James Paget University Hospitals NHS Foundation Trust

James Paget Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at James Paget Hospital

Requires Improvement 

Pages 1 and 2 of this report relate to the hospital and the overall rating of that location, from page 3 the ratings and information relate to maternity services based at James Paget University Hospitals NHS Foundation Trust.

We inspected the maternity service at James Paget University Hospitals NHS Foundation Trust as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

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

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

Our rating of the James Paget University Hospitals NHS Foundation Trust remains good. However, our rating of this hospital location went down. We rated it as requires improvement because:

- Our ratings of the Maternity service changed the ratings for the location overall. We rated safe as inadequate and well-led as inadequate and the overall rating for maternity services went down to inadequate.

How we carried out the 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.

Maternity

Inadequate ↓↓

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

- The service did not have enough staff to care for women, birthing people and babies and keep them safe. Staff did not always have training in key skills, or work well together for the benefit of women, or manage safety well. Staff generally understood how to protect women from abuse but did not always receive training on this. The service did not always control infection risk well. Staff did not always assess risks to women, act on them and keep good care records. They did not always manage medicines well. The service did not always manage safety incidents well and learn lessons from them.
- Leaders did not run services well using reliable information systems and did not always support staff to develop their skills. Staff did not always understand the service's vision and values, and how to apply them in their work. Managers did not always monitor the effectiveness of the service and make sure staff were competent. Staff did not always feel respected, supported, and valued. However, they were generally focused on the needs of women receiving care. We were not assured that people could always access the service when they needed it and did not have to wait too long for treatment. Staff were not always committed to improving services continually. There was evidence the service engaged with women and the community to plan and manage services.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this action as we believed a person would or may be exposed to the risk of harm if we had not done so. We found that the service had deteriorated since the last inspection in December 2018.

Is the service safe?

Inadequate ↓

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

Mandatory training

The service provided mandatory training in key skills but did not always make sure all staff completed it.

Midwifery staff did not always receive and keep up to date with their mandatory training. Compliance with practical obstetric multidisciplinary training (PROMPT) was 95%. PROMPT training also included new-born life support and pool evacuation training. There was a midwifery mandatory training day (MMD) which included training on various aspects of care such as diabetes, new-born feeding and Anti D, and compliance with this was 95%. However, compliance with an electronic cardiotocograph (CTG) training package was 75% and compliance with basic life support (BLS) and Baby Lifeline Training (BLP) was 82.7%.

Medical staff did not always receive and keep up to date with their mandatory training. Advanced life support (ALS) compliance was 100%. Compliance with PROMPT training was 87.5%. The compliance with an electronic CTG training package was 58.3%. The compliance for BLP was 75%.

Staff told us PROMPT was not always multidisciplinary in line with best practice guidelines, as consultants did not always attend. Staff also told us a PROMPT training session took place at another hospital, which meant it had not taken place in their own working environment.

Maternity

Staff could not remember the last pool evacuation drill that took place. However, they confirmed emergency drills took place, with the most recent drill on shoulder dystocia the week before our inspection. Staff also told us that due to staffing levels the live drills were challenging.

Compliance with the various courses in the generic trust mandatory training programme, not including safeguarding training, ranged from 63% to 100% for maternity service staff overall. Courses with the lowest compliance included resuscitation level 1, resuscitation level 2 and health and safety for managers.

The MMD included training on perinatal mental health disorders, risk assessment and referral routes, and MMD compliance for midwifery staff was 95%. We did not receive any data for perinatal mental health training for medical staff. Clinical staff were required to complete training on recognising and responding to women with mental health needs, learning disabilities, autism, and dementia. We saw this was included in trust mandatory training requirements for medical and midwifery staff, however, we did not receive this compliance data.

Managers monitored mandatory training and alerted staff when they needed to update their training, but this did not always ensure compliance. Mandatory training compliance rates were monitored on the maternity dashboard. Managers told us the practice development midwives (PDM) had responsibility for producing the training needs analysis (TNA), and the Head of Midwifery for ensuring the TNA could be completed. Midwifery matrons and line managers were responsible for making sure staff were able to attend training. The TNA was also presented to the Maternity Governance Committee to be agreed and monitored.

Safeguarding

Staff generally understood how to protect women from abuse and the service worked with other agencies to do so. However, staff did not always have training on how to recognise and report abuse or know how to apply it.

Nursing and midwifery staff did not always receive training specific for their role on how to recognise and report abuse. Compliance with level 3 safeguarding training was 66% for midwifery staff. Adult safeguarding training also included supporting people living with dementia, learning disabilities and autism, and mental ill health. Managers told us they were prioritising midwifery staff attendance at safeguarding training with a deadline of 31 March 2023, and that they had organised extra drop-in sessions to enable staff to attend around work.

Medical staff received training specific for their role on how to recognise and report abuse. Compliance with level 3 safeguarding training was 96% for medical staff.

Staff did not always know how to make a safeguarding referral and who to inform if they had concerns. We received mixed information from staff about how to make safeguarding referrals. For urgent safeguarding concerns staff would contact the duty social worker at the Multi-agency Safeguarding Hub (MASH) by completing an online form or telephoning. For non-urgent safeguarding concerns, staff would complete a 'cause for concern' form and send this to the Eden team electronically, who would make decisions about escalation or referrals. The Eden team was a team of midwives dedicated to providing care for mental health and complex social needs during pregnancy and the postnatal period. However, one member of staff we spoke with did not know who the safeguarding lead was and said they would tell the ward coordinator about any safeguarding concerns.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect women, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Ward areas and suitable furnishings appeared clean and maintained. The areas we visited were visibly clean. The curtains around beds were disposable with dates displayed.

The service did not always perform well for cleanliness. Cleaning audit data for September to November 2022 showed overall compliances of over 97.6% for central delivery suite and the maternity ward. A breakdown of cleaning audit data for central delivery suite and maternity ward for October and November 2022 showed that overall, 87% and 88% of the audit results met the service level agreement (SLA) of a 95% score for cleanliness in the different areas of central delivery suite and the maternity ward, respectively. There were no cleaning audits for December 2022, which managers told us was due to deep cleans within the trust and domestic services staffing issues. Managers told us daily checklists were completed by the domestic ward staff. We saw examples of the daily checklist proformas used for this, however we did not see completed records, except for 1 completed for the maternity ward for a day in November 2022.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Staff were wearing masks and uniforms or scrubs. However, we observed that staff did not always use hand sanitiser or wash hands before carrying out procedures. We requested hand hygiene audits for the last 3 months. The results of hand hygiene audits for central delivery suite showed compliance of 97% in December 2022 and 100% in November 2022 with no audit completed for October 2022. The maternity ward hand hygiene audits showed compliance of 91% and 92% for October 2022 and November 2022 respectively, but 79% for December 2022. Managers told us that if compliance fell below 80% this would be escalated to the area manager and re-audited within 2 weeks. We did not see an action plan for the December 2022 audit result of 79%.

The service supplied the overall results of infection prevention and control audits for September and October 2022. The matron review of delivery suite showed 100% compliance in September 2022. There was a self-review for delivery suite in October 2022, which also showed 100% compliance. The maternity ward showed 100% compliance for September 2022 on both self and matron review, and 100% compliance on self-review, but 88.2% for matron review, in October 2022. The maternity recovery area showed 100% compliance on self-review for both months. We saw the results of an IPC general ward audit dated December 2022 displayed in a staff area of the ward which showed a score of 80%, to be re-audited.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. We saw that equipment in the areas we visited was labelled with the date of cleaning and dates were current.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Access to delivery suite and the maternity ward was by swipe card only, all doors were closed, and no tailgating was observed. Corridors were brightly lit and clutter free.

