reduced fetal movements with the second most common query term labour which would be an amber RAG rating. They provided information in relation to women who were seen in query labour (27 women) the audit suggested women mostly received a timely review by midwives (the average waiting time was nine minutes with a range from zero minutes to 109 minutes). There was frequently a significant delay in a medical review with an average wait of 83 minutes for the six women who required medical review (the wait for medical was identified between 45 and 134 minutes). Information we received before and following our inspection confirmed midwives' frustration to gain medical review and ensure women received a timely review. The trust had been working with another organisation to change the system of working but commencement had been delayed due to the pandemic.

The trust used a nationally recognised tool to identify newborn babies at risk of deterioration. The trust completed newborn early warning score audits from January to June 2021, results showed 100% compliance. We looked at four records and found all observations had been completed and scored correctly on the Neonatal Early Warning Score (NEWS) charts.

A 'fresh eyes' approach to cardiotocography (CTG) interpretation was in place for those women who required continuous CTG monitoring. This was in line with national recommendations (NHS England, Saving Babies Lives v2: The 'fresh eyes' monitoring was undertaken every two hours by a team leader, a band 6 midwife, a registrar or consultant. The assessments were audited weekly. Information provided by the trust identified for May, June and July 2021 compliance

was below the trust target of 90% (87%, 82% and 87% respectively). The trust said the assessment had been shared with individual staff. The trust provided a tracker plan which identified actions in response to the audit, it included: one to one staff training (52% of delivery suite and the inpatient wards had completed it) and meetings with team leaders. The 'fresh eyes' approach had been performed in all of the seven records we reviewed.

There were appropriate systems in place for VTE assessment and carbon monoxide monitoring. The trust monitored VTE assessment undertaken. Staff followed processes to assess and put the women who needed antenatal and postpartum thromboprophylaxis (blood thinning medications) on the correct pathway of care. Thromboprophylaxis is a mechanical method used to treat venous thromboembolism (VTE). Venous thromboembolism (VTE) refers to a blood clot that starts in a vein.

The maternity dashboard showed VTE risk assessment compliance for January to June 2021, ranged from 92% to 100%. The national target was 95%. We looked at seven women's medical records and all had a completed VTE assessment.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff confirmed there were appropriate systems in place for women and midwifery staffing to ensure they had mental health support when required. We saw evidence of this during the morning handover.

The service audited carbon monoxide monitoring as part of the clinical negligence scheme for trusts (CNST) standards. This standard had been paused during COVID-19 and staff were required to ask women about their smoking status and would signpost them to the smoking cessation team. Data was recorded quarterly, it showed for March 2021 there were 224 mothers who confirmed they smoked at their initial booking and 199 for June 2021. The numbers of these women who were smoking at the time of delivery had reduced to 124 for March 2021 and 82 for June 2021. All the seven records we looked at confirmed carbon monoxide had been monitored at the time of booking.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. In the all the seven records we looked at a mental health assessment had been completed.

Staff shared key information to keep women safe when handing over their care to others. Handovers included key information about women and their risks. Staff shared key information to keep women safe when handing over their care to others. Handovers between teams and shifts were methodical and descriptive of the mother's situation. The handovers followed the Situation, Background, Assessment and Recommendation (SBAR) process. Effective communication is essential in the provision of safe patient care. Use of structured communication tools, such as the SBAR format of handover have been shown to improve patient safety. All aspects of the women's care, treatment and physiological state were discussed. Staff had enough information to inform their care planning.

Shift changes and handovers included necessary key information to keep women and babies safe but did not always include all staff. On Primrose ward, the care support workers were not included in the handovers. This showed an inconsistency in team working between the wards and the delivery suite.

We observed that all staff were included in the handover on the delivery suite. There were separate handovers for members of the medical team, including anaesthetists.

Staff completed daily conversations by video calls with the other local NHS trust maternity site teams to discuss work pressures. If necessary, teams would allocate work to the other site to ensure that workload was manageable and prevent any unnecessary risks.

Maternity (inpatient services)

There was a clear escalation policy for staff to follow either in an emergency or when activity or acuity increased. Although, five staff of the eleven we asked had not seen this.

Staff used the World Health Organisation (WHO) and five steps to safer surgery checklist 'in obstetric theatres. The trust provided us with their WHO safety checklist audit for June 2021, they were compliant at 100% in all five aspects, against a target of 90%.

Midwifery staffing

The service did not have enough maternity staff to keep women safe from avoidable harm and to provide the right care and treatment.

The service did not have enough nursing and midwifery staff to keep women and babies safe. The trust reported there were 137 whole time equivalent (WTE) in post with a required 160 WTE midwives (July 2021). The service was busy, and staff told us they were pressured. Staff who were not scheduled to work clinically were moved from their normal work, for example specialist midwives, members of the corporate team who were registered, all completed clinical tasks to support the team. The service had to regularly move midwives from Primrose ward to ensure safe staffing on the delivery suite. Primrose ward staff said this made the ward unsafe caring for both women and their babies. During our inspection a community midwife was called in to work the late shift in delivery suite and support triage. We were told this was a regular occurrence.

Midwife staffing was reported as being challenged since January 2021 but had become more concerning since May 2021. During the inspection we saw and were told that staffing was often compromised across all areas. Staff prioritised the delivery suite to maintain women and baby's safety for delivery, and post-natal areas were regularly short staffed. Staff told us that they regularly missed breaks and stayed late and had been unable to take annual leave. Information provided by the trust following our inspection identified there have been no episodes of staff being declined annual leave, except for weeks when the annual leave headroom had been oversubscribed.

