# University Hospitals of Derby and Burton NHS Foundation Trust

# Royal Derby Hospital

**Inspection report**

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## Ratings

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

# Our findings

## Overall summary of services at Royal Derby Hospital

**Requires Improvement** 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Royal Derby Hospital.

We inspected the maternity service at Royal Derby Hospital as part of our national maternity services inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

The Royal Derby Hospital provides maternity services to the population of Derby and the surrounding areas.

Maternity services at Royal Derby Hospital include antenatal, intrapartum (care during labour and delivery) and postnatal maternity care.

The maternity unit includes an obstetric consultant-led delivery suite, maternity pregnancy assessment unit, and a ward for antenatal and postnatal care. The alongside midwifery-led birth centre provides intrapartum care for women and birthing people who meet the criteria and are assessed to have lower risk pregnancies. The birth centre has four birthing rooms, one of which has a birthing pool. In the year January to December 2022 there were 5850 births at Royal Derby Hospital.

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

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

Our rating of this hospital went down. We rated it as Requires Improvement because:

- Our rating of Inadequate for maternity services changed the rating for the hospital overall. We rated safe as Requires Improvement and well-led as Requires Improvement.

We also inspected 1 other maternity service run by University Hospitals of Derby and Burton NHS Foundation Trust. Our reports are here:

- Queens Hospital - https://www.cqc.org.uk/location/RTGX1

**How we carried out the inspection**

We provided the service 2 working days' notice of our focused inspection of the maternity service, looking only at the safe and well-led key questions.

We visited antenatal clinics, pregnancy assessment unit (triage), labour ward, the midwifery-led birth centre alongside the labour ward, obstetric theatres, and ward 314 antenatal and postnatal ward.

# Our findings

During the inspection, we spoke with 36 staff including the clinical director of obstetrics, head of midwifery, obstetricians, doctors and midwives.

We reviewed 10 patient records including observation charts and medicines records.

We spoke with 3 women, birthing people and families. We received 568 'give feedback on care' forms through our website of which 277 were positive, and 291 raised concerns about the service. Where women and birthing people raised concerns, themes included: postnatal care, delays to induction of labour and pain management.

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

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

# Maternity

**Inadequate** ↓↓

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

- The service did not always assess risks in relating to fetal monitoring and post-partum haemorrhage effectively. Staff did not always complete risk assessments at every antenatal contact.
- The service did not always have enough midwifery or medical staff to care for women and birthing people to keep them safe. Staffing levels impacted on delays to induction of labour.
- Staff were not always up to date with training in key skills.
- The service did not identify, manage and investigate safety incidents in a timely way or effectively embed lessons learned from them.
- The service did not effectively audit completion and escalation of clinical observations or clinical handovers.
- There was not sufficient leadership capacity in the maternity team to manage the service well.
- Governance processes were inadequate to monitor and improve clinical outcomes. Leaders did not have access to reliable information systems to support monitoring of the service due to paper-based record keeping systems.
- Clinical guidelines were not always in line with national guidelines.
- Staff did not always feel respected, supported and valued. Staff appraisal rates were low.
- There was limited engagement with local people and stakeholders in relation to improving services.

Following our first inspection we raised our concerns with the trust and received assurances the trust had taken action on our concerns. However, following our second inspection on 23 August we imposed urgent conditions under section 31 of the Health and Social Care Act 2008 on the registration of maternity services at Royal Derby Hospital.

Under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so.

## 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 not all staff were up to date with maternity mandatory training in key skills to ensure safe care.**

Midwifery staff received but did not always keep up to date with their mandatory training. Data showed for all maternity staff across the trust, the overall average training compliance for trust mandatory training modules was 81% as of July 2023. This did not meet the trust target of 90%.

# Maternity

Midwives were not always up to date with midwifery specific mandatory training modules which included: infant feeding, perinatal mental health, substance misuse and diabetes. At Royal Derby Hospital midwifery staff compliance with midwifery training modules was 59% as of 2 August 2023. This did not meet the trust target of 90%.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had a maternity training trajectory for all staff groups to track compliance.

The mandatory training was comprehensive and met the needs of women, birthing people and staff, but staff did not always complete it. Staff were supposed to complete Practical Obstetric Multidisciplinary Training (PrOMPT) once a year. Data from the maternity specific training report showed compliance with PrOMPT was low. Following the inspection the trust submitted data that showed as of 31 August 2023 80.62% of staff overall had completed PrOMPT with training compliance being lowest for staff groups including consultant anaesthetists at 13.89% and obstetric consultants at 62.5%. Most midwives were up to date with PrOMPT and compliance for midwives ranged between 85% and 100%.

Staff compliance with yearly fetal monitoring training and competency assessments was low. Data from the maternity specific training report showed, as of 2 August 2023, at Royal Derby Hospital compliance was 87.43% overall. Data showed only 24% of obstetric middle grade doctors and 56.5% of consultants had completed the required training (and competency assessments). Compliance with fetal monitoring training for midwifery staff ranged between 80% and 100%.