However the design of the environment did not always follow national guidance.

Triage

Triage was located on delivery suite close to the main reception and had 3 bed spaces within the bay. However, the rapid assessment room which was used for the first stage of the triage process was in the midwife led unit, which was in a separate area of the maternity unit.

This meant the triage midwife would leave triage to go to rapid assessment, leaving other women or birthing people in triage unattended. We were not assured that there was oversight of women in triage when the dedicated triage midwife was seeing someone in rapid assessment. However, we were also told that basic observations were done by a maternity support worker in the rapid assessment. This also meant the triage pathway was disjointed and encouraged women, birthing people and their partners to walk through the maternity unit which posed a risk to security and birth experience. We were told there was a capital project underway to relocate the current bereavement suite to create an improved triage environment.

If there were more than 3 women or pregnant people in triage at the same time, staff told us they would be asked to wait in a room further down the main corridor on delivery suite. This was a risk because there was no direct line of sight in an emergency.

Midwife led unit

The midwife led unit was co-located at the end of delivery suite, this meant there was ease of access should women or birthing people need urgent transfer to the delivery suite. There were 2 birthing rooms with birth pools.

Delivery Suite

There were 7 delivery rooms on delivery suite. There was a maternity theatre where emergency cases took place. The elective caesarean section lists took place in main theatres, which were on the same floor near the maternity unit but in a physically different area of the hospital. This meant the consultant on call would need to leave delivery suite should they be required during elective cases.

The bereavement room was located at the entrance to delivery suite and near to the ward kitchen. This meant people using the bereavement room experienced noise from people passing by. The entrance to the bereavement room was on delivery suite, which was not private. Staff told us they were planning to move the bereavement room to the midwife led unit where it would have a private entrance, however there was no time for the completion of this work.

Antenatal and postnatal ward

The antenatal and postnatal ward had 29 beds.

There was no emergency buzzer system in antenatal clinic.

There was no environmental ligature and ligature point risk assessment in line with national guidance.

There was no dedicated transitional care area. This meant that sometimes babies would need to go to the neonatal unit for treatment. We were told there were plans to use one of the bays for this, however there was no timeframe for this.

Staff generally carried out daily safety checks of specialist equipment. The service completed emergency equipment checks on paper and electronically. It was procedure for the trust to contact the department if the daily online checks were not completed. Between August 2022 and the date of our inspection (10 January 2023) we saw on delivery suite that the emergency trolley paper checklist showed all checks were completed. However, for the adult resuscitation trolley, checks were missing for 3 consecutive days in December 2022. Equipment checks on Ward 11 were completed electronically, and we did not see these during inspection.

Maternity

The service had enough equipment to help them to safely care for women and babies, however, it was not always serviced and ready for use. The equipment we saw during inspection had in date maintenance test labels. However, the medical device equipment lists supplied for delivery suite and the maternity ward showed there were 6 pieces of equipment in service which were slightly overdue for testing (due in December 2022) and 1 in service in antenatal clinic due for testing in September 2022. We noted a significant amount of the equipment based in the community was overdue for testing.

We saw there was a shower out of order on the maternity ward, which had been reported in September 2022, however, it had still not been repaired.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman or take action to remove or minimise risks. We were not assured that staff always identified and quickly acted upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration, however we were not assured the tool was always completed correctly or that women were always escalated appropriately. The service used the Modified Early Obstetric Warning Score (MEOWS). We reviewed 6 MEOWS charts during inspection which showed the MEOWS had been completed, scored, and escalated. MEOWS audits were carried out every 6 months, we saw an audit of 20 MEOWS charts in July and August 2022 which showed areas with some non-compliance, including date of observation, urine output (0% compliance), alert voice pain and unresponsive (AVPU) score, oxygen saturation levels, oxygen given, total MEOWS score, and accurate calculation of total MEOWS score. None of the charts audited scored high enough to trigger the record of actions requirement, therefore there was no evidence to identify if MEOWS was escalated appropriately. The scope of the audit did not include whether lower scores had been escalated to the midwife in line with the policy, however, there was some non-compliance with repeating observations within 30-60 minutes for these lower scores. We saw an action plan resulting from this audit which involved amending the audit questions and emailing staff about some areas of non-compliance, then re-auditing in 6 months.

At the previous inspection, we told the service it must ensure appropriate escalation to medical staff when MEOWS are triggered. The small size of the MEOWS audit and the infrequency of audits meant we were not assured the service had robust oversight of early warning scores and their escalation. We were not assured that audit findings had been used to make improvements in the areas of repeated non-compliance.

Sepsis gram negative audits from July 2022 for delivery suite and the maternity ward showed compliance of 96% and 87% respectively, with some areas of non-compliance in considering urine output, recording oxygen delivery method and amount of oxygen given for delivery suite, and again considering urine output for the maternity ward. Audits of the National Early Warning Score (NEWS) and escalation of deteriorating patients were completed by the Critical Care Outreach team every 6 months. The results for Ward 11 showed compliance of 69% in April 2022 and 94% in October 2022. The October results also showed areas of non-compliance with similar themes to the Sepsis gram negative audit. We did not see data for the delivery suite or numbers of records checked in the NEWS audits.

The service used the neonatal alert, trigger and track (NATT) tool as an early warning system for babies requiring transitional care (TC) as well as those on the neonatal unit (NNU). Managers told us there was 100% compliance across TC and NNU with recording observations, escalation as required and pain assessment, however we did not see any further details of this audit.

We observed that a multidisciplinary team attended promptly when there was an emergency call on the midwife led unit during our inspection.

Maternity

Staff did not always complete risk assessments for each woman on admission / arrival, using a recognised tool, and review this regularly. Staff told us most women visiting triage phoned the unit in advance of attending, and that they would check their records and previous visits would be noted. We observed this had been checked for the women and pregnant people visiting triage during our inspection. However, there was no formal system or process for identifying repeat callers to triage.

There was no dedicated telephone line for triage, we saw it was shared with delivery suite and meant that calls to triage may be answered by a delivery suite receptionist. However, there was a procedure in place that clerical and support staff should not take any clinical details or give advice, only demographic information, and transfer the call to the triage midwife. However, we did observe one instance of a receptionist advising a GP that a service user should attend the emergency department.

Women attending for triage were first seen in a 'rapid assessment' process. This involved a COVID-19 risk assessment, MEOWS scoring and a Red Amber Yellow Green (RAYG) rating. The service had introduced this RAYG rated triage system in August 2022.

Staff used a folder of algorithms for the 8 most common reasons for presenting to triage, which guided them through the assessment of women and pregnant people and determined the RAYG rating of a given presentation. The RAYG rating outcome then gave instructions for escalation, including time frames. This meant that RAYG ratings and escalation should be consistent for all women and pregnant people.

The information from the assessment was initially recorded on a paper proforma and then transferred to the electronic records system by the triage midwife.

Staff told us the rapid assessment step before triage meant that women with high MEOWS scores or red RAYG ratings could be transferred directly to labour ward rather than triage. However, we were not assured the rapid assessment process provided any additional benefit as the same process could be carried out in triage if beds were available.

We were not assured that managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. The triage rapid assessment audit sheet proforma required the times for arrival to triage, initial assessment, paging the doctor, doctor returning pager call, review by the doctor and discharge or transfer from triage to be documented. The waiting time was recorded on paper, transferred to the electronic system afterwards, and could be printed from here. However, we were not assured waiting times were always recorded accurately because staff told us the waiting time was recorded from initial contact with the midwife at rapid assessment, and not always the time a woman arrives at reception. Therefore, if there was a delay between reporting to reception and being assessed in the rapid assessment room, this may not always be recorded.