The number of vacancies had been exacerbated by the need for staff to shield or report as sick due to COVID-19 and having to self-isolate. To mitigate risks, service leads had made the decision to move specialist midwives from their roles to cover vacant shifts and ensure a safe service. This left some gaps in specialist services with specialist midwives work in clinical roles. We saw there had been two incidents reported which identified the infant feeding midwives was unable to provide support to mothers and babies as they were working clinically.

Maternity staffing guidelines advocate there is at least one band 7 team leader who is supernumerary to coordinate, support and supervise midwifery staff within delivery units to promote women's safety and care. Staff we spoke with including team leaders told us, with current staffing challenge there was frequently no supernumerary midwife available as they had to work clinically. We discussed the non availability of a supernumerary midwife following our inspection. The Head of Midwifery told us there was always a supernumerary midwife on duty. Information we received following our inspection identified:

"Band 7 team leaders were supernumerary but if there was a second band 7 team leader on the shift they were not required to be supernumerary and would usually have patients. Reviewing the tool which identifies midwifery staff requirements for June and July 2021 there was one recorded episode of a team leader not being supernumerary for a brief period whilst awaiting a midwife for another area".

Maternity (inpatient services)

The trust had a target of 85% of appropriate staffing on the delivery suite. Information provided by the trust identified for the months between 1 January to 30 June 2021 the staffing target was met for January and April only. The average between the same period was 76% of all shifts met the trust target.

The trust target for midwife to birth ratio was 1 to 28. Between January and June 2021 this was not met for each month, except for January 2021.shis was not met for each month, except for January 2021.

Information we received before our inspection identified staffing challenges which had resulted in a delay in inductions of labour. Following our inspection, we requested information about delays in induction. Information identified there had been 115 inductions of labour for July 2021 and four incidents reported of induction delays. This affected 10 women on four dates the delays ranged from two hours to 24 hours. There were a variety of reasons including acuity. The incident data for July 2021 provided by the trust identified there were 18 patient safety incidents identified as excessive workload to staff rota. Information included potential harm to seven women who had significant delays to induction in labour with an average delay of 27.7 hours (and ranged between 10 and 57 hours) which was a result of staffing challenges this was inconsistent with information identified at the beginning of this paragraph.

Elective lists for caesarean sections were carried out on Tuesdays and Thursdays. There was a designated theatre team for elective caesarean sections, midwives were assigned to the elective list on a weekly basis. For emergencies there was a dedicated theatre team and the midwives looking after the patient needing an emergency caesarean was the midwife who attended for continuity of care.

Managers did not always accurately calculate and review the number and grade of midwives, nursing assistants and care support workers needed for each shift in accordance with national guidance. The acuity tool Birth Rate plus should identify correct ratio of midwives: mothers, based on acuity of their mothers. Information provided by the trust following our inspection identified: “staff rotas were not directly aligned to anything Birth Rate Plus would approve”. The trust assessment for birth-rate Plus provided the total number of midwifery staff required to run the whole service and not specific wards or units.

The ward manager could not always adjust staffing levels daily according to the needs of women. Staffing huddles were undertaken three times a day with senior midwifery staff and enable them to identify and if possible, address staffing shortfalls. Significant maternity staffing shortages below the staffing establishment meant that frequently staff were not available to fill gaps in the rota.

Whilst the trust used the Birth-rate plus system (also see previous information) for recording activity, acuity and staffing, we saw that this was not always completed in a timely manner due to staffing and increased activity. This meant the information available to managers was not always timely or accurate to reflect pressures and where staff were required. Information provided by the trust following our inspection identified: "This tool is filled in every four hours. If activity is high in between the period Delivery Suite team Leaders escalated directly to ward managers.

The staff rotas were electronic and did not always accurately reflect the actual number of staff on each shift per shift. This made is difficult for managers to accurately assess staffing and where they were deployed.

The number of midwives and maternity care assistants did not match the planned numbers. During inspection, we saw that due to maternity leave, sickness and shielding, staffing was below the planned level. The delivery suite should have had 11 midwives on duty and there were eight in the morning and six in the afternoon and six on duty the night before the inspection. There should have been three midwives on duty on Primrose ward and there were two. Midwives were often moved from Primrose ward to cover the delivery suite and triage. The planned staffing for the triage unit was

for two midwives. Following a review of the intrauterine death it was identified there should always be two midwives in triage to enable the timely review of women. We saw evidence that only one midwife was allocated with a care support worker. This meant that there was a risk that patients were not being assessed and triaged in a timely manner and did not meet the trusts own required actions to safeguard women and their unborn babies. One serious incident was recorded where a woman was not triaged for more than two hours despite absent fetal movements due to limited delivery suite staff.

The fetal assessment unit (FAU) was frequently closed at short notice to redeploy staff, women who would normally attend the FAU would Following the inspection we asked for information about closures of the FAU. Information provided by the trust identified FAU was closed 13 times in June and July 2021. As a result of long term staff sickness the FAU services were streamlined to close on Saturdays unless the shift could be picked up with bank midwives. A midwifery support worker (MSW) was deployed to cover antenatal clinics due to a shortfall of MSWs due to staff shielding staff or on sick leave.

Following the Ockenden report recommendations, there should have been a supernumerary band 7 midwife on each shift on the delivery suite. Information provided by the trust in response to compliance with Ockenden guidelines said the trust was compliant. The Head of Midwifery confirmed there was always a supernumerary midwife (team leader) on duty. Staff told us in the last two months there had not been a supernumerary band 7 midwife as they had to work clinically to cover gaps in the rota. Following our inspection the trust provided information which identified there was one recorded episode of a team leader not being supernumerary for a brief period whilst awaiting a midwife for another area.