Training compliance data showed 85% of maternity staff at Royal Derby Hospital had completed neonatal life support training. This did not meet the trust target of 90%.

At the time of inspection staff did not complete regular simulation training. The service had completed a baby abduction simulation drill on 11 August 2023 but at the time the service did not have a baby abduction policy so there was no formal process for staff to follow. Following the inspection, in September 2023 the service completed a cord prolapse simulation.

**Safeguarding**

**Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training but were not always up to date with training on how to recognise and report abuse.**

Staff received training specific for their role on how to recognise and report abuse. Staff we spoke with, had completed online safeguarding training in the past year.

Not all staff were up to date with safeguarding training. As of 2 August 2023, staff compliance with safeguarding adults and children level 3 training (which included level 1 and 2) was 79% for midwifery and medical staff at Royal Derby Hospital and was below the trust target of 90%.

Managers discussed compliance with level 3 safeguarding training in the July 2023 maternity governance group meeting and noted compliance was challenging due to staffing issues.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

**Cleanliness, infection control and hygiene**

# Maternity

**The service controlled infection risk well most of the time. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean. However, managers did not regularly complete cleaning audits.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Managers did not always complete cleaning audits to ensure the cleanliness of bedframes, trollies, couches and mattresses. The May to July 2023 cleaning audit showed these audits were not completed at Royal Derby Hospital on the Birth Centre in May, June or July or on the Pregnancy Assessment Unit in June or July. Where compliance was recorded it was not always above 90% for example compliance on the labour ward was 87% in June 2023 and 85% in July 2023.

Staff followed infection control principles including the use of personal protective equipment (PPE) and managers monitored compliance. For example, data showed hand hygiene audits were completed every month on ward 314 and the labour ward. Between January and August 2023 compliance for hand hygiene audits was consistently at 100%.

Staff cleaned equipment after contact with women and birthing people and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to show equipment was clean and ready for use.

Data on prevalence of infections was included in the maternity dashboard. Between January and March 2023 there were 0 incidents of sepsis in labour and 2 incidents of sepsis in the postnatal period (also known as puerperal sepsis).

**Environment and equipment**

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

The design of the environment followed national guidance. The maternity unit was fully secure. There was a monitored buzzer entry system to the maternity unit and the ward 314 reception area was staffed 7:30am to 8pm. The service had two maternity theatres and 4 enhanced care beds for women and birthing people requiring a higher level of monitoring after the birth.

The service had reported recent faults with cardiotocography (CTG) machines (used to monitor fetal heartbeat and contractions during labour) on the labour ward. The minutes of the July 2023 maternity governance group showed there had been four incidents where CTG machines had stopped working for 1 to 2 minutes before restarting. The service had sent data to the manufacturer and a software update had been completed. Managers had recorded this risk on the maternity risk register and were monitoring the situation.

Managers had not completed ligature risk assessments of the maternity environment. Following our inspection, the trust told us they had started undertaking ligature risk assessments, and actions had been taken to mitigate risks. Ongoing assurance would be overseen by the divisional health and safety meeting.

Women and birthing people could reach call bells and staff responded quickly when called.

Staff carried out daily safety checks of specialist equipment. For example, records of the last three months resuscitaire checklists showed resuscitaires were checked at every shift on labour ward.

# Maternity

The service had suitable facilities to meet the needs of women and birthing people's families. For example, on the alongside midwifery-led unit women and birthing people had access to birthing pools, birth balls and stools to support movement in labour.

The service had enough suitable equipment to help them to safely care for women, birthing people and their babies. The service kept an equipment register, which showed all medical devices were in date for servicing.

Staff disposed of clinical waste safely and sharps bins were labelled correctly.

Following the inspection we raised concerns about the use of manual handling slide sheets rather than nets for evacuation of birthing pools. The trust confirmed staff had access to nets for pool evacuation and pool evacuation training using the appropriate equipment was being provided and rolled out to all relevant midwifery staff.

Following the inspection we raised concerns about the accessibility of emergency resuscitation equipment on the pregnancy assessment unit. The trust confirmed they had reviewed the location of resuscitation equipment and allocated an additional resuscitation trolley to the pregnancy assessment unit.

**Assessing and responding to patient risk**

**Staff did not always complete or update risk assessments for each woman and took action to remove or minimise risks. Staff did not always quickly act when women and birthing people were at risk of deterioration.**

At the time of inspection, staff did not complete peer reviews of fetal monitoring in line with national guidance. At the time of inspection trust fetal monitoring guidelines were not in line with national guidance as the trust guideline was for ‘fresh eyes’ every two hours rather than every hour. Following our inspection visit on 16 August 2023, the service updated fetal monitoring guidance in line with national guidance in relation to ‘fresh eyes’ being completed hourly. The trust told us that following the inspection, a poster with details on ‘a new approach to completing ‘fresh eyes’ CTG review was circulated to staff as well as a letter.