As obstetric cover for triage was provided by delivery suite staff, this could cause delays when waiting for staff to be available. Staff told us there was a requirement to see women and pregnant people within 15 minutes, but that this rarely happened. Staff also told us that an incident report was not always completed following delays.

As there had not been any audit of the current triage system being used, we could not be assured that women were able to access the care they needed within the required timeframes.

Maternity

We reviewed 8 care records during our inspection. We saw 5 women had attended the rapid assessment unit or triage, and for 2 of these cases there was no RAYG rating. The RAYG rating triage process had not yet been audited since it was introduced in August 2022 but was due to be audited from January 2023. However, due to the lack of audit the service could not be assured that women were being assessed and escalated according to the required timeframes.

We saw staff used a fresh eyes approach to monitor fetal well-being. CTG documentation was applicable for 6 of the 8 records we reviewed. In all records with CTG traces we reviewed, fresh eyes had been performed. However, the service was not undertaking any CTG/fetal well-being audits. This was a risk because it meant the service could not be assured staff were recognising, documenting, categorising, and escalating deteriorations in fetal well-being according to best practice guidelines. Due to lack of capacity the service was unable to offer serial ultrasound scans from 28/40 as recommended by the Perinatal Institute GAP Growth Surveillance Programme. This was listed as one of the top 3 risks for the service.

Staff knew about and dealt with specific risk issues. In all records we reviewed women had completed venous thromboembolism risk (VTE) and the standard questions for identifying domestic abuse.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). There was a psychiatric liaison team for acute mental health conditions. Staff could complete an electronic referral or phone the team within the hospital for urgent concerns.

Staff completed risk assessments for women thought to be at risk of mental health conditions. In the 8 sets of records, we looked at, we saw that a mental health assessment using the Whooley questions had been completed.

The Eden team was a team of band 7 midwives for service users requiring additional care during the antenatal and postnatal period due to vulnerabilities, mental health conditions, or safeguarding reasons. Staff told us they would complete a 'cause for concern' form which was sent to this team, who would then decide about further escalation or involving the mental health team.

Shift changes and handovers did not always include all necessary key information to keep women and babies safe, and we were not assured that all the relevant staff members were always included. Safety huddles did not always take place and were not embedded. We observed the multidisciplinary (MDT) handover in the morning. This involved obstetric and anaesthetic staff and the labour ward coordinator. Women and birthing people on delivery suite were discussed in the expected level of content and detail. People who were antenatal or postnatal on the maternity ward were also discussed, including inductions of labour.

An audit of the MDT handover attendance over July 2022 to October 2022 showed that results recorded as yes for attendance at the MDT handover, ranged from 15.3% to 32.1% of occasions for medical staff and the delivery suite coordinator. This meant we were not assured that all the relevant staff were always present at the MDT handover. We observed the evening MDT handover and noted that there was no anaesthetist present.

We observed the delivery suite ward round. Midwifery staff used a situation background assessment and recommendation (SBAR) format to present information to the ward round. The anaesthetic consultant did not attend the ward round.

The service used a ward round book to be signed morning and evening to confirm the delivery suite ward round had been completed by the consultant. Audits of the twice daily consultant ward round in September and October 2022, showed a compliance of 64% for the morning and 68% for the evening ward rounds, with most of the reasons for non-compliance being no documentation of attendance. This meant we were not assured the delivery suite ward round was always completed with the consultant on call or that the service had good oversight of this.

Staff told us that safety huddles had been relaunched in August 2022. However, these were not always carried out, huddles were not comprehensive, and they were not embedded as a process. Staff we spoke with told us that compliance with daily safety huddles was poor. We observed a safety huddle following the morning multidisciplinary handover and found that it was noticeably short, was not well organised, and did not include representatives from all the relevant areas of the service, such as neonatal. The discussion about midwifery staffing was very brief and there was no discussion of medical staffing. We observed that following the delivery suite ward round the on-call consultant then attended part of the maternity ward round with the middle grade doctor, before being called to theatre and leaving the middle grade and SHO doctors to complete it.

An audit of delivery suite safety huddles in September and October 2022 showed that only 53% of huddles planned since the relaunch were completed. (Prior to this only 38% of planned huddles were completed in July and August, before 16 August). Of the huddles which happened, attendance was 70.8%, 98.6%, 84.7% for the obstetric consultant, senior midwife and obstetric registrar respectively, but 22.2% and 0% for the obstetric anaesthetist and neonatal team respectively. There was no attendance by matrons or managers. This meant we were not assured that safety huddles always took place or that all the required staff members attended them.

The use of the SBAR protocol was not audited, however managers told us they were planning to include an SBAR audit in the future, however there was no confirmed date for this to be completed.

We saw the results of audits of completion of the WHO surgical checklist for October, November and December 2022, which all showed 100% compliance for maternity theatre. As there was no breakdown of which elements of the WHO checklist were looked at for the audit, we are unsure of the audit methodology. We observed the WHO checklist 'time out' during inspection and noted that some elements were missed out, including allergies and ASA grade. Elective caesarean section lists were based in main theatres and as we do not know which theatre this was, we cannot comment on compliance for this.

Midwifery Staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers did not always review and adjust staffing levels and skill mix.

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance.

The service did not have enough midwifery staff to keep women and babies safe. Between June 2022 to November 2022 there were 30 maternity red flags. 57% (n17) were classified as delayed or cancelled time critical activity, 17% (n5) as missed or delayed care, 10% (n3) as missed medication during hospital admissions, 7% (n2) as less than 2 core midwives on delivery suite, 3% (n1) as less than 3 core midwives on delivery suite, 3% (n1) as a woman waited more than 30 minutes for pain relief, and 3% (n1) as delayed recognition and action on abnormal vital signs/serious health problem.

Maternity

The national reporting and learning data from 01 January 2022 to 31 December 2022 showed 10 incidents where midwifery staffing resulted in delays in providing care, or an inability to ensure staffing was in line with the planned levels and an inability to adhere to the staffing requirements laid out in the maternity incentive scheme. There were 3 incidents where induction of labour was postponed for high-risk women due to poor staffing. There were 6 incidents where midwifery staffing fell short of planned staffing levels placing women at risk. There was 1 incident where a midwife continued to work despite being unwell and this being escalated to the central delivery suite coordinator. This resulted in another staff member acting beyond their scope of practice.

Staff on the maternity ward told us they were not always able to take breaks.

Not all staff were trained to undertake the new-born and infant physical exam (NIPE) and they did not always have a NIPE trained staff member for postnatal people. This meant we were not assured NIPE checks were always completed in a timely manner. However managers told us there had been no screening gaps incidents reported to the Screening Quality Assurance Service.

The service was in the advanced stages of implementing the midwifery continuity of carer (MCoC) model in line with national recommendations. However, we saw between January and December 2022 examples of incidents where MCoC impacted on the care women and birthing people received. Data received and staff interviews showed that since MCoC started, it had been difficult to ensure there were enough staff on the maternity ward (ward 11). We saw evidence that showed there was often more than 1 woman or birthing person from the same MCoC team on delivery suite. This meant women and birthing people in the MCoC programme were not guaranteed to be cared for in labour by a midwife they knew.

We received information from staff and saw evidence that there was limited succession planning for the MCoC teams. Due to a significant number of midwives working in the MCoC teams either on or about to go onto maternity leave, more core staff had been allocated to fill these posts, which negatively impacted on the core staff workforce. In addition, there was a poor skill mix in the MCoC teams as newly qualified and inexperienced midwives were asked to case load within the teams.