Noticeboards did not correctly identify the numbers of staff on duty. Staffing required and on duty for each shift was not displayed. Staff on duty at the time of the inspection were unsure of the correct staffing numbers should be per shift for Primrose ward. This may have been due to sickness at leadership level.

The service had significant vacancy rates for maternity staff they were trying to address. For the whole of the maternity service there were 22.9 WTE vacancies. They had recently recruited 12.6 WTE to commence in August/September 2021 but there remained 10.3 WTE vacancies. During the time of the inspection they were actively recruiting.

The service had increasing sickness rates. Staff told us and we saw from data provided from the service, that sickness had increased since January 2021. Apart from Primrose and Foxglove ward, where it had improved. Primrose ward and Foxglove ward had 6.9% sickness rate in January 2021, and this had reduced to 3% in June 2021. Delivery suite had 3.3% sickness rate in January 2021, and this had increased to 8.6% in June 2021. The service's target was 3.3%. The community midwife service's sickness rate had increased from 5.5% in May 2021 to 14.7% in June 2021. Staff told us this was due to staff needing to self-isolate exhausted from having to cover shifts in the delivery suite.

The service had increasing staff on maternity leave. There were 9.5% of staff on maternity leave in June 2021 compared to 7.5% in April 2021.

Managers used of bank and agency staff and requested staff familiar with the service. The substantive staff for the service carried out bank shifts in addition to their contracted hours. We were told that if agency was used it would be agency that had worked at the service previously.

Managers made sure all bank and agency staff had a full induction and understood the service. We saw evidence of induction documents during the inspection.

Maternity (inpatient services)

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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had mostly had enough medical staff to keep women and babies safe. There were two ward rounds a day reported and consultant cover was identified to meet requirements. Weekend ward rounds were pressured as medical staff covered many areas, and rounds would commence late on Primrose and Foxglove wards. Ward round audits showed full completion and were of high quality. Information provided by the trust identified significant medical delays of women in query labour.

Midwifery staff before our inspection told us they had difficulties getting medical staff to timely review women for discharge as they were busy in gynaecology. Information provided by the trust identified there was frequently a significant delay in a medical review of woman in triage.

The weekly hours of anaesthetic consultant cover on the labour ward reached the national target of 50 hours in every month from February to June 2021. This ensured women received pain relief and anaesthetic choices for their labour and birth and emergencies.

Medical staff reported 'great team working' and that there had been improvements in the medical rota. Consultants were approachable and supportive of junior staff and their colleagues. Trainee doctors reported that consultants were supportive, approachable and were always willing to assist, for example attend the unit out of hours for complex cases.

The medical staff matched the planned number. The clinical director for the service had carried out a recruitment drive for consultants. The Royal College of Obstetricians and Gynaecology (RCOG) recommend that there should be 60 hours consultant presence per week, for units between 2500-4000 births/year, the service provided 78 hours. We saw from data the service provided there was a 100% fill rate of shifts.

The service had low vacancy rates for medical staff. They had recruited two new consultants due to commence in October/November 2021. This would leave them with one WTE vacancy to fulfil all the requirements for obstetrics with regards to the Ockenden report.

Sickness rates for medical staff were reducing. In January 2021 there was 5.5% sickness rate, in June 2020 this had reduced to zero.

The service had reducing rates of bank and locum staff. Managers could access locums when they needed additional medical staff. However, this was not needed at present. Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends. There was consultant presence Monday to Friday from 8.30am to 10.00pm, then on call overnight. During the weekends there was consultant presence from 8.30am-11:30am and 19:30pm-21:30pm to complete the ward rounds, and then there would be an on-call consultant cover once they left site.

Records

Staff did not always keep detailed records of women's care and treatment and were not available to all staff providing care. Records were mostly stored securely.

Women's notes were not always comprehensive. The medical records were largely electronic, except for prescription and observation charts. We reviewed seven women's records in full and saw some were inconsistently completed and lacked some information, as detailed in the assessing risks section. There were no triage rating scores for two out of the seven records when required (the other five records recorded not applicable). The MEOWS (modified early obstetric warning score) was completed in five of the seven records.

We found four of the eight prescription charts we reviewed had no weight recorded for the women.

When women transferred to a new team, there were no delays in staff accessing their records. Records were transferred with the woman when they were moved to different areas.

Records were stored securely on delivery suite and Foxglove ward. However, we found women's medical records to be left unattended on the nurses' station on Primrose ward.

Staff had access to computers in all departments though some staff told us they were not always available. We saw that these were locked when not in use to prevent unauthorised access.

Medicines

The service did not always use systems and processes to safely store or administer medicines.

Staff did not always follow systems and processes to safely administer or store medicines.

Staff did not store and manage medicines in line with the provider's policy. We observed poor practice regarding the storage and management of medicines on Primrose ward. We saw two opened bottles of medicine on Primrose ward with no date recorded when they were opened.

Baby and adult intravenous medicines were stored side by side on the same shelf, which meant that there was a risk that staff could administer an adult medicine to a child and vice versa.

Intravenous (IV) fluids should be kept locked in a cupboard, or in a room that can be locked. We saw IV fluids being stored in a room that was not locked, therefore there was a risk they could be tampered with.

Medicines were left out unattended on patient's lockers. A patient complaint we received identified this practice had happened before our inspection. There were no doors on the medicines room on Primrose and Foxglove wards. There had been no risk assessment completed for the medicines to be stored in a room without doors.

We escalated these risks to staff, and they were then secured in the correct cupboards.