Managers audited compliance with women and birthing people having continuous CTG monitoring during labour. Data from the Maternity summary report showed in June 2023 staff correctly interpreted CTG traces in less than 60% of cases and an appropriate management plan in only 68% of cases.

Staff did not use an evidence-based, standardised risk assessment tool for maternity triage. Staff used a form to prioritise women accessing the pregnancy assessment unit that prompted staff to assess if immediate, medium and low risk but there was not a clear framework to support clinical decision-making. Due to the lack of evidence-based risk assessment tool, the service did not have effective oversight of the timeliness of medical review.

We saw that midwives triaged women and birthing people in a timely way during the inspection. Staff told us they had recently completed an audit of timeliness of midwifery triage within 15 minutes, but this was not submitted to us as requested.

Managers did not monitor the timeliness of the response to pregnancy assessment unit phone calls. The service could not be assured calls were answered in a timely way as the response times, call abandonment rate and the time to answer calls was not monitored.

# Maternity

Staff used a nationally recognised tool to identify people at risk of deterioration and but did not always escalate these appropriately. Staff used Modified Early Obstetric Warning Score (MEOWS) to monitor vital signs. Managers did not regularly audit completion of MEOWS charts. At Royal Derby Hospital the MEOWS audit started in July 2023. This audit showed 90% of patients had a MEOWS chart completed in full. Of these patients, 10% had not had the frequency amended correctly following abnormal observations. 20% of patients had not had abnormal MEOWS scores escalated appropriately.

Staff did not use the 'Situation, Background, Assessment, Recommendation' (SBAR) process effectively to aid safe and effective communication of handover information. Managers did not regularly complete audits to ensure staff shared key information to keep women and birthing people safe when handing over their care to others. At Royal Derby Hospital the SBAR audit started in July 2023. The SBAR audit of 20 sets of notes showed the SBAR for transfer of care for the postnatal mother (from labour ward to the postnatal ward) was completed in 10 out of 20 cases (50%), was signed by two staff in 0 out of 20 cases (0%) and was dated in 0 out of 20 cases (0%).

Staff did not always complete and update risk assessments for each woman antenatally. Data from the continuous quality monitoring report 2022 – 2023 showed in quarter 4 February 2023 – April 2023 risk assessments were reviewed at every contact 70% of the time, this did not meet the trust target of 90%.

Managers did not effectively audit the use of World Health Organisation (WHO) surgical safety checklist in maternity theatres. Data showed managers completed monthly spot checks of compliance with WHO checklist in maternity theatres but did not complete an audit of WHO checklist compliance. Data from the July 2023 WHO audit showed two cases were reviewed, one where good compliance was noted and another where infection control breaches were noted including a surgeon wearing earrings and a necklace. Data showed two cases were reviewed in June 2023 and theatre lists were not reprinted when the order of the list changed. Staff risk assessed women and birthing people continually antenatally and there were clear criteria for use of the midwifery-led birth centre. The service also had clear criteria for use of the birth pool.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of deteriorating mental health during pregnancy. Staff screened women and birthing people for depression using a specific questionnaire referred to as the 'Whooley questions.'

The service had provision for virtual transitional care beds on ward 314 (postnatal and antenatal ward) for babies needing additional observation. The provision of transitional care was not in line with safety action three of the maternity incentive scheme to have transitional care services in place to minimise separation of mothers and their babies. The service had a multi-professional maternity and neonatal working group which was working to agree the transitional care pathway.

Shift changes and handovers included all necessary key information to keep women, birthing people and babies safe.

**Midwifery Staffing**

**The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women and birthing people safe from avoidable harm and to provide the right care and treatment. Staff did not always receive a yearly appraisal to ensure they were competent for their roles.**

The service did not always have enough nursing and midwifery staff to keep women, birthing people and babies safe. The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence

(NICE) guideline 4 ‘Safe midwifery staffing for maternity settings'. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. Data reported to the July 2023 trust board showed during May 2023 there was a rise in red flag incidents during intrapartum care (labour ward). The rise was due to delays in induction of labour processes and an increase in midwifery vacancy rates. The service reported 57 red flags in March 2023, 32 red flags in April and 97 in May 2023 across the trust. The most common red flag incidents were delays between admission for induction and beginning of the process (47% red flags between December 2022 and May 2023), delivery suite co-ordinator not being supernumerary (19% red flags between December 2022 and May 2023) and missed or delayed care (19% red flags between December 2022 and May 2023).

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support workers needed for each shift in accordance with national guidance. Leaders completed a maternity safe staffing workforce review in line with national guidance in May 2021.This review recommended, 256.07 whole time equivalent (WTE) midwives’ band 3 to 7 were needed against the funded staffing of 250.56 WTE, a shortfall of 5.51 WTE midwives. The service was in the process of completing another midwifery staffing review which was due to be completed in December 2023.

At the time of inspection, the maternity vacancy level was 41.71 WTE. In the short term and to mitigate the risk, the service offered enhanced rates of pay for midwifery bank shifts and employed agency midwifery staff when available. In the longer term, the service was recruiting international midwives to improve staffing levels. The service reported to the trust board in July 2023, that 21 internationally educated midwives had been recruited and were due to arrive in Autumn 2023. The service had made 30 job offers to newly qualified third-year student midwives. Staff who had accepted this offer were due to start in October 2023.

At the time of inspection, the senior midwife on-call rota was not adequately staffed to ensure the safety of the unit. Band 7 senior midwives worked on an on-call rota that included matrons to cover the maternity service between 4pm and 8am. Senior midwives told us they frequently stayed on the unit working additional hours to support colleagues due to low staffing levels. We raised concerns about the safety, sustainability and effectiveness of band 7 staff working on the on-call rota. Following the inspection, the trust told us a business case had been submitted to introduce the role of a flow coordinator. This new role and a planned increase in matron staffing supported a plan to introduce an on-call rota staffed with midwives of Band 8a seniority and above.

At the time of inspection, the service did not have a process to monitor the number of hours worked by band 7 senior midwives on-call. Following the inspection, the trust told us the divisional leadership team had introduced a new oversight process to ensure that staff working additional hours had the appropriate amount of compensatory rest.

The ward manager could adjust staffing levels daily according to the needs of women and birthing people. Matrons and senior midwives reviewed staffing in the morning and afternoon across both sites every weekday. The weekend staffing rota is supported primarily by the on-call manager and senior nurse where appropriate.

The service had a clear escalation policy for management of staffing shortages and reduced bed capacity. The service used an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and birthing people accessing the service. The matron of the day completed the staffing acuity tool every 4 hours. The service used a regional maternity escalation framework which included traffic light black 4, red 3, amber 2, green 1 system to determine the capacity of the unit. Green status meant the unit was functioning at normal capacity, amber status meant there were insufficient staff to meet elective demand in addition to the ongoing spontaneous workload and black status would lead to a regional discussion in relation to potentially closing the unit. The unit leader updated the traffic light status 4 times during a 24-hour period.

# Maternity

Planned versus actual midwifery staffing levels were reported to trust board. The September 2023 board report showed in June 2023 88.2% of registered midwife and nurse shifts were filled during the day and 81.8% were filled during the night.

The service had reducing sickness rates. The sickness rate was 6.9% for midwifery staff across the trust as of April 2023. This was a reduction in midwifery sickness from 8.4% in October 2022.

The trust used bank and agency midwifery staff where appropriate to support the safety of women and birthing people. Managers made sure all bank and agency staff had a full induction and understood the service.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Data showed 52% of midwives working at Royal Derby Hospital had received a yearly appraisal as of August 2023, compliance for midwives working on ward 314 was 97% but compliance for midwifery staff working on the labour ward was only 36.5%.

**Medical staffing**

**The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep women, birthing people and babies safe from avoidable harm and to provide the right care and treatment.**

The service did not always have enough medical staff to keep women, birthing people and babies safe on labour ward. Data showed as of July 2023 the labour ward had 83-hours of consultant cover. This was not in line with Royal College of Obstetricians and Gynaecologists Safer Childbirth Guidance on minimum standards for the organisation and delivery of care in labour for maternity units with 4000 to 5000 births a year that states 98-hour consultant obstetrician cover is needed. In June 2023 the trust delivery group approved a maternity safety case to provide an additional £5.4million investment in the midwifery and medical workforce teams. The trust planned to used part of this investment to increase obstetric consultant presence on the labour ward at the Royal Derby Hospital site to meet the 98-hour consultant obstetrician recommendation.

The service always had a consultant on call during evenings and weekends.

The service did not always have twice daily consultant led ward round on labour ward.

Staffing of the middle grade doctor rota was a recorded risk on the trust ‘extreme risk register’ which was reviewed by the trust board. The risk was mitigated by using enhanced bank shift payments and locum doctor staff. As of July 2023, the service had a middle grade medical staff vacancy rate of 4 WTE staff which included 3 vacancies for senior registrar doctors and 1 junior doctor vacancy. Following the inspection, in November 2023, the trust told us 3 WTE middle grade doctors had been recruited.

**Records**

**Staff kept detailed records of women and birthing people’s care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

The trust used a combination of paper and electronic records. All staff had access to women and birthing people's notes, but they could be difficult to navigate and audit as information was recorded in different places inconsistently.

# Maternity

We reviewed ten records on inspection and risk assessments were completed antenatally and during labour.

The trust had plans to transition to fully electronic records by August 2024.

Managers audited 20 maternity records every 3 months. The most recent July/August 2023 documentation and consent audit showed all metrics were above 90% compliance.

Records were stored securely, and electronic patient records were password protected.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each woman's medicines regularly and provided advice to women and birthing people about their medicines. Staff completed medicines records accurately and kept them up to date. All the medicines records we reviewed were clear and up to date.

Staff had access to medicines used to respond to emergencies safely. On the delivery suite, staff had access to emergency 'grab boxes' to respond quickly to conditions such as pre-eclampsia, sepsis and cord prolapse.

**Incidents**

**Staff did not always recognise and report incidents in line with trust policy and national guidance. The service did not investigated incidents in a timely way. Managers did not ensure learning from incidents was embedded to prevent re-occurrence of similar incidents.**

Staff did not always report incidents in line with trust policy. For example, the major obstetric haemorrhage (MOH) paper to the executive leadership team in August 2023 showed of 42 cases of MOH which occurred in May 2023 across the trust (29 at Royal Derby Hospital and 13 at Queens Hospital Burton) only 17 were reported through the trust electronic incident management system. To mitigate the risk of low incident reporting, as of August 2023, the service had a weekly triangulation meeting with the digital midwife and maternity risk team reviewing MOH emergency activation data and the MOH incidence reported through the electronic incident management system.

The service did not investigate incidents in a timely way. Data from the maternity update to trust board in July 2023 showed the service had a total of 272 open maternity incidents across the trust at various stages of the incident review process. This was a decrease from 457 in March 2023 and 311 in April 2023.

The service reported incidents, themes and trends to the trust board. The last update to trust board in July 2023 showed that levels of incident reporting had shown a small increase with the highest number of incidents being reported in May 2023 (197) for two years. The top three themes of incidents reported for April and May 2023 were staffing, communication and escalation.

Managers identified themes and trends from incidents and reported on these to the trust board. The July 2023 maternity update to the board showed themes from incidents in the past year included: maternity triage pathway, fetal growth

pathway including management of fetal movements, CTG categorisation and escalation, lack of senior obstetric medical oversight / inappropriate delegation and management of MOH. However, during our inspection it was not clear improvements had been made in relation to the above themes to prevent similar incidents occurring again. The trust acknowledged that learning from incidents was not always embedded.

The service had recognised the risk of ineffective processes for learning from incidents. The service had a specific workstream in the Maternity Improvement Programme (supported by the NHS England maternity support team).

Managers investigated incidents. We reviewed the last three completed patient safety reviews and found that there was involvement of the families involved in the incidents', detailed chronology was completed with care and service delivery problems considered and learning identified. The investigations we reviewed showed duty of candour had been carried out in line with the regulations.

The local Integrated Care Board (ICB) had commissioned the Healthcare Safety Investigation Branch (HSIB) to complete a thematic review of maternal deaths and maternal collapse events that happened between January 2021 and May 2022 at Royal Derby Hospital. We reviewed the progress the trust had made against the five HSIB safety investigations that were made in relation to the massive obstetric haemorrhage process, communication with women and families who have experienced a significant event and rapid review processes following incidents. We found at the time of inspection, learning from the review was not fully embedded.

## Is the service well-led?

**Inadequate** 

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

**Leadership**

**The service did not have sufficient leadership capacity to effectively manage the service. Leaders were not always visible or approachable in the service for women, birthing people and staff. Staff were not effectively supported to progress into more senior roles.**

Maternity services at Royal Derby Hospital were managed as part of the maternity, gynaecological and genito-urinary medicine business unit in the division of women's and children's services. The division across the trust was managed by a Director of Midwifery (although this post was vacant at the time of inspection), a Divisional Nurse Director, a Divisional Director of Women's & Children's Services and a Divisional Medical Director.

There was no stable maternity leadership team with vacancies being filled by staff in interim roles. The maternity, gynaecological and genito-urinary medicine business unit was managed by an interim Head of Midwifery, an interim Deputy Head of Midwifery, an interim General Manager, and an Obstetrics Clinical Director. The interim Head of Midwifery was supported by two interim Deputy Heads of Midwifery, one with responsibility for risk & governance, and another who was operational, a lead midwife for continuity of carer, an intrapartum matron, an inpatient matron, and a community midwifery matron. At the time of inspection, all the matron roles were cross-site roles working at Royal Derby Hospital and Queens Hospital. The trust had plans to recruit additional matron staff into a new management structure to allow two matrons to have dedicated roles on each site.

# Maternity

Following the inspection, in November 2023, the trust told us they had successfully appointed a new Director of Midwifery and a new Divisional Director. The interim general manager and interim deputy heads of midwifery were also appointed too substantively as of November 2023.

Matrons did not regularly work clinically on labour ward to provide clinical leadership, advice and support or to ensure staff could take breaks. An operational 'matron of the day' model had begun in July 2023. Staff we spoke with told us this model was not yet embedded and they rarely saw matron staff in clinical areas.

The board level non-executive director maternity safety champion was new and not available for interview during the inspection period. CQC spoke with the executive chief nurse an additional board level maternity safety champion.

We requested the last six months of maternity and neonatal safety champion open forum reports of concerns raised. The service did not submit recent data but reports from February 2022 to July 2022 which showed the actions from safety forums that had occurred in previous years.

**Vision and Strategy**

**Maternity services did not have a clear vision and strategy at the time of inspection. The service had recently set up a comprehensive plan to improve maternity services.**

The service was developing a vision and strategy for the service at the time of inspection. Managers held a strategy session on the morning of 28 July 2023 to discuss clinical priorities across the local maternity and neonatal system, trust, divisional and business unit priorities. Key priorities included: workforce development and improving compliance with national maternity safety initiatives such as the Clinical Negligence Scheme for Trusts (CNST), the Ockenden report and the Saving Babies Lives care bundle version 3.

There were several maternity improvement programme workstreams which included: safe practice, capacity, governance, digital, people, training, communication and service development. Priority areas within this included: safe management of major obstetric haemorrhage, fetal monitoring, informed choice and consent, improving culture and civility including escalation and oversight and maternity triage. The maternity improvement programme was supported by the NHS England maternity improvement team.

Following the inspection the trust told us the division had a multi-disciplinary away day on 10 of October 2023 which included quality improvement work to support the vision and strategy. The service planned to complete this work by the end of March 2024.

**Culture**

**Staff did not always feel respected, supported or valued. Complaints were not always responded to in a timely way.**

Senior managers had recorded a poor safety culture as a risk on the maternity risk register in November 2019 and the risk was still current at the time of our inspection. The NHS England Maternity Services Diagnostic Report completed February 2023 raised concerns about an 'us and them' culture between the trusts two acute maternity locations, Royal Derby Hospital and Queens Hospital Burton and the maternity manager on-call rota was not fit for purpose. We raised concerns about the safety and sustainability of the maternity manager on-call rota following the inspection and the

trust told us recruitment to band 8 matron roles in Autumn 2023 would allow them to remove band 7 staff from the on-call rota by December 2023. Following the inspection the trust told us they had started monitoring the hours worked by midwifery on-call managers to ensure staff could take periods of compensatory rest. The trust told us in November 2023 that due to the mitigating actions taken the risk of poor safety culture had reduced from 9 to 4.

Staff did not always feel respected, supported, and valued. Several staff we spoke with during the inspection became visibly distressed due to the overwhelming workloads and lack of clinical and emotional support. Staff had access to a professional midwifery advocate who worked full time for support.

We reviewed the maternity staff survey (2022) feedback presented to staff as of June 2023 and found areas for improvement in the women and children's division included: appraisals, health & wellbeing and flexibility. Managers promoted trust wide wellbeing resources such as the employee assistance programme at monthly maternity unit meetings.

Staff understood the policy on complaints and knew how to handle them. The service had a process for de-escalating complaints to resolve women and birthing people's concerns about their care in a less formal way.

Managers investigated complaints and identified themes but did not always investigate complaints in a timely way. Between 2 March 2023 and 4 August 2023, 44 formal complaints were reported to the trust, and these were investigated and responded to in line with the trust policy. At the time of the inspection, 13 of 44 complaints had been reviewed and completed with the remainder ongoing and with 8 requiring additional investigations.

Timeliness of complaint responses was a recorded risk on the maternity risk register since February 2022. As of August 2023, the risk level was rated as 9, high risk.

The trust reviewed complaints raised in line with the incident investigation framework when needed. For example, in July 2023 two patient safety reviews were completed following complaints raised by women and birthing people who used the service.

The service was working to improve the safety culture in the department and had started to roll out cultural competency training. Staff from the practice development team attended sessions in June 2023 that covered cultural bias and supporting a culturally sensitive approach. The practice development team planned to share learning from this training to the wider maternity team.

At the time of the inspection supplementary information cards had been created to further assist with communication for women, birthing people and their families who spoke Polish. Incident forms did not consider women and birthing people who in relation to ethnicity or disadvantage affected treatment and outcomes.

**Governance**

**Leaders did not operate effective governance processes to ensure the safety of the service.**

The maternity risk and governance team was not well resourced at the time of inspection. The interim Deputy Head of Midwifery for risk & governance lead worked two days a week. They were supported by two band 7 senior risk midwives, one who worked full time on the Queens Hospital Burton site and one who worked 3 days a week on the Royal Derby Hospital site.

# Maternity

There were significant delays to the Perinatal Mortality Review Tool (PMRT) process. The process included the use of a nationally recognised methodology to review baby deaths. The service reported in February 2023 they were non-compliant with the maternity incentive scheme requirement to start all PMRT reviews within 2 months of the death. Data showed as of 3 August 2023, that 13 cases were being reviewed, 16 were at report stage, 3 were assigned from other trusts and 2 cases had not started the review process. Managers discussed the challenges to completion of PMRT reviews at the July 2023 maternity governance meeting.

Leaders had reviewed the numbers of stillbirths between those from ethnic minority groups against the outcomes for all patients. Findings were presented to the trust board in July 2023 and showed the still birth rate for patients from ethnic minority groups was higher than the stillbirth rate for all patients, in line with national findings. The service acknowledged the need to further understand the problem to improve outcomes and ethnicity was included as a factor in perinatal mortality reviews.

Staff did not always have access to up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed policies including the fetal monitoring and the reduced fetal movements. These were not in line with national guidance. The service updated fetal monitoring and reduced fetal movements guidelines immediately following our inspection visit.

Royal Derby Hospitals and Queens Hospital Burton merged to form one organisation in 2018, however, we found that policies and procedures had not always been aligned across the two locations. The trust had identified and recorded “Patient harm due to staff incorrectly selecting the wrong site guideline from the Trust intranet” as a risk on their maternity risk register from November 2020. This risk was mitigated by clinical guidelines being risk assessed in order of clinical priority.

At the time of inspection, the service did not audit compliance with guidelines to ensure they were effective. As part of the newly implemented continuous quality monitoring standard operating procedure, the service planned to complete targeted audits of newly implemented guidelines. Following the inspection, the trust told us a process had been implemented to audit clinical practice against guidelines.

A review of governance structures at the trust and in the women & children’s division was in progress at the time of inspection. The review would support managers to streamline governance processes and meetings.

Leaders monitored key safety and performance metrics through a series of governance and performance meetings. There were four levels of governance meetings starting with: maternity & gynaecology business unit meeting, women& children’s divisional meeting, divisional performance review meetings with the executive team and the quality assurance committee that reported up to board.

We reviewed minutes of the last 3 maternity governance group meetings attended by the Head of Midwifery, Obstetric Clinical Director, Deputy Head of Midwifery, matrons and specialist midwives. A standard agenda was used to discuss topics including but not limited to maternity training compliance, risk management, maternity quality reporting, compliance with Saving Babies Lives care bundle and quality improvement.

The service submitted the continuous quality monitoring standard operating procedure to the CQC on 21 August 2023. This document was in draft form so we could not be assured that the new oversight mechanisms were effective as they were not yet in use.

# Maternity

## Management of risk, issues and performance

**Leaders and teams did not use systems to manage performance effectively. There were significant failures in audit systems and processes which impacted on the management of risks.**

The local audit programme was not sufficient to monitor and improve performance over time. Many of the audit programmes did not adequately measure the quality-of-service provision, for example MEOWS audits had only been recently restarted and had only been completed in July 2023. Vital information was missing from the audit and therefore the trust was unable to confirm if 10% of women reviewed as part of the audit had been escalated correctly. The trust had recognised this risk and was implementing a continuous quality monitoring standard operating procedure. This was in draft at the time of inspection.

The service had a yearly audit programme and participated in relevant national clinical audits but action plans to improve clinical practice were not effective. For example, the service participated in the avoiding term admissions to neonatal unit's audit. Data showed for 2.38% of term babies were transferred to the neonatal unit, of which 40% of these term admissions to the neonatal unit were avoidable in quarter 4 from February 2023 to April 2023. The service reported in February 2023 that it did not meet safety recommendation 3 of the maternity incentive scheme that requires all babies transferred to neonatal care to be audited and audits and action plans to be reported up to the trust board.

Clinical outcomes were not in line (worse than) with the national average Data showed as of July 2023 the still birth rate for births across the trust was 5.02 per 1000 births. This was above the national average of 4.3 were stillbirths for every 1,000 births.

Data on the maternity assurance tool that was reported up to the trust board was not sufficient to effectively monitor and improve services at the time of inspection. For example, data in relation to women had a 3rd or 4th degree perineal tears and post-partum haemorrhage (PPH) of over 1500ml were not monitored on the maternity assurance tool that was reported up to trust board but was included in the maternity dashboard. The rate of women who have had a PPH at the trust as of June 2023 (40 per 1,000 births) was higher than the national average (31 per 1,000 births), and in the highest 25% of all organisations. The service had recognised that trends were higher than national average and had taken actions to address them. As a response to this trend, the service started a workstream in 2021 aimed at reducing morbidity and mortality caused by Obstetric Bleeding and linked in with the national OBS-UK team as an active member. The trust created an action plan based on the recommendations of the Obs Cymru Project with the aim of improving PPH management and clinical outcomes. However, many of the stages remained only partially implemented with many processes requiring further embedding as well as quality control through audit.

Top risks across maternity services at the trust included: midwifery staffing, medical staffing, maternity mandatory training requirements, and increased risk of patient harm and maternal morbidity.

These risks were mitigated by agreement being secured from trust board to invest in additional midwifery staffing. The trust delivery group agreed the maternity safety case in June 2023 to invest £5.4 million across the midwifery and medical workforce.

Leaders monitored compliance with the Ockenden Independent Maternity Review mandatory actions to improve safety regularly at trust board. The July 2023 maternity update to board showed the trust was fully compliant with 1 out of 7 of the immediate essential actions from the 2020 Ockenden report. The trust reported as of June 2023, they were at 57% with all the sub-elements of the 7 immediate essential actions.

# Maternity

The trust was eligible to claim additional funding by the NHS Resolution Clinical Negligence Scheme for Trusts (CNST). The last maternity update to trust board in July 2023 showed the service met only 2 out 10 CNST safety standards. Failure to achieve compliance with all 10 safety actions in the CNST was a recorded risk since December 2020. The current risk level as of August 2023 was recorded as 9, (high risk).

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The Royal Derby Hospital used multiple paper and electronic records systems at the time of inspection.

The service had a recorded risk in relation to data and information being circulated that is incorrect on the maternity risk register since January 2022, as of August 2023 the current risk score was 12, high risk. The service was working to mitigate the risk through scrutinising the data at maternity risk meetings and manually updating and checking spreadsheets.

The service had plans, and funding, to implement an electronic maternity records system by Autumn 2024. Divisional managers had attended initial meetings to discuss the rollout of the new electronic system in July 2023.

### Engagement

**Engagement with local people who used the service was underdeveloped.**

People could feedback to the service through surveys, complaints and through the local Maternity and Neonatal Voices Partnership (MNVP).

The service had links with the local MNVP but were not involved in the governance of the service and there was limited evidence of co-production. However, the MNVP had completed a visit on 5 July 2023, following the report areas for improvement were recommended, including but not limited to better signage and information, busy waiting areas. Members of the MVP we spoke with told us that there were themes around lack of breastfeeding and follow up for women and birthing people as well as some poor staff attitude and communication issues.

Additionally, the MNVP has worked with the trust to improve patient awareness of complaints process, after highlighting a theme where women, birthing people and their families did not know how to complete a formal complaint, they created a complaints process as well as the matron of the days contact number.

People could feedback to the service through surveys, complaints and through the local maternity and neonatal voices partnership (MNVP). The MNVP also worked with local charities such as Spring Housing who support young parents and homeless people.

The CQC Maternity Survey results for 2022 showed, in comparison to other trusts, University Hospitals of Derby and Burton NHS Foundation Trust scored about the same for 46 questions and ‘worse than expected’ for 5 questions. Areas of improvement identified by the survey included the quality of information provided to women and birthing people antenatally and about induction of labour.

# Maternity

The 2022 General Medical Council National Trainee Survey (GMC NTS) which trainee doctors complete in relation to the quality of training and support received, at Royal Derby Hospital most indicators were similar to the national average except for Overall satisfaction and Feedback which were worse (but not significantly so) than the national average. This was a decline for overall satisfaction from the previous year's results.

### Learning, continuous improvement and innovation

**Evidence of quality improvement and innovation was limited.**

The service was involved in a limited number of research studies. For example, the service was involved in a national research study looking at whether testing pregnancy women and birthing people to see if they carry Group B Streptococcus (GBS) reduces the risk of infection in newborn babies.

## 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.

**Royal Derby Hospital maternity services**

**Action the service MUST take to improve:**

- Ensure staff have access to an evidence-based standardised risk assessment and prioritisation tool for maternity triage. Regulation 12 (2) (a) (b)
- Ensure staff are up to date with midwifery mandatory training modules including level 3 safeguarding training and yearly obstetric emergency skills and drills training. Regulation 12 (2) (c)
- Ensure regular cleaning audits are completed. Regulation 12 (2) (h)
- Ensure regular audits are completed to ensure patient safety. To include regular audit of escalation of modified early obstetric warning score (MEOWS) charts, use of situation, background, assessment, recommendation (SBAR) to handover clinical information, escalation of fetal monitoring traces and timeliness of triage. Regulation 17 (1) (2) (a)
- Ensure accurate data is available to monitor and review. Regulation 17 (1) (2) (a)
- Ensure effective governance and oversight of audits and action plans developed to improve performance, including analysis of key performance indicators by ethnicity and deprivation. Regulation 17 (1) (2) (a) (b)
- Ensure there enough suitably qualified midwifery staff to ensure safety. Regulation 18 (1)
- Ensure the midwifery on-call rota is staffed by midwives who are suitably qualified, competent, skilled and experienced. Regulation 18 (1)
- Ensure staff working hours are monitored and staff have the appropriate amount of compensatory rest. Regulation 18 (1)
- Ensure there enough suitably qualified medical staff to ensure safety and ensure obstetric consultant staffing is in line with national recommendations for maternity units with 4000 to 5000 births a year. Regulation 18 (1)
- Ensure midwifery staff receive a yearly appraisal. Regulation 18 (2) (a)

# Maternity

**Royal Derby Hospital maternity services**

**Action the service SHOULD take to improve:**

- Complete and regularly review ligature risk assessments of the maternity environment.
- Should ensure all relevant staff receive training in the use of pool evacuation and regular refresher training.

# Our inspection team

The team that inspected the service comprised a CQC lead inspector, 3 other CQC inspectors, 3 midwifery specialist advisors and an obstetrician specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.