Staff we spoke with corroborated these concerns that MCoC was resulting in inexperienced midwives, lack of the correct skill mix and experience in the team, junior midwives not receiving the support they need, against a background of the COVID-19 pandemic affecting the amount of experience they may usually have gained, and pressure for junior midwives to go out to provide MCoC.

There was a band 6 midwife and band 3 maternity support worker covering triage during the day from 7am to 8pm. However, there was no dedicated triage midwife at night. This meant that from 8pm to 7am triage was managed by the night team on delivery suite. Managers told us they were planning to decide whether to make a business case for a dedicated triage team overnight.

Staff told us there were 25 to 30 appointments per day at the maternity assessment unit (MAU). This unit was staffed by 1 midwife, 1 maternity support worker and 1 registrar. Staff said they often finished late and when they stopped for a break there was no cover.

The ward manager could not always adjust staffing levels daily according to the needs of women. Managers told us the manager on call would be made aware of staffing gaps and would plan to manage acuity and capacity, which may include the on-call manager working clinically. However, interviews identified the maternity service did not always

conduct safety huddles, and those which did take place were not comprehensive, which was not in line with NHS Improvement (2019) guidance. The inspection team observed 1 huddle and observed there was minimal discussion relating to midwifery staffing and service user flow across the maternity unity and no discussion regarding medical staffing. There was no mechanism to audit the effectiveness of safety huddles.

Staff we spoke with at inspection told us they did not know who the on-call manager was and would instead escalate concerns to the delivery suite coordinator. They said the manager on call during the day does not do a round and that all staffing goes through delivery suite coordinators.

The number of midwives and healthcare assistants did not match the planned numbers. Fill rates reported in board papers had been consistently below planned levels. For example, in August 2022 the registered midwife fill rate was reported as 72.6%, in September 2022 the registered midwife fill rate was reported as 76.5%, and the midwifery support workers fill rate was reported as 63%. We saw staffing was challenged during the inspection. Planned staffing levels on the antenatal and postnatal ward was 3 midwives, however we saw 2 midwives (1 was the midwife in charge and the other was newly qualified), 1 registered nurse, 1 nursery nurse and 1 healthcare assistant. There were 19 patients including 3 women awaiting induction of labour. Staff reported the ward was staffed below planned levels most of the time, usually having only 2 midwives and a general nurse, and that the registered general nurse was often sent to other wards around the trust.

The maternity dashboard for April 2022 to December 2022 showed that in only 1 of these months there was 100% one to one care, 2 months where one to one care was red rag rated at 95.2% and 95.7% and with the other months being amber rag rated. For April 2021 to March 2022, the dashboard showed 1 to 1 care was amber rag rated for all months with an average rate of 97.6%.

The service had low and/or reducing vacancy rates. Board papers for December 2022, October 2022 and September 2022 showed vacancies of 1.8, 1.7 and 2.73 WTE respectively for band 7 substantive staff and 0, 3.27 and 2.5 WTE respectively for band 5/6 substantive staff. We did not see vacancy data for maternity support workers.

Sickness rates for midwifery staff for the 6 month period July 2022 to December 2022 ranged from 3.98% to 5.23%.

Managers told us they would offer additional shifts to all substantive midwives and bank/agency midwives. They could also ask continuity midwives who were under hours to work a shift. They told us that if unable to cover midwifery shifts, they would try to increase support for this shift with more maternity support workers or staff nurses.

There was an agency midwife maternity induction pack, however we do not know compliance rates with induction for agency staff.

Managers did not always support midwifery staff to develop through yearly, constructive appraisals of their work. Data for annual appraisals showed that compliance ranged from 68.3% to 100% within the 6 groups of midwifery staff, being 100% for community midwives and 68.3% for the core maternity team, then 76.9% for continuity of carer, 78.6% for antenatal clinic, 80% for midwifery management and 87.5% for specialist midwives. Managers advised us that there were known data discrepancies such as people on maternity leave, long term sickness, and leavers but without further detail we were not assured that all staff currently working in the service had received an annual appraisal.

Managers did not always make sure staff received any specialist training for their role. Evidence showed the service did not have any high dependence trained midwifery staff to support women and birthing people requiring enhanced observation. This was previously identified in our inspection of maternity services in 2018. We found 28 instances where

women and birthing people experienced significant post-partum haemorrhage which would require an enhanced level of observation but would not require transfer to the general high dependency unit. Therefore, we were not assured midwifery staff had the appropriate skills and training and experience of enhanced or high dependency care to be able to recognise and care for women and birthing people with greater care needs.

Medical staffing

The service did not have 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. We were not assured managers gave locum staff a full induction.

The service did not have enough medical staff to keep women and babies safe. There were 11 consultants employed within the service, however, only 6 were working clinically supplemented by one part time consultant, and 2 were locums.

The on-call consultant covered all emergency duties for both obstetrics and gynaecology. This meant senior obstetric staff may not be able to attend delivery suite in an emergent situation. We saw evidence which showed that between 01 January 2022 to 31 December 2022 there were 9 incidents when the lack of consultant staffing had impacted on care. We were not assured there was sufficient oversight of the consultant rota, and we found incidents where unsafe medical staffing had impacted on delivery suite care.

The elective caesarean section list was carried out in main theatres and was covered by a middle grade obstetric doctor with support from the on-call consultant as required. However, as there was only 1 on call consultant, this meant if they were busy with delivery suite or other areas, they may not be available to assist the middle grade with elective sections if needed.

At the time of our inspection the consultant rota provided 65 hours of consultant cover per week. Plans were in place to increase this to 79.5 hours (Monday to Friday 08:00 to 20:30 and 08:00 to 13:30, 17:30 to 20:30 at weekends).

During our inspection we were told the medical workforce was under review with Operational Management liaising with the board to support the recruitment and retention of staff. We were told the service had recruited 2 obstetrics and gynaecology consultants due to commence February and March 2023. Plans were being developed to recruit a further 3 obstetric consultants to separate the obstetrics and gynaecology rota with an aim to provide continuity of care to service users and staff, however, there was no proposed date for completion.

There was a dedicated middle grade anaesthetist for the elective caesarean section list who reported to the delivery suite consultant anaesthetist.

Anaesthetic cover of the delivery suite and obstetric emergency theatre would typically be a consultant and trainee. This meant that if assistance was required for electives, the trainee would potentially be left in delivery suite or obstetric emergency theatre. However, we were told the middle grade anaesthetist covering electives was usually very experienced.

There was an obstetric anaesthetic consultant on site 80 hours per week (07:00 – 19:00) during weekdays. They were accompanied by junior doctors in training. Support out of hours was covered by a senior anaesthetist (19:00 – 07:00), supported by a consultant on call.

Staff told us theatre recovery would be covered by staff from main theatres, including overnight.

The medical staff did not match the planned number. We found there were also shortfalls in the junior doctor rota which was back filled with locums. Staff we spoke with told us there were 2-3 locum doctors on the junior doctor rota and it was typical for there to be 1-2 locum junior doctors per day.

Sickness rates for medical staff were high. We saw that in September 2022 the sickness rate was 11.9%.

We were not assured managers gave locums a full induction. Information from interviews, and incidents, identified that locums were not always fully aware of trust processes and procedures.

Consultants had yearly appraisals of their work. Data submitted by the service showed that consultants were all compliant with annual appraisal until February 2023. We did not see appraisal data for junior doctors.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always clear, up-to-date, and easily available to all staff providing care, but were stored securely.

Women's notes were not always comprehensive, and staff could not access all relevant information easily.

We found multiple record systems with no single point of overall visibility. The electronic care records system was completed in the community, for antenatal appointments and for day admissions. Information gathered at triage attendances was also entered on to this electronic system from paper triage forms.

Risk assessments such as carbon monoxide monitoring and domestic abuse were recorded electronically. Inpatient admissions were recorded on paper notes, including intrapartum care.

Risk assessments such as VTE and MEOWS were completed on paper. In addition, service users had their own records which were not completed when an inpatient. This posed a risk to women and birthing people because community midwifery teams would not be aware of any interventions which occurred during inpatient episodes of care.

There was an orange booklet in the paper notes for child protection issues for both existing and expected children.

There was no mobile computer system in use at ward rounds, which meant during ward rounds there was no access to previous notes including antenatal care, electronic risk assessments, scans, blood results, and safeguarding concerns to support decision making by the multidisciplinary team.

We reviewed 8 sets of care records during our inspection. However, we found these were completed to varying standards. For example, vitamin D had not always been offered appropriately, carbon monoxide check had not always been done at booking, in triage SBAR was completed, but there was no RAYG rating, and child sexual exploitation assessments for young women under 18 and children were not always completed. Managers told us they were not undertaking any documentation audits. With the absence of records audits the service could not be assured staff were documenting care contemporaneously and in accordance with their registration and best practice guidelines.

Findings from a perinatal mortality review identified records were incomplete or not contemporaneous and there was a lack of management plans and risk assessments.

Staff told us that themes from incidents included difficulties with the electronic care record systems and wrong notes/ wrong forms being completed.

Records were stored securely.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines, however these were not always safe.

Staff followed systems and processes to prescribe and administer medicines, however these were not always safe. The service had both electronic prescribing and paper medicines charts. This meant there was a risk of prescribing and administration of medicines errors.

Staff did not always complete medicines records accurately and keep them up to date. In one record we saw there was a prescription for vitamin K with no route or date, and no signature to say the medicine was given, but the electronic discharge/community form stated vitamin K had been given.

Staff generally stored and managed medicines and prescribing documents safely. Medicines we saw during inspection were in date. Medicines and FP10 prescriptions were stored in a secure locked room. Controlled medicines were stored in a locked cupboard in a locked room and there were no gaps in the controlled medicines record.

However, we found open formula milk in a fridge on the maternity ward without the date or time of opening marked, nor was there any identification on it stating which baby it was being used for.

Incidents

The service did not manage safety incidents well. Staff did not always recognise and report incidents and near misses. Managers did not always investigate incidents and share lessons learned with the whole team and the wider service. When things went wrong, staff did not always apologise and give women honest information and suitable support.

Staff did not always raise concerns and report incidents and near misses in line with trust/provider policy and national requirements.

We reviewed incidents reported by the service and by peer trusts selected based on similar attributes, context and levels of activity (from Model Hospital/NHS England). This comparison showed that between 06 December 2021 and 03 January 2023 the maternity service reported significantly lower numbers of incidents compared to peer trusts.

We saw the maternity dashboard for April 2022 to December 2022. This showed 36 cases where there was a post-partum haemorrhage of 1500mls or more. However, we reviewed the national reporting and learning system for the same time period, and this showed only 28 notifications of a post-partum haemorrhage of 1500mls or more. Therefore, there were 8 post-partum haemorrhages which were not reported.

The dashboard showed 11 instances of shoulder dystocia between April 2022 and December 2022. However, there were only 2 notifications of shoulder dystocia for the same period when we reviewed the national reporting and learning system. Therefore, there were 9 cases of shoulder dystocia that had not been reported.

Maternity

The dashboard showed 4 occasions when women and birthing people had unplanned admissions to the intensive care unit (ITU) or high dependency unit (HDU) between April 2022 and December 2022. However, there were no notifications of any unplanned admissions to ITU or HDU on the national reporting and learning system during this period. There was 1 notification where a woman had been admitted to ITU, but the notification was about poor communication and handover to the community, not the ITU admission.

Staff reported incidents to the Healthcare Safety Investigation Branch (HSIB). The service had reported 2 incidents to HSIB as per the HSIB criteria in the last 6 months. 1 incident was rejected and closed and the other was ongoing at the time of inspection. We also saw the HSIB final report for an incident that occurred in 2020. However, we could not be assured all HSIB reportable incidents were reported.

Staff told us they understood the duty of candour. However, they were not aways open and transparent, and did not always give women and families a full explanation if and when things went wrong. Managers told us there had only been 1 incident eligible for the duty of candour process in 2022, occurring in August. We saw evidence of a duty of candour discussion with a woman by telephone in August 2022, and of a letter further to that discussion dated August 2022. We also saw an example of a duty of candour letter from March 2021. One of the infographics we saw stated duty of candour had been carried out. However, duty of candour should be applied when patient safety incidents are classified as moderate or severe harm or death. We found between April and December 2022 there were 23 incidents reported as moderate in severity.

Staff received feedback from investigation of incidents, both internal and external to the service. However, there was limited evidence of lessons learned from this. The service produced infographics to share the summary of an incident and learning from the incident. We also saw some of these displayed on boards in areas around the service. Some of the examples highlighted care/service delivery problems and lessons learned but this information was quite limited. Managers told us infographics and final reports for incidents, including root cause analyses (RCAs), HSIB and Perinatal Mortality Review Tool (PMRT) reports and action plans, would also be circulated to all maternity staff via email. There was also a monthly newsletter about risk for maternity staff which contained information from the risk and governance team, including number of incidents raised, themes, learning and actions from incidents and serious incident updates. We saw examples of this for September, October, and November 2022. However, we were not assured that this was an effective way to share learning. Managers told us staff involved in incidents would receive individual emails from the risk and governance team for feedback and updates on the incident. We were also told staff could access the Professional Midwifery Advocate as required.

Staff were beginning to meet to discuss the feedback and look at improvements to the care of women and birthing people. Managers told us weekly CTG review meetings had recently been re-introduced and staff were encouraged to attend, along with paediatric led morbidity and mortality meetings where possible, which may include PMRT cases.

We were told the new quality and safety matron was planning to consider how the department could work more closely with the Practice Development team to improve learning.

There was limited evidence that changes had been made because of feedback. A few of the infographics we saw referred to changes that had been made in a guideline or policy as a result of the incident. We saw an action plan for an HSIB incident which occurred in April 2020, and which rated all actions as complete, however we did not see robust evidence of changes made.

Managers did not always investigate incidents thoroughly. There was no risk and governance clinical lead from obstetrics at the time of inspection, and staff told us that RCAs of incidents were completed by a different hospital.

Therefore, we were not assured that the investigation of incidents received the necessary medical obstetric perspective, and staff told us some consultants were not engaging in the incident analysis and learning process. However managers told us the external completion of RCAs by partners within the Integrated Care System (ICS) was occasional and that it was routine for incidents to be investigated internally.

At the time of inspection there were 2 incidents that had been open for more than 60 days, 1 of which was classified as minor harm and 1 as no harm.

Is the service well-led?

Inadequate 

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

Leadership

Leaders did not always have the skills and abilities to run the service. There was evidence they understood some of the priorities and issues the service faced but no robust evidence that they were able to manage these effectively. They were not always visible and approachable in the service for women and staff. They were not always able to support staff to develop their skills and take on more senior roles.

The maternity service sat within the Division of Surgery and Women's and Children's Services within a group which also included obstetrics, gynaecology, and paediatrics. The Head of Midwifery (HoM) was new in post, having joined the trust in November 2022. There was no Deputy Head of Midwifery, but the HoM was supported by a Consultant Midwife. These posts were in turn supported by a Midwifery Matron and a Maternity Quality and Safety Matron.

There was no clinical lead for obstetrics and this post had been vacant since August 2022. The Assistant Medical Director (AMD) for the Division of Surgery and Women's and Children's Services was covering this role with support from an obstetric consultant as they were not an obstetrician. The absence of an obstetric clinical lead meant there was a lack of obstetric specific leadership and a lack of obstetric clinical input and support for governance of the service.

We were not assured that leaders always understood the challenges and issues within the service. Where there was evidence of understanding of the challenges facing the service, we did not see evidence that effective plans translated into tangible actions and improvements, particularly as some of the issues identified had existed for an extended period, and some had been identified at the previous inspection in 2018.

There was evidence that the MCoC model was impacting on safety, quality and sustainability, and the impact on staffing had been acknowledged in a review and communicated by staff. However, the service had not reviewed the model of care to ensure there was safe staffing in the acute setting.

There was a named non-executive director with responsibility for Maternity Services. We saw the minutes of meetings of the maternity and neonatal safety champions for December, August and May 2022 and an update from November 2022. There was some evidence that representatives from the maternity service met with board level champions to escalate current and emerging safety concerns, and to consider progress with action plans. These meetings were intended to be monthly, however they suffered from a lack of attendance and were not always quorate. This meant we were not assured there were consistent and reliable channels in place for timely escalation of safety issues. We did not see the action plans so cannot comment on evidence of progress.

Feedback on the visibility and approachability of leaders was mixed. There was some limited evidence from staff that leaders were visible. However, some staff raised concerns about a lack of visibility of managers and the senior midwifery team. They also raised concerns that they had tried on numerous occasions to raise safety concerns with the maternity management team. They stated an absence of any action/support and felt concerns were not always listened to, or were listened to but not acted upon. They had written a letter to the trust board highlighting their concerns.

Managers told us they had implemented the advocating for education and quality improvement model. There was a team of professional midwifery advocates (PMA) and lead PMA, and all had completed the PMA module at university. Midwives could self-refer to PMAs for support and there was a PMA session on the MMD.

There were 2 practice development midwives (PDM) working with newly qualified midwives to complete the 1-year preceptorship programme.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, which it told us had been developed with relevant stakeholders. The vision and strategy acknowledged the importance of sustainability of services and alignment with local plans within the wider health economy.

The service provided evidence which described the vision as 'providing a high quality, safe maternity service' which was 'fundamentally built upon the principles of kindness, professionalism and caring to all' and which aimed to 'provide continuity of care in partnership with our service users throughout their pregnancy to achieve the best outcomes based upon the individual need' and to 'help create and nurture the families of the future.'

The aims to be achieved within the strategy 2019-2024 were personalised and effective care, access to maternity care, promoting positive emotional health for women and staff, preparation for birth and beyond, safety and quality and future workforce. They had identified key priorities to achieve these aims, and endpoints which would signify when they had been achieved. Managers told us this strategy was developed in collaboration with staff and women and their families.

The vision and strategy demonstrated an appreciation of the need for sustainability. The strategy aim of future workforce referred to ways to make the workforce sustainable, including succession planning, work life balance and training. The strategy aim of safety and quality referred to commitment to system wide working in collaboration with the Local Maternity and Neonatal System (LMNS), maternity network and regional partners (in relation to shared learning).

The service also supplied a draft service development plan (SDP) dated December 2021 (but not signed off), which included some information about the specialty vision, which were aspirations for what it wanted to achieve. These also demonstrated an appreciation of the importance of sustainability. They included delivering the best possible level of safe and effective care, providing education, support, and development for staff to deliver excellence in practice and be employer of choice, effectively managing financial resources, estate, and infrastructure to ensure sustainability and actively participating in innovation, research, and partnerships to transform services. The document also referred to local health inequalities and Integrated Care System (ICS) alignment and integration, albeit not comprehensively. Managers told us about a revised SDP for 2023 that was currently in development and was due to be completed by the end of January 2023.

Interviews showed that the leadership had a good understanding of the nature and demographics of the population they were serving and the importance of addressing their specific needs. They were able to recognise important components such as MDT working, however they still planned to pursue the continuity of carer model as a key part of their strategy, despite findings in relation to this model suggesting they should do otherwise.

Although the service was able to articulate the vision and strategy and an appreciation of salient factors in relation to this, we did not see robust evidence of good progress with this that provided us with assurance that it was well underway.

Culture

Staff did not always feel respected, supported, and valued, but most were focused on the needs of women receiving care. The service did not always have an open culture where staff could raise concerns without fear.

There were limited numbers of staff only who felt supported, respected, and valued.

We saw the results of a pulse survey undertaken with the obstetrics and gynaecology workforce in June 2022. Of the 235 staff who were invited to participate in the survey, only 36 responses were received (11 from medical staff and 25 from midwifery staff).

The results from the pulse survey showed 88% of midwives and 18% of medical staff had experienced or witnessed behaviours which were not in line with the beliefs and values of the trust. In addition, when asked if multidisciplinary working had improved in the last 6 months, all medical staff felt it had either improved or remained the same, but 52% of midwifery staff felt it had deteriorated. The pulse survey identified an ongoing divide in experiences working within the maternity service between the obstetric and midwifery staff. This had persisted and remained evident at the inspection, and in information received after the inspection. The service had tried to address this previously without success, but anticipated improvements could be made with actions such as the new consultant job plans, the new Head of Midwifery and continuation of the Leadership to Care programme.

The service displayed information about how to raise a concern in women's' and visitors' areas. There was a family and friends / service user feedback form displayed on a trolley with a box for completed forms. However, there was no signage to identify cards on the trolley. We also saw family and friends' information displayed in the maternity ward.

Evidence provided by the service showed they had received 3 formal complaints during October to December 2022 which were still under investigation at the time of the inspection. However, the service was able to give some examples of improvements or changes that had been made because of complaints.

There was a maternity experience midwife who monitored and investigated complaints. We were told any trends in complaints would be escalated to the relevant ward manager, and potentially the Matron and HOM if serious, and concerns about clinicians would be escalated to the relevant line manager.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities and did not always have regular opportunities to meet, discuss and learn from the performance of the service.

Maternity

There was a governance structure in place with lines of reporting within the maternity service. The structure was intended to allow for escalation upwards and information to flow down the divisional structure. In addition, the HOM would bring maternity issues to the weekly divisional triumvirate meetings. There were also informal twice weekly meetings of the maternity triumvirate where safety and performance issues could be discussed.

However, whilst the service was able to describe the structures in place, these did not translate into effective governance systems in practice to ensure that risk and performance issues were identified, escalated appropriately, and addressed with timely action.

An obstetric consultant had been supporting the obstetric governance role and there was an arrangement for support from an obstetrician from another local NHS trust going forward. At the time of our inspection there were no formally identified leads for clinical governance, labour ward or fetal monitoring. These were key roles to ensure and promote patient safety and were not currently job planned for any of the consultant obstetric workforce. The service advised that they were creating new consultant job plans, which included allocation of these roles, however there was no confirmed date for the completion of these.

We saw the minutes of clinical governance meetings of the Division of Surgery and Women's and Children's Services for September, October and November 2022. While all 3 had been attended by the Risk and Governance Matron, we could not see HOM and Divisional Operations Director (DOD) presence at 2 out of 3 of these. At the October meeting the HOM, DOD and both Assistant Medical Directors were absent. As there was no obstetrics clinical lead, there was no medical obstetrics representation at these meetings.

Incidents were not consistently reported and there was limited evidence of learning from incidents. This had continued since our previous inspection in 2018 inspection, when maternity services were told "it must ensure all incidents are graded according to harm and are reviewed in full in a timely manner." However, we found the service had not made significant progress on rectifying this, due to discrepancies between the number of incidents reported on the dashboard compared to the national reporting and learning system.

We saw the minutes of the Maternity Clinical Incident Panel (MCIP) for September, October, November and December 2022 and saw that incidents and actions were discussed, however we could not tell from the minutes how comprehensive this was as information was limited. We noted the outsourcing of a RCA to an obstetrician at a local NHS trust. We also saw the minutes of Maternity Clinical Governance (MCG) meetings for September and November 2022 (combined with MCIP). This showed that items including service risks, complaints, compliments, standard operating procedures (SOPs) and guidelines and mandatory training were discussed.

Managers told us that all staff members were invited to attend the MCIP and MCG meetings, including obstetrics, midwifery, neonatal and anaesthetics, and external professionals and the LMNS. We were also told this was a sign off requirement for preceptorship midwives. However, we did not see evidence that a wide range of staff from all levels attended both the MCIP and MCG meetings, as most staff attending were senior staff or staff in leadership roles for the minutes we saw.

The divisional triumvirate was planned to meet weekly, however, we saw from minutes for some of the divisional triumvirate meetings, that the triumverate did not always meet on a weekly basis. Items discussed included updates on quality and safety and maternity. The most recent minutes available were 10 October 2022. Managers told us minute taking was paused due to a vacancy but would be starting again in January 2023.

Information about incidents and risks was displayed around the service on risk and governance display boards, this information was also disseminated by email.

Managers told us there were also twice weekly senior management team meetings, weekly one to one meetings for the senior team with their direct line managers, monthly meetings for the midwifery coordinators, weekly core team drop-in sessions for staff to attend if they wished, and continuity of care team meetings. The new HOM was planning to relaunch unit meetings.

The service was participating in national audit programmes and confidential enquiries, including diabetes in pregnancy, maternity, perinatal audit and MBRRACE programmes. Managers told us any recommendations from these reports which were not met would have an action plan put in place, and this would be circulated on a monthly basis from the clinical effectiveness and quality assurance department to the maternity leadership team and discussed at governance meetings. However, we did not see robust evidence of action plans translating into changes.

The service was not completing key audits at a local level. For example, there were no audits of the triage process, CTG and fetal wellbeing, the SBAR tool and maternity records. This meant we were not assured the service had oversight of fundamentals of care and performance. Given that issues with MEOWS scores had been raised at the previous inspection, it was concerning that there did not appear to be a robust and frequent audit programme for this.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance, but these were not always effective. They had not always identified and escalated relevant risks and issues or identified actions to reduce their impact and did not always have effective plans to improve.

The service had identified the top 3 approved maternity department risks as delays to upgrading the electronic records system, preventing the installation of an electronic patient portal, which is preventing access to services at the earliest opportunity for service users, high smoking at time of delivery (SATOD) rates and lack of serial tri-weekly ultrasound scans for high risk cases from 28 weeks gestation in line with the GAP Growth surveillance programme. The register showed action plans with persons responsible and target dates. However, information supplied by the service showed that the risk of the depleted consultant work force was currently a provisional risk on the trust risk register, even though this had been an issue for several months with significant impact.

Managers told us that risks would be highlighted at the monthly MGC meetings, provisionally added to the trust risk register, and then escalated to the monthly Divisional Clinical Governance (DCG) meetings where they would be discussed for divisional approval. We saw that the review of divisional risk registers was listed as an item in the minutes of the DCG meetings, but that this was reviewed outside of the meeting. Managers told us that the downgrading of divisional risks occurred only after discussion with the maternity leads at the MCG meeting.

There was also a Patient Safety and Quality Committee (PSQC), which was a sub-committee of the board. Risk and performance were standard agenda items and we saw that there was a maternity and Ockendon update at meetings in October, November and December 2022. We also saw that monthly reports were made to the PSQC on Ockendon updates from May to November 2022 and on CNST updates from July to November 2022. Managers told us a sub-committee of the PSQC had been set up specifically for maternity assurance and that the first meeting for this was in January 2023.

The service participated in MBRRACE perinatal mortality surveillance and perinatal morbidity and mortality confidential enquiries, and maternal mortality surveillance and confidential enquiries.

Maternity

We requested, but did not receive, minutes of the Perinatal Mortality Review Tool (PMRT) meetings for the last 3 months. Instead we saw a perinatal mortality review summary report which was generated following mortality reviews carried out using the national PMRT. This showed 1 review had been completed and 4 reviews were in progress for the period June 2022 to January 2023. We saw the review for the completed case and associated action plan. The single action had a target date for December 2022 but had not yet been met.

We were told cases were always reviewed with a minimum of midwifery and obstetric presence (from across NHS Trusts), and that anaesthetic staff attended if the case being discussed required their input. There was also representation from neonatology where cases of neonatal death were discussed. Representatives from the child death overview panel also attend for neonatal deaths.

The service had a programme of local audits for 2022/23 based on national guidelines and reports. There were 12 audits listed on the programme, 6 of which were marked as complete, 1 as awaiting sign off, 2 with a deadline of the end of January and 3 as overdue. Of the 6 completed audits, 3 stated an action plan had been fully implemented and 2 stated an action plan was in place. Of the 12 audits in the local programme, 2 were assessing whether recommendations from a previous audit had resulted in improvement. Overall there was limited evidence of repeated audit to drive improvement over time. There was a lack of auditing of key areas of performance (MEOWS, CTG, records), which meant that there was a lack of oversight of performance.

We saw the maternity dashboard for April 2022 to December 2022. This showed the total inductions were red RAG rated for October and December and inductions for first pregnancies ranged from 41.8% to 56.9% for 7 of these months. For 8 out of these 9 months, less than half of first pregnancies had a vaginal delivery, with rates ranging from 38.9% to 49.2%.

One to one care was amber RAG rated for 6 months, and red RAG rated for 2 months, out of these 9 months.

Stillbirths over 24 weeks gestation were red RAG rated for 4 out of these 9 months.

Smoking at time of delivery (SATOD) rates were red rag rated for 8 out of 9 months on this dashboard and amber for 1 month. SATOD rates for April 2021 to March 2022 were also red rag rated for all months with an average rate of 18.4%.

We saw the findings from the Ockendon assurance visit in June 2022. This had identified concerns in some of the same areas as we identified at our inspection in January 2023. For example, the service was amber RAG rated for sending all maternity serious incident reports to trust board and the LMNS quarterly, a day and night consultant led MDT ward round on labour ward, and dedicated obstetric governance lead and attendance at in-house multi-professional maternity emergencies training sessions. We did not see a comprehensive action plan for the Ockendon assurance visit.

The East of England regional perinatal quality oversight group highlight report for the reporting period November 2022 showed the service was partially compliant with monitoring fetal wellbeing for Ockendon requirements and 'working towards' compliance for reducing smoking for the Saving Babies Lives Care Bundle, and 'working towards' compliance for the CNST requirements of clinical workforce planning, core competency framework/multi-professional training and Saving Babies Lives Care Bundle.

We saw action plans for compliance with Saving Babies Lives Care Bundle from December 2022 and January 2023. Some actions had their due dates amended/extended to future dates between the December and January action plans.

We saw that the PSQC was updated on the status of CNST safety actions with a report.

Maternity

We saw a self-assessment report for the MBRRACE national audit report recommendations which included actions, persons responsible, timescales and RAG ratings, for the report published in October 2022. Managers told us actions and learning from the MBRRACE report were discussed at MCG meetings, through the risk and governance display boards and communications and at the MMD training.

The service had also requested an external staffing review from the National Lead for Continuity of Carer who had confirmed the service had safe staffing levels to continue the continuity model.

Information Management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated. Data or notifications were not always submitted to external organisations as required.

The service operated with a combination of electronic and paper records for different elements of care within the service. This meant it was not always easy for staff to access all the salient information they required, increasing the risk of errors, and drawing upon time to care for service users. There was a lack of integration with trust systems, primary care and other maternity services.

The service did not always have good oversight of performance in key or fundamental aspects of the service due to the nature of the records arrangement that was not fit for purpose, a general lack of auditing and a potential for unreliable data collection, for example with regard to triage waiting times. Discrepancies with regard to incident numbers meant we were not assured that all the necessary data submissions and notifications were reliably made to external organisations.

Managers recognised the need to improve data quality. They told us errors within data were audited, mainly regarding maternity services data set (MSDS) information, to identify trends, and feedback was provided to staff where omissions and errors had occurred. There was a self-reflection tool to encourage staff reflection on errors and omissions being developed by the East of England digital midwives expert reference group, which the service planned to roll out.

The service had a maternity digital strategy for 2022 to 2024. The strategic vision was a 'digitally enabled maternity service that is connected, inclusive and supports smart working' and 'where our users are empowered to manage their personalised maternity journey and clinicians are digitally supported to provide safe, timely care regardless of setting'. We saw that priority actions to enable this to happen had been identified with time frames. This included a permanent digital midwife role and the self-reflection tool.

Engagement

There was some evidence that leaders and staff engaged with women, staff, equality groups, the public and local organisations to plan and manage services.

Managers provided evidence of engagement with staff via weekly general newsletters and monthly risk newsletters. We saw the last 5 weekly newsletters, most recently December 2022, and risk newsletters for September, October, and November 2022. Information in the risk newsletters included the maternity voices partnership (MVP) details, incidents and other operational information. Managers also communicated information to staff via the risk and governance display boards.

Managers had carried out a pulse survey for staff in June 2022, however there had been a very low response rate to this.

In recognition of behavioural and cultural issues within obstetric MDT working and the impact of this on service user care and experience, the trust was able to evidence that it had engaged with the staff to try to resolve these issues. This included facilitated sessions, meetings and the Leadership to Care Programme which was launched in October 2022 and was still ongoing. We saw an improvement plan for the programme of improvement work for the maternity team.

The MVP held independent listening events and linked with the service to provide a channel for service user views. It was intended that the MVP and maternity service worked in a 'co-production' way. We were told there was a monthly informal meeting between the MVP chair and consultant midwife to work on projects such as informed consent and birth choices after caesarean section. There was also a quarterly formal MVP meeting, however these had not been minuted. The MVP chair also attended maternity safety champions meetings.

Other links included with the Eden team and via involvement in trust projects, such as the fetal monitoring project, and the MVP chair had been invited to the MMD training day.

In addition to collaboration with the consultant midwife, we were told there was a midwifery inclusivity advocate and maternity experience midwife who were also collaboratively working with the MVP. The maternity experience midwife attended MVP listening events, and facilitated birth debrief appointments, so was able to identify feedback.

The service offered English language courses to pregnant people who did not speak English.

Both the MVP chair and consultant midwife demonstrated good understanding of the population served by the service and the issues they faced. However, concerns existed over care outside of guidance, which was an area where it was felt service users were not always engaged with.

Learning, continuous improvement and innovation

Staff wanted to learn and to improve services. However, there was limited evidence of quality improvement projects and research at the present time.

Staff demonstrated an appetite for learning and improvement, but this did not always translate into gains in a timely and effective way.

Managers were able to provide examples of ways in which it was trying to make improvements, such as relaunching safety huddles, reviewing continuity of carer, consultant job plans, revised duty manager role and a new elective coordinator role. While these measures would improve the service, some of these, such as safety huddles, were standard or expected items which the service had fallen behind on.

The LMNS had chosen the service as the pilot site for a tobacco free pregnancy quality improvement initiative. However, this project was behind schedule by approximately 6 months.

The service was participating in a pilot for an 'embedded researcher' model in collaboration with a higher education institution in the region and another NHS Trust. With this model, research activity is intended to be a formal part of the job role of clinical staff, providing opportunities for research focusing on the healthcare needs of the local population. It also included strengthening links with higher education institutions.

Maternity

The consultant midwife role incorporated 15 hours of protected learning and development time. This research element was part of a national UK pilot to improve research capability. Managers explained their intention to focus on the demographics of the population they served with respect to improvements to research capacity. However, there was no Deputy Head of Midwifery, meaning the consultant midwife effectively deputised, and there were concerns about capacity for this role.

Managers told us good clinical practice (GCP) training was part of the induction programme for all newly qualified midwives and was part of appraisals for senior midwife coordinators. GCP provides the international standard to which clinical research is carried out. They also told us all staff would be informed of funding for extra training opportunities.

The service had set up a process for 'fast track' COVID-19 vaccinations in 2021 during a national drive to increase the number of pregnant people vaccinated, due to their greater risk of severe COVID-19. This involved the offer of vaccination at the same visit as the 20 week scan and a fast-track route to the vaccination without need for a separate appointment. This was shortlisted in the Maternity and Midwifery Initiative of the Year category for the Health Service Journal Patient Safety Awards 2022.

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:
James Paget Maternity Services must

- The service must ensure all staff complete mandatory training. (Regulation 12)
- The service must ensure environmental ligature and ligature point risk assessments are completed and actioned. (Regulation 12)
- The service must ensure risk assessments are completed and reviewed. (Regulation 12)
- The service must ensure that triage waiting times are monitored to ensure that women and pregnant people are assessed within the required timeframes. (Regulation 12)
- The service must ensure there are enough midwifery and medical staff with the right qualifications, training, and experience to keep women and pregnant people safe from avoidable harm and provide the right care and treatment. (Regulation 12)
- The service must ensure that all incidents are reported internally and externally in line with trust policy and national requirements, investigated thoroughly and that learning from incidents is shared. (Regulation 17)
- The service must ensure that key and fundamental audits are completed so that performance can be monitored and actioned. (Regulation 17)
- The service must ensure that specific lead roles for obstetrics, such as obstetric clinical lead, are job planned and in place. (Regulation 18)
- The service must ensure that staff are trained in high dependency level 2 care. (Regulation 12)

Maternity

- The service must ensure the culture within the service significantly improves so that it does not impact upon service user safety and care. (Regulation 18)

Action the trust SHOULD take to improve:

James Paget Maternity Services should

- The service should ensure all staff have training on how to recognise and report abuse and all staff know how to make safeguarding referrals.
- The service should ensure all staff use infection prevention and control measures to control infection risk.
- The service should ensure that all members of the MDT attend delivery suite ward rounds and safety huddles.
- The service should ensure all staff receive an annual appraisal.
- The service should ensure there is a records system that is clear, complete, and up to date to enable staff to provide safe and effective care.
- The service should ensure there is a single prescribing system to minimise the risk of prescribing and administration of medicines errors.
- The service should ensure that duty of candour is carried out for all eligible incidents.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 3 CQC inspectors and 3 specialist advisors (a consultant and 2 midwives) with a specialism in maternity services. The inspection team was overseen by Carolyn Jenkinson, Deputy Director or Secondary and Specialist Care.