The medicines audits for May and June 2021 showed the same issues with medicines management that we had found on inspection: opened bottles of medicine with no dates recorded, unlocked medicine rooms and cupboards. An action plan had been started for Primrose ward and Foxglove ward, after an audit showed that the IV fluid room and medicine fridges had been left unlocked. The plan showed that 'spot' checks had commenced, and it would be reviewed in August 2021. However, this was still happening at the time of the inspection. Maternity theatres were 100% compliant in the audit.

We saw that the service had reported eight medicine errors for April to May 2021, one was classified as a near miss and the other seven were classified as no harm. They were due to medicines being delayed or not given.

Staff reported there was a stock of 'to take home' medicines available. Staff told us this made the discharge process a better experience for the women, as they would not have to wait for medicines to arrive from pharmacy.

Medicine fridge and room temperatures were recorded appropriately and were within required temperature.

Staff mostly followed current national practice to check women had the correct medicines. We observed medicines being given on delivery suite and the midwives followed current practice to ensure this was done safely. We saw patients' weight was not always identified. There was a risk that women may not receive the required safe and effective amount of their medicines.

Controlled drugs (CDs) were stored securely and checked twice a day. Controlled drugs are those defined by the Misuse of Drugs Act 1971 as subject to strict legal controls and legislation due to risks of being misused. All CDs administrations were confirmed by two members of staff in line with national guidance.

Medication errors provided by the trust showed three occasions where antibiotics had been delayed so infections were not being treated in a timely manner.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Any national safety alert regarding medicines would be communicated to the different teams during handovers and in the maternity newsletter.

Incidents

The service did not always manage patient safety incidents well. There were delays in the investigations of incidents and lessons learned were not always shared amongst the whole team and the wider service.

Systems to report incidents were not robust. Staff told us they did not always report 'difficult shifts' or where they were short staffed. We were told concerns were escalated to the service leads. This meant there was no transparency of information available to other senior managers in the trust or to others outside the trust.

Staff did not always raise concerns or report incidents and near misses in line with trust policy. Whilst some staff told us they did report incidents others told us they did not due to staffing challenges. Staff in delivery told us they reported all transfers to special care units and all pre-term deliveries. We received information following the inspection which identified there had been 18 incidents raised in July which included staffing concerns. It was evident from a review of other staffing information all staffing concerns had not been reported. We were aware at the time during our inspection clexane a medicine used to prevent blood clots had not been being administered by night staff due to staffing challenges and had not been reported. Staff said they rarely reported incidents as they received no feedback, and nothing happened, and one staff member said "what's the point? "

Shoulder dystocia is a head-to-body delivery interval of more than 60 seconds that requires additional obstetric manoeuvres to deliver the fetus after the head has delivered and gentle traction has failed and can result in ongoing problems which require follow up. An internal audit of the management of shoulder dystocia in May 2021 for women identified no incident was reported for 14 women who had a baby with shoulder dystocia. There is a risk to both mothers and babies born following shoulder dystocia. Both mother and baby require ongoing medical review to check no complications have occurred. A failure to report and identify these incidents may mean mothers and babies may not receive all required checks both within the maternity unit and when they are discharged home under the care of other health professionals and may not then receive required treatment.

Some staff told us there were not enough computers, making it difficult to report incidents especially when they were busy as incident reporting was undertaken electronically. Whilst several staff told us they struggled to report incidents we saw 513 incidents and near misses had been reported from January to June 2021. The most prevalent incidents reported were, access, admission, transfers and discharge (125), treatment and procedures (104), staffing (73) and communication and confidentiality (53).

The head of midwifery told us all incidents were reviewed by a multidisciplinary panel who identified which incidents required further investigation. Incidents were shared at the weekly safety huddle. Investigations detailed actions taken immediately and outcomes. However, staff told us they did not always receive feedback from incidents and were not made aware of learning from incidents reported. Information provided by the trust following our inspection identified all staff received " Incidents at a glance" report by email which was also shared within staff forums for example the Inpatient forum, Community Midwifery forum and team leader meetings.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There had been one historical never event reported elsewhere in the trust. Managers said never events that happened elsewhere would be reported during handovers and within the maternity newsletter. The service reported no incidents which were classified as never events for maternity.

Staff reported serious incidents in line with trust policy. There had been 15 serious incidents reported from July 2020 to June 2021. We saw details of serious incidents were shared as part of the maternity risk report. Staff we spoke with were unclear about serious incidents or identification of lessons learnt. A full investigation of a serious incident should be completed within 60 working days. The trust provided details of five serious incidents, four did not meet this requirement. Of the five serious incident reports we received the average time to complete the investigation was 88.8 working days. This meant there could be a significant delay sharing incidents with staff. Information provided by the trust identified where an initial review, and initial learning was recognised, and actions put in place however no other information was provided.

Staff understood the duty of candour (DoC). They were open and transparent and gave women and families a full explanation if things went wrong. Any incident was reviewed to identify the need for DoC, and this was recorded within the incident detail. We were given examples of where DoC had been applied and staff told us women and their families were always involved with investigations and outcomes.

Staff did not consistently receive feedback from investigation of incidents, both internal and external to the service. Not all staff could tell us of examples where they had received feedback from incidents they had reported or were involved with. We saw no evidence of changes that had been made as a result of feedback from learning from incidents.

Senior staff met to discuss the feedback and look at improvements to patient care. There were regular clinical governance meetings where incidents were discussed.

Managers investigated incidents. Women and their families were involved in these investigations. We were given examples of how staff and when appropriate staff, women and their families had been involved with incidents that had been referred to the Healthcare Safety Investigation Branch (HSIB). There were 21 referrals made by the trust to HSIB, from the 21, 13 were rejected due to not meeting the HSIB criteria, or the family did not give consent for further investigation. Information provided by the trust showed they reported incidents such as late gestation intrauterine deaths/ stillbirths, neonatal and maternal deaths to The Healthcare Safety Investigation Branch (HSIB) for independent investigation.

Maternity (inpatient services)

Managers debriefed and supported staff after any serious incident. Staff told us that there were no formal support systems in place following incidents, however they knew how to access support if necessary. Managers told us they debriefed and supported staff after any serious incident. investigation. A debrief is important to ensure staff are aware of ongoing actions, lessons learnt and where they may access support when needed.

Safety Thermometer

The service collected information for the safety thermometer but did not always use it to improve safety and findings were not shared with staff, women and visitors.

Whilst the national direction to gather annual data had stopped in March 2020 in line with the response to the covid pandemic, the organisation had continued to collect safety data within its maternity dashboard. However, not all staff were aware of the maternity dashboard or the information it included. There was a notice board on delivery suite detailing recent monitoring and safety activity for June 2021, but information was not displayed in other areas.

We were told that there were maternity safety champions for each staff level. Maternity safety champions were not embedded and staff on duty at the time of the inspection were not aware who they were.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Patient outcomes

The effectiveness of care and treatment was monitored but the timeliness of reviews and implementation of change was variable, which delayed improved outcomes for women.

The service participated in relevant national clinical audits. Staff told us some clinical audits had stopped during the pandemic but were now being undertaken. The service sent us details on clinical audits undertaken between April and July 2021. Information identified there had been eight clinical audits undertaken for maternity services and included management of gestational diabetes, management of epilepsy, post caesarean section pain management, shoulder dystocia, managements of sepsis, pre-eclamptic toxaemia (PET) and modified emergency obstetric warning score (MEOWS) audit and the use of folic acid. The audits identified good practice and where improvements were required. Despite our request that all relevant action plans should be included no action plans were provided. We received no assurance required actions were in place to ensure women and their babies received improved care and treatment.

The service used a maternity dashboard to monitor performance against key indicators and national targets. We saw activity such as the number of home births, multiple births, percentage of women receiving one to one care, caesarean section rates, elective and emergency percentages and numbers of women with different tears was compared to peers and national averages to inform performance. A red, green and amber (RAG) rating system used to highlight areas where performance was not in line with planned. The dashboard was not displayed or actively shared with staff.

Outcomes for women were inconsistent and did not meet required expectations, such as national standards. The dashboard identified the service had mixed performance against other maternity services or meeting the trust own targets between February and July 2021. This included:

Maternity (inpatient services)

The rate of Still Births (MBRRACE) per 1000 Births were higher than the MBRRACE target of 3.7

Non -invasive delivery rate was better than the trust target and exceeded the national target of 57%.

The percentage of women receiving a caesarean section was above the local target of 30%.

The percentage of women receiving an emergency caesarean section from February to July 2021 was above the local target (18%) for all but one month (April).

Instrumental delivery (percentage of ventouse and forceps delivery) was better than the trust target (fewer women received an instrumental delivery).

The service was not meeting any of the 95% national standards for the friends and family test (FFT). The percentage of women who would recommend the service for the delivery suite for June 2021 was 69%. For Primrose ward it was 73%.

Some staff felt that woman were asked to complete too many questionnaires, which could confuse them. Work had been completed to try and improve friends and family results. Every woman who attended antenatal clinic would be asked to complete an FFT regardless of what stage of pregnancy they were in.

We could see evidence that managers used the results to improve women's outcomes.

Managers and staff carried out a programme of repeated audits to check improvement over time. We saw an audit programme was carried out some of which identified repeat audits. There were some actions for medicines and early warning score completion. However, this was not always driving the improvements needed as the same issues were recurring.

The maternity governance group meetings discussed follow up of some (but not all) audits when compliance did not meet the required target. We saw that the caesarean section rate was discussed. The caesarean section rate for June 2021 was at 36.8%, the majority of these cases were emergencies. An action for the following meeting was for a nominated consultant to formulate a plan and to provide assurance that they were not carrying out inappropriate caesarean sections. We did not see consistent evidence that managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Managers did not always share and make sure staff understood information from the audits. This was shown by the staff we spoke with during this inspection not knowing recent audit results, or where to find the information.

We could not see that improvement was checked and monitored. There was evidence of local and national audits being completed, but not where improvement had been made.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Maternity (inpatient services)

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge as able. Managers reported that finding the balance between ensuring staffing levels were maintained and promoting development was difficult. Staff we spoke to told us they used to be able to access additional training, however, this had reduced over the few months due to staffing levels and the inability to release staff for training.

Training compliance was tracked by the practice development midwife (PDM) who produced a report of compliance twice a month. The reports were used by the managers to prompt staff to complete training, and if the training expired staff were sent a letter requesting that they update training as soon as possible.

Managers made sure staff received any specialist training for their role. We saw that 92.1% of midwives had completed their cardiotocography (CTG) training for June 2021, against a target of 90%.

Midwives also completed PROMPT training. PROMPT (Practical Obstetric Multi-Professional Training) is a multi-professional obstetric emergencies training package that had been developed by the prompt maternity foundation for use in local maternity units with the aim of reducing preventable harm to mothers and their babies. We saw evidence that 93.9% of all the maternity staff, including medical staff had completed this training, against a target of 90%.

Compliance with the gestation related optimal weight (GROW) training met the 90% target for all staff groups. Data showed that 91% midwives and 92.4% doctors had completed the training which was in line with recommendations from Saving Babies Lives 2019.

Managers gave all new staff a full induction tailored to their role before they started work. We saw evidence of a good induction for new staff in transitional care. Midwives were supernumerary when they commenced their employment, depending on their experience.

Managers supported staff to develop through yearly, constructive appraisals of their work. Compliance with appraisal completion for midwives was, 91.2% for delivery suite and 97.2% for Primrose and Foxglove wards. Maternity staff appraisals were updated on a monthly basis within the maternity dashboard.

Compliance with appraisal completion for the medical staff was at 100%

A practice development midwife (PDM) supported the learning and development needs of staff. The PDM worked alongside new staff to ensure competence and help with any development needs. Staff reported the PDM were excellent and helped with them with their development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There was also a monthly newsletter for maternity staff although not all staff were aware of this.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Most staff we spoke with confirmed they were able to discuss their training needs with managers. However, staff on Primrose ward felt due to the non-availability of a ward manager this was not possible.

Managers identified poor staff performance promptly and supported staff to improve. Any concerns with skills or practice were shared with the practice development midwife (PDM) who were reported as being very proactive and supportive of the team. PDM took action to address any concerns offering additional training or development plans.

Maternity (inpatient services)

Multidisciplinary working

Doctors and midwives and other healthcare professionals mostly worked together as a team to benefit women.

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. Doctors and midwives reported effective team working and collaboration to provide care.

The service had a minimum of two ward rounds per day. These were conducted by the consultant of the week and included the midwifery team. We observed handovers although maternity support workers were not included in handovers on the wards. Handovers we observed were recorded and identified detailed plans and actions required. Staff were respectful of each other and listened to opinions.

Handovers and ward rounds followed a structured tool, called the SBAR (Situation, Background, Assessment and Recommendation). The delivery suite regularly updated white boards to record women's details and what was care/ treatment was required. These were used to inform discussions at MDT meetings and handovers. This was in a private staff area, not accessible to members of the public.

Safety huddles were held in the morning at 8.30am and 3pm. The morning safety huddle was held at the same time as the doctors' handover. The service also had safety huddles for each department. Information provided by the trust following our inspection identified the 3pm huddle was an overarching huddle attended by the the maternity midwifery manager on-call, consultant on labour ward (or registrar) and the Delivery Suite team leader. The manager on-call shared information about other parts of the service. However information we saw at the time of the inspection identified silo working.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw detailed communication across teams regarding a woman with a mental health concern from a previous shift. We saw other communication with social services, community midwives and health visitors.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. We reviewed seven sets of women's records which showed that all had a mental health assessment completed and when required appropriate actions were taken.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Not all leaders had the skills and abilities to run the service. They understood but did not always manage the priorities and issues the service faced effectively. They were not visible and approachable in the service to all staff.

Maternity services were part of the women, children's and clinical support division. Maternity was led by a triumvirate, a head of midwifery, director of operations and a clinical director.

Maternity (inpatient services)

The leadership team were supported by a community and an inpatient matron and two ward managers. At the time of our inspection, the community matron was covering the inpatient matron, due to annual leave and one of the ward managers was on long term sick. Staff told us due to staff sickness they were covering more than one role. The ward manager for the delivery suite had recently commenced this role in May 2021. Information we received following our inspection identified a new interim ward manager was in place from 1 August 2021.

Midwives had mixed opinions of the senior management team and their ways of working. Some staff particularly on delivery suite felt supported. However, other staff felt senior managers were not supportive, acted as a barrier to change, were overly critical, not visible, supportive or approachable.

Service leads attended regular meetings with the trust board and senior leadership team (SLT). We were told that these meetings were focused on performance and the team were regularly held to account for performance. There was a nominated non- executive director lead for maternity services however, staff we spoke with were not aware who this was.

Staff on delivery suite told us that service leads would visit the clinical areas and could be accessed when necessary. The staff reported that changes to the leadership had been a positive action and that they felt more confident action would be taken to improve the service. However, this was not the same response from staff on Primrose and Foxglove wards. Staff reported that leads were often busy, and they could not always access them or get support when it was needed and when suggestions were made, they were dismissed.

During inspection, service leads we spoke with were knowledgeable of the risks, performance and development needs of the service. There was a cohesive plan to address concerns and a shared understanding of individuals roles and responsibilities in ensuring the service developed. However, service leads were not aware of the strength of feeling about staff concerns on Primrose and Foxglove wards.

We saw the clinical director was present and staff spoke highly of them.

Vision and Strategy

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

The service vision had been produced in conjunction with the staff, patients and the wider health economy and was aligned to the trust vision.

Service leads were clear about their aims and recognised that there was significant work that needed to be done. They told us they wanted to embed new ways of working before taking on additional challenges, so were implementing changes initially based on safety.

The new maternity strategy document was commenced in January 2021 in conjunction with the MVP (maternity voices partnership). This was currently in the developmental stages following five meetings with the MVP and midwifery team. This was being supported by the head of business development and planning for the trust.

There was a five-year strategy in place. The service took coordinated action to address the challenges faced by its population in terms of maternal and infant health and planned to create a single Black Country maternity plan that were inter-related with Birmingham and Solihull where necessary.

Maternity (inpatient services)

Staff worked with stakeholders to ensure the region had improved maternity services and outcomes based on the Better Births guidance. Service leaders had close links with maternity units and commissioners in the Black County region, this was called Local Maternity Systems (LMSs).

Culture

Staff did not always feel supported and valued.

Staff were focused on the needs of patients receiving care however, the culture of the service did not encourage or support staff to raise concerns without fear. We were not assured concerns were progressed appropriately. There were mixed views regarding whether staff felt respected, valued and supported.

Some midwifery staff were frustrated by staffing levels and some were visibly upset when talking about their experiences. Staff told us they did not always feel listened to when they escalated concerns about staffing levels and were often unsure on the number of staff that should be working, particularly on Primrose ward. Staff recognised that higher risk areas, such as the delivery suite, needed appropriate staffing but felt this regularly left other areas vulnerable with unsafe staffing. Staff told us they had escalated their concerns but did not feel the information they shared was considered or that were always listened to. The staffing pressures and movement of staff had led to divisiveness and silo working across areas.

Service leads told us they were aware of the issues that were being raised by staff and were attempting to address them, however, recognised that there was no quick solution. There were some support processes in place for staff which included pastoral support.

Some but not all staff told us they could use the freedom to speak up guardian (FTSuG) to raise concerns about the service. The FTSuG, supported staff in raising concerns and feeding back to senior leads any themes from conversations. Some staff we spoke to were not aware of the FTSuG

Some midwives reported that concerns were not always escalated due to ineffective relationships with matrons and some team leaders in other areas. We were told that on occasions when concerns had been escalated, staff felt their concerns had been taken ‘personally’ or as a criticism by managers, this had deterred individuals to continue to raise their concerns.

Staff contacted us after our inspection and said there had been bullying which had not been resolved or action taken. Staff said this was one reason why staff had left. Staff also said there was favouritism. Staff said some staff returning to work with medical needs were told they cannot accommodate 'light duties' and were put on back to back shifts whilst other staff were given 'light duties' and were also allowed to have extra shifts.

Staff told us management could be disrespectful and left them feeling unsupported and not important or valued. When staff expressed how unhappy they were within their role and asked for advice and support or in some circumstances transfer, nothing was put in place to support them to help avoid them terminating their contract. told us this had resulted in multiple staff leaving within the past year.

Service leads told us that the consultant group were very supportive and had taken on additional lead roles as part of the service and their own development. For example, there were consultant leads for labour, foetal, maternal and antenatal medicine. The leads were expected to review pathways as part of the lead role.

Maternity (inpatient services)

Governance

Leaders did not operate effective governance processes. Arrangements to share findings with staff were not robust and valuable opportunities to improve performance, learn and make required improvements were lost.

The service held a range of meetings to share learning and monitor performance with middle and senior managers however effective arrangements were not in place for other staff. The meeting structure was replicated across the service and trust at all levels. For example, the maternity governance meeting fed into the trust wide safety and governance meetings. We found arrangements to ensure other staff were aware of learning and development was not robust and valuable opportunities to improve patient safety and performance were lost.

Staff were not reporting all incidents which meant middle and senior managers were not aware of all concerns identified. Managers told us there was a weekly multidisciplinary (MDT) review of all moderate harm and above incidents a summary of all incidents were reviewed and then were shared with the weekly safety huddle (this was usually attended by senior staff throughout the service) and then at the divisions governance meeting but this meant other incidents such as no harm, low harm and near misses may not be identified or appropriate actions taken to mitigate against a potential risk. Information provided by the trust following our inspection confirmed all incidents including no harm, low harm and near miss incidents were reviewed by the MDT weekly in addition to be reviewed by the manager of that area. Concerns were escalated from this group if required. We also found there was a delay completing investigations.

Meetings were chaired by the most appropriate person, with clinical leads and the director present. We saw a selection of meeting minutes and found them to be detailed and clear. Meetings were well attended with full multidisciplinary attendance, and actions were highlighted and reviewed at each meeting. Service leads confirmed that they met with the board regularly to discuss performance. We reviewed minutes from a selection of meetings for April to June 2021. Standing agenda items were considered including performance. and oversight of maternity dashboard and serious incidents. Reports were presented from different specialisms such as infant feeding, bereavement services community midwifery and the midwife led unit. Progress against the Ockendon standards were considered and some ‘red’ areas in this were highlighted, it was recorded staff felt they had not got an insight into the Ockendon Report. Aspects of risk were identified such as staffing and delay in inductions.

Minutes we looked at did not include the findings of the medicines audit and limited information about CTG monitoring and infection control and prevention and actions to improve performance. The CTG monitoring was identified as improving (was 36% in January 2021 following the introduction of computerised CTG which was introduced in January 2021) although was still not meeting the trust target.

There was an action log which was alongside the minutes. The action logs showed significant delays but only included minimal information and not actions against all areas identified within the meeting to ensure timely actions were in place. For example the action for April identified two actions : Attendance monitor, action for this had been identified for completion initially in December another action was data reports and to request the dashboard and PALs reports were shared within the first 10 days of the month, this had been outstanding since February 2021.The May action log included just one action, the ongoing attendance monitor. The action log for June included three new actions to be completed in July 2021. Two of the actions identified included feedback to staff around the friends and family test and VTE assessment. At the time of the inspection (28 July 2021) staff were not aware of this.

Maternity (inpatient services)

During the inspection we had to escalate that one clinical guideline, one clinical pathway and one standard operating procedure (SoP) had not been reviewed in a timely manner. These were the, assessment criteria guidelines, review date was April 2020, caesarean section surgical site pathway, review date was 2016 and the wound readmission management standard operating procedure SoP, the review date was 2017. Leaders were aware of reviews being required and a working group was tasked with completion.

Staff received newsletters about the service. Key information was shared through meetings, minutes, and newsletters. However, some staff told us they did not always feel informed, as they did not have time to read newsletter or meeting minutes.

Partnership working was evident, with regular meetings and collaboration with the wider maternity services, such as the Local Maternity and Neonatal Service (LMNS) and the maternity voice partnership (MVPs).

There were clear managerial lines of accountability. Registered practitioners were also registered with and accountable to regulatory bodies in terms of standards of practice and patient care. For example, midwives were professionally accountable to the Nursing and Midwifery Council (NMC).

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and but did not always identify actions to reduce their impact.

The divisional director could escalate to the trust management board and the trust board had oversight of performance within the maternity division.

Service leads were aware of the risks across the service and had plans in place to address them. Risks and performance were being managed in line with service improvement plans and informed decisions regarding pathways and developments, however we did not find this was always currently effective. The main area of concern was identified as staffing. Managers reported recruitment had been undertaken with additional staff commencing employment in August and September 2021. Staff were not aware of a strategy to retain staff or consider alternative skill mix. Information provided by the trust following our inspection identified a maternity strategy was being developed which included actions to address staff retention. Risks associated with staffing and patient safety had not been fully impact assessed or rectified.

Additional risks were largely linked to the improvement of pathways, lack of scanning capacity and work to be completed in response to poor audits.

There was a risk register in place which detailed mitigation taken to address concerns and identified regular reviews. Risks had named leads for reviewing or implementing changes. Timelines for target and then the next review were recorded. The risk register did not identify when the risk had been identified.

Managers did not proactively consider risk for example maternity staffing had been a long-term concern. The trust had previously been required to maintain 10 vacancies due to the planned closure of Foxglove ward, despite the ward remaining open. The service risk register identified maternity staffing concerns were not new and historically over the last five years the service had at least ten whole time equivalent (WTE) midwives each year on maternity leave. We were not provided with any evidence how these shortfalls had been mitigated against. The maternity dashboard was inconsistent in recording staffing levels on the labour ward with this being highlighted as red February – July 2021. However staffing levels for the post-natal areas were not included.

Maternity (inpatient services)

There was a maternity dashboard which was used to display performance. The maternity dashboard was reviewed at the local maternity and neonatal system (LMNS) level to identify benchmarking across the area. However, this was not shared with or accessible to staff.

The service had a quality improvement plan which addressed areas for development such as pathways of care and staff culture. The team were being supported by the operational development team to address some of the areas.

Service leads were using birth-rate plus to monitor the management of acuity and workload. Staff were expected to submit data into the tool to enable the identification of pressure, however, staff reported that they did not always have time to complete this due to reduced staffing.

We saw that Saving Babies Lives was an agenda item in the maternity governance meetings. Their performance against the elements were discussed and actions brought forward to discuss at the next meeting.

Information Management

The service collected, analysed and managed information. However, information was not widely shared across the service or always used effectively.

Managers demonstrated understanding of performance which looked at people's views with information on quality, operations and finance. Managers had a framework to oversee the quality and safety of patient care which included the maternity dashboard. They reported a range of service performance measures and discussed quality in governance meetings. We found the maternity dashboard was not widely shared with staff.

Arrangements ensured availability, integrity and confidentiality of identifiable data, records and data management systems in line with data security standards. Staff followed the General Data Protection Regulation (GDPR).

Staff on Primrose ward told us that they could not always access a computer terminal due to not enough on the ward. Senior managers told us there had recently been a delivery of new computers for the service, so would review this concern raised.

Engagement

Arrangements by leaders to engage with patients and staff were not effective. There was some collaboration with partner organisations to help improve services for patients.

Peoples' views and experiences were gathered but not always acted upon to shape and improve services and culture. The patient experience Friends and Family Test (FFT) recorded the percentage of patients who said they would recommend the maternity services. The percentage of women who would recommend the service for the delivery suite for June 2021 was 69%. For Primrose it was 73%. The results were discussed at the governance group and were described as rated as 'red' and progress was not being made over time. Some plans to improve the FTT were in place.

FFT results were presented and discussed at board level. FFT results were also included as part of the maternity dashboard. However, because the dashboard was not displayed in ward areas staff were not kept up to date with the results.

Maternity (inpatient services)

There were safety champions within all staff groups. However, these were a new role and had not been embedded throughout the service. Staff we spoke with could not name their safety champions. Therefore, there had not been a chance to meet with the board safety champion to share information and any concerns or feedback yet. However, the clinical director told us that Primrose ward staff had reported the staff shortages and low morale.

Positive and collaborative relationships were maintained with external partners. The maternity service at Walsall engaged regularly with their partners at the nearby acute NHS trust.

We saw from meeting minutes and from speaking with staff during the inspection that, they felt they had not had insight from their leaders regarding the Ockenden report. An action was to share the report with the wider team. Staff also said that they like to be more involved with any clinical changes, such as the Ockenden report and serious incident investigations.

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that there are adequate numbers of staff to meet the demands of the service, including, midwives, and supernumerary coordinators. (Regulation 18 (1))
- The trust must ensure that all risk assessments and women records are completed accurately and reflect risks based on full assessments. (Regulation 12 (2) (i)).
- The trust must ensure that medicines are stored safely and securely. (Regulation 12)
- The trust must ensure that all staff maintain effective infection control and prevention practices. (Regulation 12 (2) (h)).
- The trust must ensure governance arrangements are robust to ensure risks and poor performance are identified and any identified risk is mitigated against. (Regulation 17(1) (2 a, b, c)

Action the trust SHOULD take to improve:

- The trust should ensure that all equipment cleaning is recorded in line with local policies and procedures.
- All patients' records should be stored securely.
- The trust should ensure that all clinical areas are fully suitable to the service needs.
- The trust should ensure that there is adequate support and processes in place for staff to escalate concerns.
- A review of the premise should be undertaken to ensure appropriate and timely maintenance can be arranged.
- A review of the provision of bereavement rooms should be undertaken.
- A review of incident reporting should be undertaken to ensure incidents are reported and learning is shared.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two specialist advisors who were senior midwives. The inspection team was overseen by Sarah Dunnett Interim Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance