Ashford and St. Peter's Hospitals NHS Foundation Trust

St Peter's Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement

Our findings

Overall summary of services at St Peter's Hospital

Requires Improvement 

Pages 1 and 2 of this report relate to the overall hospital ratings of this location, from page 3 the ratings and information relate to maternity services based at St Peters Hospital.

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

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

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

St Peters Hospital is in Chertsey Surrey and part of the Ashford and St Peters NHS Foundation Trust. The trust serves a population of 410,000 people. Maternity forms part of the Women Health and Paediatric division with an annual birth rate of 3,280 births with 6% of women choosing to give birth in the co-located Abbey Birth Centre or at home.

Maternity services offered low and acute care during the antenatal, intrapartum, postnatal and community care. Services included antenatal clinics, antenatal education programme a maternity day assessment unit, maternity triage, an obstetric led labour ward, and antenatal and postnatal wards. Women and pregnant people could access their personal care records digitally.

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

- Our ratings of the Maternity service went down but the ratings for the hospital remained the same. We rated safe as inadequate and well-led as requires improvement and the hospital as requires improvement.

How we carried out the inspection

This maternity thematic review was a focused inspection; we inspected the domains of safe and well-led using the CQC's specific key lines of enquiry designed to support the National Maternity Services Inspection Programme.

Inspectors visited maternity services on 4 January 2023. We spoke with 20 staff and reviewed 6 sets of patient care records. We looked at a wide range of documents including audits, standard operating procedures, meeting minutes, risk assessments and recently reported incidents.

After the inspection we requested further documentary evidence to support our judgements including training records, staffing roster, reports, and quality improvement initiatives.

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:

- Not all medical staff had completed their 'maternity' mandatory training.
- There were significant issues with risk assessments especially in triage. Staff did not have enough time to appropriately risk assess women, or act upon identified risk within safe time frames or maintain accurate care records.
- There were significant issues with the location of maternity planned elective theatres due to risk highlighted by the trust that compromised dignity and privacy. The service had gaps in their infection prevention control measures.
- There were significant staffing shortages that reflected national shortfalls. Staffing levels did not always match the planned numbers putting the safety of women and babies at risk. The service had issues with sickness, recruitment, and retention of staff.
- The service did not always progress all safety incidents within national time frames. The governance and risk processes required significant improvement because of a back log of outstanding incidents which caused delays and inconsistency in identifying themes and trends and shared learning for staff.
- Maternity leaders faced substantial challenges because of the opposing trust priorities which created missed opportunities to drive the required improvements of the service. Trust leaders did not always respond swiftly to the challenges within maternity, which meant services did not always run well. Managers did not always have enough time to monitor the effectiveness of the service or utilise reliable information systems. Managers did not have time to support staff to develop their skills to ensure they were competent.

However:

- All clinical staff received emergency skills and drills simulated training and midwives had completed their maternity matters key skills training. Staff worked well together for the benefit of women, understood how to protect women from abuse. They managed medicines well.
- There was a positive transparent culture. Staff worked hard despite workforce challenges and felt valued and included in plans to improve services. They were sympathetic to the needs of women receiving care. Staff understood the service's vision and values, and how to apply them in their work.
- The service engaged well with women and the community to plan and manage services. Staff were committed to continually improving 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 urgent action as we believed women and people 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 March 2015.

Is the service safe?

Inadequate

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

Maternity

Mandatory training

The service provided mandatory training in key skills to all staff and made sure midwives completed it. However, not all doctors had completed their training.

Midwifery and nursing staff received and kept up-to-date with their obstetric emergency skills and drills mandatory training. Ninety-five per cent of midwives and nurses had completed all obstetric mandatory training courses against the trusts target of 95 %.

Medical staff received but did not always keep up-to-date with their training. Records confirmed that overall medical staff compliance to the trusts 'maternity matters' core skills training was 80.4% which fell short of the trusts own target. This was because workforce pressures affected attendance. Records showed that only 33% of consultants and 42% of other grade obstetric doctors were compliant which bought down the overall average for the service under the trusts 90% target.

The service made sure that staff received multi-professional simulated obstetric emergency skills and drills training. There was an emphasis on multidisciplinary training leading to better outcomes for women and babies. Obstetric simulated training was aligned to the requirements set out by the Clinical Negligence Scheme for Trusts (CNST) and included human factors, newborn life support and perinatal mental health. Records showed that compliance averaged 95% for all mandatory obstetric emergency training courses.

The mandatory training was comprehensive and met the needs of women and staff. The service implemented the 'Maternity Education' Strategy which was updated and approved in 2022. The Strategy for maternity focused on the development of a dynamic, innovative and multi professional approach to learning and included the recommendations set out in the Ockenden review of maternity services at Shrewsbury and Telford (2022) and the Maternity Incentive Scheme Core Competency Framework for CNST year 4.

Training included a fetal monitoring training day and a cardiotocograph (CTG) competency test. Records confirmed that 97% of staff had passed this test. Staff who did not pass repeated the test within one month. Training was up-to-date and reviewed regularly.

Staff caring for mothers and pregnant people during labour completed evacuation of the birthing pool training which included a simulated evacuation of the pool session. Records confirmed that attendance was recorded. However, we did not receive a copy of overall staff compliance for this training.

Managers monitored mandatory training and alerted staff when they needed to update their training. The maternity education team completed a training needs analysis and developed Maternity Matters CNST training and staff attended study days that included the following modules

- Bereavement
- Saving babies lives risk assessments
- Management of labour
- Infant feeding
- Screening

- Personalised care plans for women from different ethnic backgrounds
- Perinatal mental health
- Local learning from incidents
- Epidural management
- Birth choices

Newly qualified midwives had to complete the following modules within their first 6 months of their employment

- Attend obstetric emergency training
- Fetal Monitoring Training (within supernumerary period)
- Attend two days of BFI training for new starters (allocated by the Infant Feeding Lead)
- Complete all online mandated training- within the first 2 months of employment
- Attend any mandated training that was not provided on Trust induction
- Attend the Maternity Matters CNST-guided local update day
- Attend any further training required for their role (to be determined by CPE team and Maternity Matrons)

Staff said they received email alerts so they knew when to renew their training.

Safeguarding

Most staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, not all medical staff were compliant with their level 3 training.

Staff received training specific for their role on how to recognise and report abuse. The trust had a 4 year Safeguarding Children Training strategy. The purpose of the strategy was to make sure that the trust and staff met their responsibilities in terms of safeguarding. Records showed that 93% of midwives had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. However, only 67% of doctors had completed this training. This meant that doctors reviewing care may fail to identify safeguarding concerns and did not reflect the national guideline Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019), which states all healthcare professionals who are involved in risk assessing people should complete regular level 3 safeguarding training.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples of individual safeguarding concerns which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics.

Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women had birth plans with input from the safeguarding team. The trust worked closely with the integrated care board to signpost women to support networks within the local community.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward. Access to the ward was via a door buzzer system, staff carried electronic passes and patients and families had to announce who they were before entering.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. Records confirmed that the service had practised a simulation of what would happen if a baby were abducted twice during the last 12 months before inspection.

Leaders reviewed an incident of a potential baby abduction and records confirmed learning was circulated to staff caring for babies.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Regular audits showed gaps in compliance. Because of this, leaders implemented an infection prevention control action plan. However, staff used equipment and control measures to protect women, themselves, and others from infection and the equipment and the premises were visibly clean.

Cleaning records were not always up-to-date and did not demonstrate that all areas were cleaned regularly throughout. We found examples in gaps in cleaning records on the wards and data from the trust confirmed that the service was under performing for cleanliness. Annual Infection Prevention and Control (IPC) audits confirmed that the overall compliance for the service was 69%. Common themes to non-compliance was the lack of cleaning to frequent touch sites and estates, for example repair issues to walls, ceilings and doors that compromised IPC standards.

The service displayed housekeeping & cleaning boards in most areas. Cleaning supervisors updated this weekly and listed weekly tasks to help embed effective IPC measures.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were not always completed each month in all maternity areas. However, records confirmed compliance had improved from under 85% to 100% in December 2022. Because of this the service provided an action plan to increase staff compliance to IPC during 2023. Area leads were assigned to oversee staff compliance. Managers assigned cleaning tasks at the beginning of each shift. However, the managers in ward area's due worked clinically 70% of the time which meant there was lack of time to monitor IPC.

Maternity

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained in most areas. The Abbey birth centre was visibly clean and equipment that was not in use displayed nationally recognised 'I am clean' stickers. The service used a digital application for staff to record cleaning in each area.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use. However, other areas of maternity did not appear as visibly clean for example on labour ward we found blood stains on the blood gas analyser and blood spots on the floor in a delivery room.

Staff regularly checked birthing pool cleanliness and the service had a contract for testing for Legionnaires' disease. Clinical staff were responsible for cleaning the pool after childbirth. The standard operating procedure: 'Waterbirth; The use of pool for Labour and Birth' (version and date) included the process for cleaning the pool. However, the procedure was due to be reviewed. Legionnaires checks were completed by the trust estates team.

Environment and equipment

The design and maintenance did not meet national guidance in most areas and staff did not always complete safety checks on emergency equipment. However, the use of facilities and premises had been risk assessed to keep people safe until the unit could be updated. Equipment and medical devices kept people safe and staff were trained to use them. Staff managed clinical waste well.

The design of the environment did not follow national guidance in most areas. The maternity unit was spread out over 4 levels. The Abbey Birth Centre, antenatal clinic, and the maternity day assessment unit (DAU) were on the ground floor. The Abbey birth centre was opened in 2014 and was well designed to facilitate low risk childbirth. For example, there were 3 birthing pools, and a host of childbirth equipment including birth chairs, stools, matts, and balls.

The DAU and Antenatal clinic were spacious and light. Staff had access to all the equipment necessary to care for patients safely.

Maternity triage was situated on the 4th floor with rooms off the side of labour ward, the area was accessed via a reception desk which was not manned on the day of our visit which meant that women and pregnant people arrived and were not checked in. The triage department was cramped, and the space did not conform to current health and safety guidance. Space around beds was limited, there were trip hazards, lack of privacy and infection control issues. The service had added the issues with their estates to the divisional risk register. After the inspection we fed back concerns about the lack of space and a receptionist to ensure people were registered effectively and the trust acknowledged that by the 31 March 2023 estates worked to improve the layout of triage would be completed.

The labour ward, maternity theatres, and the neonatal intensive care unit were situated on the 4th floor. The environment was outdated look tired and one of the maternity theatres had been taken out of use because of concerns around space and infection control. Because of this, the service had completed a risk assessment and decided that planned caesarean sections could take place in main theatres which were in the main building. However, this meant that women and their partners had to walk through corridors and a surgical ward for the procedure and the recovery area was a mix sexed bay and meant that dignity and privacy were compromised. We fed our concerns back to trust leaders after the inspection and asked them to review the elective caesarean process to ensure privacy and dignity were maintained.

The maternity unit was fully secure with a monitored entry and exit system.

Maternity

Staff did not always carry out daily safety checks of specialist equipment. In November 2022 the trust had introduced a digital system to record daily checks of medical devices and emergency equipment, along with a process for monitoring compliance. Quick response (QR) codes were visible on all lifesaving equipment throughout maternity, and staff used handheld devices to check the equipment and scan in the code to record compliance.

Records on the wards confirmed that daily checks were completed on the adult resuscitation trolley and the cardiac arrest trolley. However, there were 7 days during December 2022 when resuscitaire checks were not recorded on the digital record. A resuscitaire is a neonatal resuscitation unit. Staff told us that there had been some initial challenges to completing the data on handheld smart phones which was reflected in the lack of data for this period.

Records showed that resuscitation equipment on labour ward had not been checked daily. From 27 November 22 to 8 Jan 2023, the resuscitaire checklist audits showed staff missed checks on 7 days. The trust implemented a safety check working group to make sure use of the new digital safety check system was embedded.

The service had suitable facilities to meet the needs of women's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment to help them to safely care for women and babies. The service had an asset register and leaders had oversight of the available equipment in the unit. For example, the unit there was a portable ultrasound scanner, cardiotocograph machines, resuscitaires and observation monitoring equipment.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Women could reach call bells however due to workforce issues staff did not always attend quickly when called. During out visit we noted call buzzers ringing for over a minute. Also, the CQC had received several complaints regarding care on the wards that stated long wait times for responses to buzzers.

Assessing and responding to patient risk

There were significant gaps in risk assessments in some areas of maternity. Staff did not always safely assess, monitor, or manage risk assessments or take action to remove or minimise risks for people using the service. There were times when opportunities to prevent or minimise harm were missed.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately most of the time. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman. MEOWS records were included in the patient observation aspect of the digital patient care record. We reviewed 6 records and found staff correctly completed them and had escalated concerns to senior staff in 5 of those. Managers completed a monthly audit of 10 records to check they were fully completed and escalated appropriately. Audits for September 2022 showed compliance of 70% and audits for October and November 2022 showed 80% compliance.

Staff used a system to manage premature births. The PREM 7 care bundle reflected the National Neonatal Audit programme. Women at risk of pre-term labour were risk assessed to ensure they were in the right place for childbirth, that preventative medication was offered in pregnancy and during labour. The care bundle included prompts for optimal management of the umbilical cord and checks on neonatal temperature and infant feeding after the baby was born.

Maternity

Staff accessed diagnostic testing results on the trust wide pathology and diagnostic imaging system. Staff caring for women in the antenatal, postnatal and community setting were responsible for checking their own results and on the day assessment unit staff recorded diagnostic tests in a diary to make sure they were checked daily.

Staff did not always complete risk assessments for each woman during their antenatal care, on arrival, and did not always use recognised tool, or review this regularly, including after any incident. Staff had access to evidence-based, standardised risk assessment tools for care in maternity via the service's digital patient care plans.

Managers monitored compliance to the Saving Babies Lives care bundle last updated in 2020 which is designed to reduce poor outcomes for babies. The five key recommendations are:

1. Reducing smoking in pregnancy, including regular measuring of carbon monoxide (CO)
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour
5. Reduction of preterm birth rate

Records for December 2022 showed that staff compliance varied. For example, 84% of women and pregnant people had their CO levels monitored at booking. Data confirmed that 97% of women who presented with reduced fetal movements had a computerised CTG.

Staff compliance to the identification of fetal growth restriction at booking had improved since the service introduced a new application. The overall detection rate for fetal growth restriction was 98%.

Staff recorded ethnicity and body mass index at booking. Records confirmed 96% compliance to record these two factors of the overall booking risk assessment.

Leaders implemented a national tool to help mothers and staff monitor baby movements during pregnancy. Staff used the application to make decisions about caring for women who reported reduced fetal movements. When movements were normal staff advised women and birthing people to download an application to their smart phone to help them assess their babies movements.

Staff knew about specific risks but we found gaps in care that delayed treating patient risk issues. Inspectors found that staff in triage did not effectively assess and respond to ongoing risks to women and their unborn babies in line with national guidance. Staff were unable to comply to the standard operating procedure (SOP) for triage which was based on the Birmingham Symptom Specific Triage (BSOTS) model because the support systems required were not implemented. This meant that staff in triage followed an ineffective SOP which affected their ability to safely risk assess women and birthing people and their unborn babies or escalate concerns. Inspectors found gaps in risk assessments and we found evidence of a lack of professional curiosity which resulted in missed opportunities to identify risk.

The service did not have a process or policy to identify or escalate 'frequent attenders' (women and pregnant people who attended often within short time frames). Staff did not review previous attendances all the time.

Staff did not always use a 'fresh eyes' approach to fetal heart monitoring. Leaders audited how effectively staff monitored women during labour having continuous cardiotocograph (CTG). Also, audit of babies over 37 weeks

admitted to the neonatal intensive care unit highlighted delay in the recognition of abnormal CTG readings. Managers implemented spot check audits of staff compliance but records did not show recent outcomes. However, records from October 2022 showed that delays in recognition and escalation of abnormal CTG recordings was a factor to babies being transferred to the neonatal intensive care unit. Because of this the service created the 'fresh eyes' action plan, which included plans to remind staff of the importance of fresh eyes, to include the labour ward handover board to show when fresh eyes reviews were due and to agree an audit schedule and ownership at the perinatal governance meeting at the end of January 2023.

Staff working on the birth centre monitored the fetal heart with a handheld device that listens to the heart rate during low risk labour. National guidance recommends every 15 minutes during childbirth and every 5 minutes during the second stage of labour. Managers monitored compliance and found gaps in the 2nd stage monitoring, data from June 2022 to October 22 showed that midwives were only 30% compliant in recording the fetal heart rate during the 2nd stage of labour. During the factual accuracy process leaders provided additional date which showed an improvement of 68% to 98% and intermittent fetal monitoring was a feature in the theme of the week newsletter for December 2022.

Managers and staff had recently implemented a quality improvement measure to improve the quality and recording of risk assessing women and pregnant people during childbirth in the birth centre with a view to extend the programme to labour ward. The PAUSES buddy review project was introduced so that a midwife 'buddy' reviewed the care plans of their colleagues. The project covered 6 aspects of care.

• P-Partogram review (chart used to plot the progress of labour)

• A-Analgesia

• U-Uterine Contractions

• S-Situation change over the last hour

• E-Escalation – is it required?

• S- Staff wellbeing

Leaders had an action plan to make sure staff used PAUSES effectively and data submitted during the factual accuracy process showed that there had been a reduction of babies admitted to the neonatal intensive care unit from the Abbey birth centre.

Staff did not always have the support of a second midwife during the 2nd stage of labour, to ensure the safe delivery of the baby. Records confirmed that audit data for intermittent fetal heart monitoring confirmed this, as well as staff we spoke to during the inspection.

Staff did not always follow the sepsis six care pathway when a woman showed signs of sepsis. Managers monitored staff compliance to completing actions and used this data to ensure practice was embedded. Records showed that during September 2022 staff compliance varied from 16% for taking the necessary blood samples to 100% for taking blood cultures (a different type of blood test). November 2022 data showed a marked decline in compliance for taking necessary blood samples (50%) and only 75% for blood cultures.

Maternity

Leaders did not monitor waiting times in triage and were not assured women could access emergency services when needed and received treatment within agreed timeframes and national targets. Inspectors found leaders did not have a safe process to admit women to the triage unit and make sure they were seen within safe times frames. This did not reflect national guidance. The Royal College of Obstetrician and Gynaecologists guidelines Providing Quality Patient Care Maternity Standards: A framework for Maternity Service Standards (2016). States '*Maternity services must identify women who need to be seen more urgently than this and have guidelines and capacity to facilitate rapid review*'. In triage, we saw that not all women were prioritised based on risk and obstetric interventions were not requested in safe time frames. We found gaps in the recording of 'arrival' times and 'time seen' by a doctor was not accurately recorded or monitored. This was because doctors had multiple priorities, the consultant covered labour ward and triage and registrars and senior house officers covered labour ward, triage, and gynaecology. After the inspection we raised concerns about gaps in medical reviews. The trust provided a written response which states '*We have robust Obstetric cover for our labour ward, and Triage will continue to be covered by that team. However, with immediate effect Triage will be included in Labour Ward Rounds, Consultant Ward Rounds and Safety Huddles'*

Staff did not record all telephone calls received in triage. Women called a central telephone line, located off site when they had concerns or thought they were in labour. Midwives manning the telephone line made referrals to triage and signposted women to attend. However, there were times when women called direct to triage or calls were put through to triage. Staff did not document these calls. This was highlighted in a recent Health Safety Investigation Branch (HSIB) review of a serious incident because inaccurate records cause delays in care and treatment.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. The service had a specialist perinatal mental health team to support women and pregnant people during times of crisis. Records showed that staff compliance to completing psychosocial risk assessments at booking was 100%.

Staff shared key information to keep women safe when handing over their care to others. The patient care record was on a secure electronic patient record system used by all staff involved in the women and birthing people's care. Staff told us they completed an SBAR (Situation Background Assessment and Recommendation) handover. However, records showed that managers did not monitor compliance to the accuracy of handovers.

Consultants completed daily ward rounds for women admitted to the antenatal ward and women in childbirth on the labour ward. Medical staff reviewed women who had a caesarean and escalated concerns to senior colleagues.

Staff on the postnatal ward were supported by a wound care trainer to make sure dressings were applied correctly. The service had worked hard to reduce the number of surgical site infections because of a quality improvement programme to improve outcomes and data showed that incidents fell below national outcomes. Because of this project the service produced an academic paper to inform national practice.

Shift changes and handovers included all necessary key information to keep women and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and babies safe was shared. Staff had one safety huddle per shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about the patients. The handover shared information using a format which described the situation, background, assessment, recommendation for each patient.

Maternity

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly most of the time. Following childbirth midwives completed a RAG (red, amber, green) rated risk assessment, based on the mother's antenatal history including any relevant medical conditions, current medication, method of delivery and birth weight to reduce admissions to the neonatal intensive care unit (NICU). Managers completed ATAIN (avoiding term admissions into neonatal units) audits every 6 months. Records between April to October 2022, showed that admission factors included inappropriate risk allocations found around feeding plans and vulnerable babies not being identified, which meant there was a potential to provide the wrong care or treatment.

The service provided transitional care for babies who required additional care. Staff working on the postnatal ward cared for babies who needed additional treatment and were supported by paediatric staff to do this. There were 2 designated transitional care rooms on the postnatal ward so that mothers could stay with their babies whilst they received treatment.

Staff completed risk assessments prior to discharging women and pregnant people into the community and made sure third-party organisations were informed of the discharge. Doctors reviewed care pathways to make decisions for women identified with known risk. Midwives completed risk assessments for mothers who delivered on the birth centre.

Staff gave mothers infant feeding advice during their pregnancy and after birth. The service achieved Level 3 Baby-Friendly status. The assessors were impressed with improved staff knowledge with 20% increases in some standards and parental satisfaction scores of 80%.

Midwifery Staffing

There were substantial staff shortages. Staffing levels did not always match the planned numbers putting the safety of women and babies at risk and this was a theme in incident reporting data. The service faced challenges around recruitment and retention.

Staffing levels did not always match the planned numbers which could put the safety of women and babies at risk. Staffing levels in maternity were not sufficient to provide safe care and treatment. On the day of inspection there were 12 midwives plus 1 supernumerary coordinator instead of the planned 15 midwives plus 1 supernumerary coordinator. Staff told us low numbers of staff made them feel unsafe.

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' (2015). A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. From July to December 2022 there were 21 reported red flag incidents. Acuity data for December 2022 showed there were 6 times when women did not receive one to one care during childbirth. Other information captured in the NICE 'red flag' data showed there were regular delays in the induction of labour. All delays are risk assessed by consultant.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and maternity support workers needed for each shift in accordance with national guidance. Managers completed a maternity BirthRate+ safe staffing workforce review in line with national guidance in October 2022. This review recommended 157.58 whole-time equivalent (WTE) midwives Band 3 to 7 compared to the funded staffing of 125.34 WTE, a shortfall of 29.42 WTE staff. The services specialist and managers 'funded ask data' confirmed lack of funding for 6.52 WTE. The review included a 21% uplift on current workforce numbers to cover annual leave, sickness and study leave. Also, the report showed that the service had several posts that were unfunded or funded for the short term which included 5.42 WTE maternity unit coordinators.

Maternity

The service had high vacancy rates, turnover rates, sickness rates and high use of bank nurses. The service provided a workforce report for Women's Health and Paediatrics which showed a combined total for the division and nursing vacancy rate of 17% and the vacancy pipeline report showed a shortfall of 23.4 whole time equivalent (WTE) midwives. With a combined turnover rates of 22%. Records showed that 6 midwives were on maternity leave, and 3.23 WTE midwives were on long term sickness leave.

There was a supernumerary labour ward shift coordinator on duty 24 hours a day 7 days a week who had oversight of the staffing, acuity, and capacity most of the time. Also, the service provided a manager on call (MOC) who held a bleep and was responsible for managing staffing and care issues. NICE red flag staff incidents data showed that there was only one report in July 2022 of labour ward not having a supernumerary coordinator. However, the most recent acuity data from May to October 2022 showed there were 22 times when the shift coordinator was not Supernumerary.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women. Managers completed a daily 'acuity tool' which often showed staffing shortfall. This meant staff were moved according to the number of women in clinical areas.

Maternity support workers supported healthcare professionals to care for women and pregnant people. The vacancy and pipeline report showed that there were 3.38 whole time equivalent (WTE) vacancies for maternity support workers. There were plans for 2.8 to start in Feb 2023.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. Records showed that the trust backfilled midwifery staffing with bank staff. Records for November 2022 showed a 34 % backfill rate. This reflected the shortfall in staffing, including sickness and annual leave rates.

Not all staff had received a recent appraisal on their work performance or had supervision meetings with their managers to provide support and development.

Managers had not supported all staff to develop through yearly, constructive appraisals of their work. Staff told us that due to workforce pressure managers were working clinically up to 70% of the time. This meant they did not have enough time to make sure staff received adequate feedback about their performance. Records showed that 65% of nursing and midwifery staff had received their annual appraisal this was a 25% shortfall on the trust target of 90%. The impact of this was that staff are not able to measure their performance.

Managers had systems to support some staff to apply for additional specialist training for their role. A practice development team supported midwives. The team included a maternity education and 3 clinical practice educators (CPE). The service employed 10 specialist midwives. These included but was not limited to the antenatal screening lead, diabetes, fetal monitoring, bereavement, perinatal mental health, and infant feeding midwives. These midwives completed training, audits, and supported staff to embed practice. Staff who wanted to develop their knowledge and skills could apply for two additional university course funding if they had completed their mandatory training. Managers were responsible for signing off funding for the following courses, Examination of the Newborn and Advance Neonatal Life Support (ANLS).

However, the maternity education strategy did not mention, 'Midwifery High Dependency Care' courses designed to support midwives with additional intensive care skills for seriously unwell women and birthing people. We did not see records that confirmed how many midwives had completed additional specialist training. During the factual accuracy process the trust provided additional information that stated 'There are currently 4 midwives on the High Dependency Unit (HDU)' course and 4 HDU trained currently practicing in the unit.

Staff provided bereavement care for women who had experienced a stillbirth or neonatal (newborn baby) loss. There was a specialist bereavement midwife and a set process to care for grieving parents. The service provided a bereavement room so that parents could stay with their babies to grieve. Staff identified that when offering support to grieving parents and those who have experienced a traumatic birth. The trust offered a private environment called the 'Eternal Garden' for patients and people who had experienced a bereavement.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers reviewed and adjusted staffing levels and skill mix most of the time and gave locum staff a full induction. However, there were gaps in medical staff training compliance for 'maternity matters' core skills training was significantly below trust targets and there were long delays for patient reviews in triage.

The service had enough medical staff to keep women and babies safe.The medical staff matched the planned number. The service had low vacancy, turnover, and sickness rates for medical staff. The obstetrics and Gynaecology workforce report showed that the service had over recruited 5.7% whole time equivalent doctors. There were 13 obstetrics and gynaecology consultants currently working at the trust each had specialist interests. These included but were not limited to, caring for women in early pregnancy, fertility and pre-term birth, perinatal mental health, bereavement and quality improvement and gynaecology governance lead. Also, 3 consultants had special interests in high risk obstetrics, labour ward and fetal medicine, one was also a maternity safety champion. This meant the service achieved 60 hours of onsite consultant cover which was aligned to national guidance. However, training data suggested that doctors did not have enough time to complete their mandatory training.

The service had low rates of bank and locum staff.Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Leaders provided locums with an information pack when they started at the trust. This contained key information including orientation and the contact details of key people. Staff on duty during the inspection told us they were well supported and received a comprehensive induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Leaders produced labour ward job plans to oversee medical workforce requirements. Obstetric teams were assigned to labour ward. Also, there was a daily registrar and senior house officer (SHO) on call team who covered gynaecology and obstetrics emergencies. Inspectors found in triage that during busy periods medical reviews were delayed, this had been highlighted on the services internal risk register and by staff completing incident reports.

The service always had a consultant on call from home during evenings and weekends and lived within 30 minutes of the service.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work most of the time. Medical, staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. However, records provided by the trust in January 2023 showed that 68% of doctors had an appraisal in the past year.

Records

Records of women and birthing people's care and treatment were not always completed in detail. Digital care records were comprehensive and all staff could access them. Records were stored securely and easily available to all staff providing care.

Women's and pregnant peoples care records were comprehensive and all staff could access them easily. The trust used electronic patient care records. We reviewed 6 sets of electronic records and found records were clear and complete in 5 of these. However, inspectors found gaps in recording in another set. Lack of accurate recording was also highlighted by the Health Safety Investigation Branch (HSIB) in their review of a serious incident.

Managers monitored compliance to the recording of assessments and compliance to the correct care pathways. Records provided by the trust in January 2023 showed that out of 15 records reviewed by managers, only 4 had risk assessments completed and most antenatal contacts did not have an associated risk recorded. Because of this the service leaders had implemented a working group to review amendments, update education and promote effective completion of risk assessments. However, this was ongoing and there was no evidence of improvement during the inspection.

When women transferred to a new team, there were no delays in staff accessing their records. This was because patient care records were digital and could be accessed remotely.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets. Access to patient care records was 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. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 6 prescription charts and found staff had correctly completed them.

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

Staff completed medicines records accurately and kept them up-to-date. Medicines records were clear and up-to-date. Midwives had access to the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems for the 6 sets of records we looked at were fully completed, accurate and up-to-date.

Staff learned from safety alerts and incidents to improve practice. Leaders had systems to reduce medication errors. The trusts 'Quality, Experience, Workforce and Safety Monthly Triangulation & Predictor Dashboard (QEWS) collected data on reported medication errors. Records for November 2022 showed that there we no medication errors resulting in harm. There were 2 low risk reported errors on labour ward and 3 low risk errors on the postnatal ward.

Incidents

The service did not manage safety incidents well as there were long delays in investigating incidents. Also, manager did not always monitor outcomes of changes in practice made because of incident reviews. However, staff recognised and reported incidents and near misses. Managers shared themes and shared lessons learnt from incidents. When things went wrong, staff apologised and gave women honest information and suitable support.

Staff knew what incidents to report and how to report them.Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 9 incidents reported in the 3 months before inspection and found that there was a varied approach to completing incidents, for example there was lack of details in some of the reports.

The service had reported one 'never' event between June and November 2022. Never events refer to a list of serious medical errors or adverse events that should never happen.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. The perinatal governance team conducted a weekly safety summit where incidents were reviewed as part of the governance process. The team completed a maternity safety summit proforma which summarised the discussions of incidents and the planned actions.

Managers discussed moderate and serious harm incidents as standing agenda items at the perinatal and board level safety champion meetings.

However, the perinatal governance lead had worked alone for some time because the service was in the process of recruiting 2 band 7 midwives to support them, and the administrative staff were not currently available. Inspectors found evidence that there were 152 open incidents and 69 had been open for over 60 days. Because of this the perinatal governance lead was being supported by the trust-wide senior quality and governance lead from the central patient safety team to help reduce the amount of outstanding investigations but dealing with backlog was challenging because of the complexity of some of the incidents.

Managers did not always have time to investigate incidents thoroughly. However, they did involve women and their families in these investigations. Inspectors reviewed 3 serious incident rapid review investigations and found staff had involved women and their families in the investigations. In all 3 investigations, managers shared duty of candour and noted feedback to families for comment. The 3 incidents had led to formal investigations by the Healthcare Safety Investigation Branch (HSIB) who completed reviews and provided the trust with recommendations to improve care.

We found discrepancies in the type of incident reports. For example, National Reporting and Learning System NRLS data submitted by the trust from June 2022 to December 2022 showed 5 incidents referred to long wait times or lack of staff

in triage which caused delays in care and treatment. However, the National Institute for Health and Care Excellence (NICE) red flag incident reports from June 2022 to December 2022, only recorded two incidents related to delays in triage of 30 minutes or more. The impact of under reporting, or delays in thorough reviews is that there were missed opportunities to make the necessary changes to improve care and treatment.

After the inspection we raised this with divisional and trust leaders who advised us that there was a trust-wide ongoing project to reduce the amount of overdue incidents and that progress had been made to reduce the amount of open incidents. Also, during the trusts representation process in March 2023 trust leaders provided evidence that the amount of outstanding incidents had been reduced to 47.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff.

Staff reported serious incidents clearly and in line with trust policy. Data confirmed that there had been nine maternity related serious incidents reported by the trust between June 2022 to November 2022. Records showed that to January 2023 there had been 8 serious incidents that had met the threshold to be referred to HSIB.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Governance reports included details of the involvement of women and their families in investigations and monitoring of how duty of candour had been completed. Consultants offered families the opportunity to debrief and arranged special one hour appointments. However, the appointments were not job planned, which meant they were not captured on trust data to reflect workload.

The service had a birth reflections team of midwives who had received counselling training. The team received alerts about women who had experienced a traumatic event, women were given a birth reflections leaflet which included the contact details of the team. However, the most recent board quality report reviewed complaints stated that "*A review of reopened complaints was undertaken and found that maternity service users were not always offered the support of Birth Reflections at their initial contact when complaining, which may be beneficial"*.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, managers discussed a serious incident and shared learning at a perinatal governance meeting in July 2022 and told staff that immediate changes would be made to the defined category 3 caesarean section timeframes. Also, throughout the unit there were quality and safety staff notice boards, which shared information about reported incidents for the previous week, the total number of open incidents, guideline updates, theme of the week and current quality improvement projects.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. The perinatal governance lead met with the senior quality and governance lead from the Trusts central patient safety team. The team looked at the most recent themes to inform the 'theme of the week' strategy which was discussed at every handover for each week.

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a traumatic event. Obstetric emergency simulated training sessions were updated annually to reflect the previous year's themes and trends.

Managers debriefed and supported staff after any serious incident. The professional midwifery advocates and various medical staff received Trauma Risk Management (TRiM) training and provided support to staff after a traumatic event.

Maternity

Is the service well-led?

Requires Improvement

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

Leadership

Maternity leaders faced substantial challenges and differing trust priorities which created missed opportunities to drive the required improvements of the service. They didn't always have time to manage services or help staff develop their skills. However, the recently appointed maternity leadership team had the skills and abilities to run the service and they understood the priorities and issues the service faced. They were visible and approachable in the service for women and staff.

Leaders in the Women's Health and Paediatric division had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They understood the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. The service was led by a recently appointed divisional quartet which included an interim head of midwifery, the associate director, head of operations and the divisional chief nurse for women's health and paediatric services. They told us they shared responsibility for all services within the division which included gynaecological services. Records showed that local leaders had completed workforce and risk reports and had oversight of most of the challenges faced in the Women's Health and Paediatric division. However, challenges in the trusts priorities meant challenges like workforce shortages could not always be acted on quickly.

Service leaders were visible and approachable in the service for women and staff. Maternity leaders were well respected, approachable, and supportive. Staff told us that the interim head of midwifery was approachable and visible, and they felt supported by their line managers, ward managers and matrons. Staff told us that managers were now working clinically a lot more than before.

The quartet met weekly, attended divisional meetings and had plans to meet more often to share the workload.

The service was supported by maternity safety champions and non-executive directors. Maternity services were supported by 5 maternity safety champions, this included a non-executive director (NED), the executive director who was the chief nurse, the maternity safety champion was the interim head of midwifery, the obstetric safety champion was a consultant and the neonatal safety champion was the divisional director for maternity.

Maternity safety champions held monthly and quarterly meetings with a set agenda, they reviewed actions from previous meetings, reviewed compliance against the Clinical Negligence Scheme for Trusts (CNST) ten safety standards, looked at quality improvement projects and reviewed the patient experience with input from the Maternity Voices Partnership (MVP). They understood the challenges faced by the service. There was a process to escalate issues to the board. However, our inspectors found that complex reporting processes, led to some delays in oversight by trust leaders to respond effectively.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress. However, this was dependent upon the current budget and gaps in the workforce and data showed not all staff had received their appraisal.

Maternity leaders shared an overview of maternity services and escalated concerns to the divisional leadership team who produced bimonthly reports for the quality of care committee and trust board. The Quality of care committee was chaired by the NED and attended by the Chief Executive, Chief Nurse and Medical Director. There were monthly escalations of concerns to the safety champions. Leaders confirmed that the interim head of midwifery attended trust board meetings.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The current vision for the service was 'One team working together delivering safe and outstanding care for every woman and her family'. There was a 'golden thread' statement which was a culture of continual improvement. The vision and strategy was under review so that it would echo the trust-wide vision in the future. There were plans to consult with staff and families.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services at The Shrewsbury and Telford Hospital NHS Trust and planned to revise the vision and strategy to include these recommendations. The head of midwifery delivered a rapid review of the Kirkup (2022) report 'Reading the Signals' to the trust board in December 2022. The report was thorough and highlighted key factors that contributed to poor care.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The plans included changes to the estates, the plans had been delayed as a result of capital development limits placed on the trust. This meant that the current layout of maternity did not meet national standards because there was only one obstetric theatre in operation within the maternity unit and area's like triage and the wards needed to be reconfigured.

Leaders and staff understood and knew how to apply them and monitor progress. Leaders had recognised that current vision needed updating to align to the trusts vision, meet current maternity recommendations, and demonstrate inclusivity. The NED, safety champions, and the maternity voices partnership had been included in the plans to review the strategy.

Culture

Most staff felt supported and respected but shortfalls in the workforce meant staff did not feel they had realistic time to care for women and pregnant people. Staff were not always able to focus on the holistic needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

Maternity

Staff felt respected, supported, and valued**.** Staff were positive about the service and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff knew how to contact the freedom to speak up guardians. Most staff were positive about their professional development, although only 7% felt that the current appraisal system improved their job.

Staff felt unable to focus on the needs of women receiving care most of the time. Staff worked within and promoted a culture that placed patient care at the heart of the service and 79% of staff felt that the care of women and pregnant people was a top priority. Staff felt there were opportunities to show initiative frequently in their role. However, the staff survey results reflected dissatisfaction about their workload, responsibilities, and lack of staff. Only 5% of staff felt there were enough staff to do the job properly.

Leaders understood how health inequalities affected treatment and outcomes for women and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

Workforce Race Equality Standard (WRES) records showed that there were differences between white and Asian and black staff. Records showed that 7% of white staff and 4% of Asian and black staff were in senior roles. Also, data showed 13% of white staff appointed to a position after being shortlisted and 10% of Asian and black staff were appointed to a position after being shortlisted. The trust had several schemes to increase development opportunities for staff from different ethnic backgrounds.

The Workforce Disability Equality Standard data showed the results were like the national average.

Leaders told us there was a strong culture to improve safety culture. Maternity safety champions regularly met with the executive safety champion and non-executive safety champion, to review maternal and neonatal deaths, still births and to review learning. Also, they had a forum so that staff could discuss and escalate risk issues like staffing, student support and continuity of carer provision.

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

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women's feedback to improve daily practice.

Maternity

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. During the inspection the trust displayed a CQC poster to signpost women and pregnant people on how they could give us feedback on their care. After the inspection the CQC received 8 complaints about care from 8January 2023 to 18 January 2023. Patient experience was reviewed in the maternity safety champion monthly meeting. The team reviewed compliments and complaints, maternity voice partnership meeting and staff feedback and surveys.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Strategies to improve governance capacity and capability were not introduced or embedded effectively. Some policies did not reflect national guidance which meant care did not reflect best practice. However, although clinical staff were clear about their roles and accountabilities, they did not always get time to update or embed their practice.

Local leaders governance processes were not always effective, throughout the service or with partner organisations. The service had a governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. We found several examples of quality improvement. However, historically gaps in the governance team meant that the required changes to the service were not always implemented effectively because of issues with staffing within the team and lack of protected time for managers to complete their audits and reviews. For example, the lack of time to complete regular audits to embed new practices. During the factual accuracy process in March 2023 trust leaders told us there had been a drive to improve governance and increase the governance workforce by employing 2 band 7 midwives.

Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff. However,

Staff followed policies to plan and deliver high quality care according to evidence-based practice and national guidance. However, some policies had to be updated by leaders because they had not reflected national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. Quality and safety notice boards displayed monthly policies that were due for review.

Leaders did not make sure that incidents were closed within national timeframes. The perinatal governance team had been understaffed for a long period of time whilst waiting for funding to increase support with the investigations of incidents and in particular serious incidents. Leaders had reported a large backlog of incidents and perinatal mortality reviews to the trust board in the first quarter of 2022. Because of this the trust had provided additional cover the senior quality and governance lead from the central patient safety team, had supported maternity to reduce the backlog for several months. Consultant clinical governance had not been job planned which meant they did not attend the divisions quarterly safety summit. This oversight meant that doctors did not have time to review serious incidents, although the division had recently recruited an obstetric governance lead. The consultant of the week was responsible for completing rapid reviews. Therefore, the current system meant there were missed opportunities to identify key themes early on and introduce measures to avoid repeated mistakes.

Inspectors reviewed trust and third-party data to inform decisions around the strength of governance in the division. Records showed that concerns identified by CQC inspectors had been previously identified but not acted upon. For example, an external review was completed in August 2022 which reviewed the first 7 immediate actions recommended

in the Ockenden (2022) report. They provided positive feedback. However, they acknowledged that there were significant workforce challenges and highlighted issues relating to the digital patient care records, a need for more administrative support, particularly in governance and for further consideration to be given to task shifting to ease the pressures on the Midwifery workforce. Also, a Health Safety Investigation Branch (HSIB) report in December 2022 echoed the findings of inspectors and recommended that the trust ensured that '*risk assessments were robust and dynamic and included holistic overview of care, including evolving risks, to ensure that the correct timing of birth is planned'.*

We found that care and treatment did not always reflect national guidance. Two serious incidents confirmed that standard operating procedures like the categorisation of emergency caesarean section and the maternity triage process did not reflect national guidance. Incident records confirmed that staff submitted incidents about the challenges they faced with capacity that had a negative effect on their ability to provide safe care. Also, the trust risk register contained a risk entry relating to the ability to provide safe care in triage. Moreover, leaders had missed opportunities to improve care in triage because of lack of compliance to recording telephone conversations or monitoring arrival and wait times in triage meant they could not demonstrate to the board the severity of capacity and workforce issues that led to poor care.

During conversations with staff, we found a disconnect between the divisional priorities and the trust wide priorities and noted a lack of board oversight relating to the challenges faced by the governance team.

The CQC fed back concerns to the trust board after the inspection. The trust responded to our concerns relating to the lack of staff in triage, timings of clinical reviews, long delays in serious incident reviews and reviewed the care of a mother that had received poor care. Trust representatives said they had implemented improvements to staffing and quality of care reviews in triage and reviewing the estates to make changes where they could. The CQC has asked the trust to continue to make significant improvements within set times frames.

Management of risk, issues, and performance

There were missed opportunities at corporate level to ensure local risks were endorsed by the corporate risk register. The trust had not been able to create effective workforce strategies to improve the non-clinical burden for clinical staff and provide protected time for managers to monitor and implement the changes required to drive improvement. Divisional leaders used systems to manage performance but these systems were not always effective and did not always influence change. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. Outcomes for women were aligned to local and national standards. Managers and staff used the results to improve women's outcomes. The Women's Health and Paediatrics division collected and submitted data for 23 national audits. These included but were not limited to; the Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality Surveillance and Confidential Enquiry (MBRRACE-UK), the National Diabetes Audit (NDA): National Diabetes in Pregnancy Audit, the National Maternity and Perinatal Audit (NMPA) and the UK Obstetric Surveillance System): Amniotic Fluid Embolism (UKOSS). Outcomes of audits fed into compliance reviews against the Clinical Negligence Scheme for Trusts (CNST) 10 recommended safety standards.

The service carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. Records showed that from January to December 2022 there were 36 maternity audits. The leadership team were responsive when staff identified where improvements could be made but did not always have the resources to make the changes necessary to improvements. Several audits showed poor compliance to record keeping, and gaps in care that reflected the workforce challenges.

Managers shared and made sure staff understood information from the audits. Managers shared key outcomes via the maternity quality and safety staff notice boards, trust theme of the week updates and newsletters.

Divisional leaders met monthly to review the risk register, identified relevant risks and issues and identified actions to reduce their impact but trust board priorities did not always reflect the severity of the known maternity risks. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

The divisional risk register had an entry which stated '*risk that maternity patients attending triage will not receive timely care prioritised according to clinical need'* dated 27 May 2021, with a review on the 4 January 2022. The register stated that a *'Prospective data monitoring of triage performance data - waiting times and BSOTS compliance'* should be completed to provide assurance. However, this had not been acted upon to mitigate risk. For example, inspectors found that leaders did not have a process to safely monitor arrival and wait times in triage to ensure that women were prioritised based on risk. After the inspection we raised concerns about ineffective triage processes. The trust completed an investigation and the triage risk was moved to the corporate risk register.

The associate director and the new divisional director completed an operational overview of maternity workforce. The midwifery workforce had been on the divisional risk register since September 2020 and although recently updated did not reflect all of the discussion dates entered on the internal incident board. Workforce challenges and actions were also included in the maternity quality of care report. The local maternity and neonatal system funded a 12 month extension of the dedicated workforce development, recruitment, and retention lead midwife post. The most recent report (November 2022) showed that there was an action plan to mitigate midwifery workforce risks and stated that the risk remained on the corporate risk register.

Inspectors found issues with staffing that affected the quality of care within maternity services. The trust had not created 'quick win' solutions to support gaps in clinical workforce. For example, there was a lack of administrative support. Administrative staff are vital because they can complete non-clinical tasks, register people when they arrive, answer the telephone, input data and signpost patients and families to the correct areas. The divisional risk report showed that a review of administrative roles had been requested to assess if this would release clinical and managerial capacity.

During the factual accuracy process in March 2023 leaders confirmed that midwifery workforce had been included in the 'trust – wide' 'staffing' risk, not as a standalone maternity workforce entry. Therefore, funding was reliant upon trust leaders who had conflicting responsibilities which meant there were delays in the recruitment process due to trust-wide budget challenges.

Also, third party organisations had visited the trust and identified that the recruitment of extra administrative staff would help ease the non-clinical tasks of healthcare professional and thus improve record keeping, but this was not forthcoming. The CQC fed back concerns about lack of support staff in triage because we noted gaps in the recording of wait times and risk assessments. As a result of our feedback the trust appointed a receptionist to the triage area and assured us that the maternity care assistant assigned to the area would not be moved to backfill shortages in other areas. However, this measure was not reflected in other areas.

The service faced challenges to achieve all 10 expected safety actions against the Clinical Negligence Scheme for Trusts (CNST). This was because of several factors for example, recent changes to the maternity leadership team had created a short-term lack of consistency. Also, NHS Resolution had updated technical guidance within the maternity incentive scheme 10 safety standards, and divisional leaders had to adhere to several reporting requirements that included but

was not limited to the Perinatal Mortality Review Tool report and The Ockenden report (2022) 15 Essential action plan. Divisional leaders cited that the numerous reporting commitments, changes to reporting requirements and changes to leadership had been barriers to achieving all safety actions. Compliance to CNST safety action 5: Supernumerary status of labour ward shift leader and delivery of 1:1 care in labour, and safety action 8: MDT training in obstetric emergencies, fetal monitoring and Neonatal Life Support requires 90% compliance across each staff group had been challenging. This was because the current training requirements required midwives and doctors to complete 60 hours per year maternity specific training and records confirmed that this was hard to achieve due to workforce challenges. During the factual accuracy process the trust provided evidence of compliance as of the 20th of January 2023.

Leaders produced reports for the trust board quality of care committee. The quality of care committee report for November 2022 showed that the MBRRACE-uk (2020) report identified that the trust had a neonatal death rate 'more than 5% higher than the average' when compared to 'comparable' trusts with Level 3 Neonatal Intensive Care Units. At the time of inspection, a multi professional perinatal deep dive was underway. There were plans to update the quality of care committee verbally.

There were plans to cope with unexpected events. Staff followed the maternity escalation policy, which contained escalation pathways for insufficient staffing and capacity issues. The policy included a RAG (red, amber, green) rated system with clear lines for escalation. The matron on call carried a bleep and completed an escalation log, and updated the staffing acuity tool, with the identified issues. Leaders reviewed combined acuity data, and this fed into trust workforce reports. The report reflected the workforce challenges and there were regular entries regarding delay or cancelled care for some women. However, workforce issues meant that staffing in some area's was insufficient to provide safe care and treatment.

The Executive director and non-executive director (NED) safety champions completed walkabouts of the maternity unit to speak to women, pregnant people, and their families. They found a continued theme around impact of chronic staffing shortfalls. The action plan produced in response to the staff escalating concerns to the NED safety champion was based on the following themes: Staffing, Leadership support, IT, Staff wellbeing, Operational Overview, Governance, Estates. Progress against the actions is being monitored via the Trust's Quality of Care Committee and reflected the findings of the CQC. During the factual accuracy process leaders told us a quality improvement process had been implemented and progress has been made. Although we did not see data to confirm this.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance and make decisions. However, improvements in key clinical areas were not forthcoming. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it most of the time**.** The service was part of a first phase for implementation of an electronic system to efficiently manage medical devices in the trust and all devices were being mapped against their area. Introduced in November 2022, the new system was designed to help manage equipment each area making it a much easier way to ensure staff had what they needed. The system included QR codes that staff could scan when completing equipment checks. This data fed into a central system and managers in each area were responsible for making sure equipment checks had been completed. However, there had been challenges because

managers worked 70% clinical in some areas and did not have time to review compliance to staff checks. Inspectors found numerous gaps in equipment checks. Therefore, we were not assured that emergency equipment was being managed effectively. After the inspection leaders told us that there was a quality improvement project underway to address the issues and assured us that matrons are non-clinical 70% of the time.

The service had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Staff accessed digital maternity patient care records. The digital system was robust and collected data that could be used to inform the division on their challenges. However, some staff felt they had not received the appropriate training when the care record was implemented. Also, audits showed gaps in the recording of patient care.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff could access standard operating procedures, safeguarding referral forms and care pathways via the trusts intranet systems.

The information systems were integrated and secure**.** Computers could only be accessed by secure personal login information. However, during the inspection we noted times when due to care priorities patient care records were left unattended.

Data or notifications were consistently submitted to external organisations as required most of the time. Leaders submitted data to stakeholders like the local authority and the health and safety investigation branch.

Engagement

Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women. Leaders worked with the local Maternity Voices Partnership (MVP) in decisions about patient care.

Service leaders attended monthly meetings with the Local Maternity Network System (LMNS) to review governance and incidents and records confirmed these meetings had a formal agenda and that incidents were reviewed to make sure they had considered all the evidence.

The service made available interpreting services for women and pregnant people during the antenatal period and collected data on ethnicity. However, the telephone interpreting service system used during labour was difficult to access especially at night.

The MVP received funding to review services 8 days per month. Workload was shared with a vice chair who also worked at the trust. The local maternity and neonatal system provided a strategic lead and was overseen by local third party healthcare stakeholders.

The MVP chair was invited to divisional governance meetings but did not always attend, records showed that they had attended once during the reporting period. However, they attended labour ward forum meetings and had a slot to present feedback from women. The MVP were involved in the various quality improvement measures and leaflet production. They met with the transformation midwife and had met with the head of midwifery.

Leaders understood the needs of the local population. The MVP was involved in national strategies to tackle health inequalities and chaired a national ethnic minorities service user group. Because of this they were able to inform local strategies to improve relationships for women from different ethnic backgrounds and where English was their second language.

The divisional leadership had hosted antenatal classes in local mosques and planned to reach out to women from war torn countries like Ukraine and Afghanistan so that they accessed safe informative information.

The MVP was collaborating with staff to introduce infant feeding 'padlets' (leaflets on a digital tablet) so that women had ease of access to essential infant feeding information.

The MVP had completed walks around the maternity unit, spoken with to women and birthing people and had started to collect data about women ethnicity, to help improve access to services at the trust.

They spoke positively about the divisional leadership team stating that the Ockenden report (2022) had been pivotal to bringing relationships together and that they had direct contact with the head of midwifery.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The division was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who coordinated development of quality improvement initiatives. The was a trust drive to improve the quality of care. However, inspectors found that there were missed opportunities to make fundamental changes. Some progress was hindered at times due to workforce and trust-wide financial restrictions implemented by the government during the Covid-19 pandemic recovery programme strategy.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. Staff created and participated in several audits to help support improvements to maternity care. Current research projects included but were not limited to, the 'ActimProm' project of a rapid, test to diagnose premature rupture of membranes (PROM.). Pre-term pre-labour rupture of membranes (PPROM) complicates 2% of pregnancies but is associated with 40% of preterm deliveries. An early review of data confirmed that a positive 'ActimProm' can be crucial to the decision making to admit patients. However, records showed that practice was not fully embedded.

The Maternity Team won the Innovation Award at the Staff Achievement Awards for their quality improvement work in driving the surgical site infection rate down for caesarean sections.

Inspectors found several examples for quality improvement and innovation within the Abbey Birth Centre. Midwives had co created a 4-week rolling programme of antenatal education that all women could access. The programme included information on health care, childbirth, and postnatal care including infant feeding. Women could book the classes via a third party application.

Maternity

Certain staff were trained to provide aromatherapy treatments during childbirth. The service had recruited a lead midwife consultant to carry out the training and resources aromatherapy oils. Staff on the birth centre offered massage and inspectors found that the oils were dated and stored safely.

The service had achieved UNICEF level 3 baby friendly infant feeding accreditation.

Outstanding practice

We found the following outstanding practice:

- Staff in their own time had created a Biomechanics workshop to increase staff knowledge about facilitating natural childbirth for women who didn't want interventions. The workshop was designed to educate staff on optimal maternal and fetal positive during childbirth. Staff spoke positively about the biomechanics improvement measures. Although, outcomes were not measured at the time of the inspection.
- Staff created a comprehensive antenatal education 4 week programme. Women and pregnant people could book online and the course was free to attend.

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:

Maternity

- The service must ensure that it improves compliance to local infection prevention and control measures and that managers are given protected time to monitor this. Regulation 12 (1) (2) (h).
- The trust must ensure staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (a) (d)).
- The trust must ensure that there is 'birth pool' evacuation nets and equipment in every room that has a birthing pool. Regulation 12 (1) (2) (a) (e)
- The service must ensure that it improves the quality of cardiotocograph (CTG) risk assessments and the use of 'fresh eyes' for women and pregnant people during childbirth and monitors this to ensure practice is embedded. Regulation 12 (1) (2) (a) (c)
- The trust must ensure that it improves the quality of processes and practices in relation to patient risk assessments to make sure women and pregnant people's care is aligned with national guidelines and that staff escalate concerns withing safe time frames. Regulation 12 (1) (2) (a) (b) (c)
- The trust must ensure that staff accurately review and update personal care plans for all women, pregnant people and newborn babies, to ensure they are on the correct care pathway and continue to monitor compliance. Regulation 12 (1) (2) (i).

Maternity

- The trust must ensure that staff record arrival and 'time seen' of all women and pregnant people who attend triage or labour ward and monitor compliance and outcomes. Regulation 12 (1) (2) (a)(b).
- The trust must ensure that there is a system to identify 'frequent attenders' to the maternity triage or the day assessment unit so that staff can escalate concerns appropriately. Regulation 12 (1) (2) (a) (b)
- The trust must ensure there is a system to record and monitor all telephone calls made to triage and include recommendations on the patient care record. Regulation 12 (1) (2) (a) (b)
- The trust must ensure medical staff cover for maternity triage is reviewed so there are enough suitably qualified, competent doctors to deliver the service in line with national guidance. Regulation 12 (1) (2) (c)
- The trust must ensure it improves maternity governance systems so that staff have time to review and investigate incidents, share learning, and monitor the effectiveness of the policies and practices on a regular basis. Regulation 17 (1) (2) (a) (b) (c) (3)
- The trust must ensure that it completes a full review of the Women's Health and Paediatric Divisions risk register and separates maternity risk and incorporates long standing maternity risk on to the corporate risk register. Regulation 17 (1) (2) (a) (b) (c) (3)

Action the trust SHOULD take to improve:

- The trust should ensure that it continues to improve mandatory training compliance for doctors. Regulation 12.
- The trust should ensure that it continues to improve staff compliance to accurately following the sepsis 6 care bundle when women and pregnant people present with symptoms. Regulation 12.
- The trust should ensure that medical staff are complaint with their level 3 safeguarding training in accordance with national guidance and trust targets. Regulation 13.
- The service should ensure that women and pregnant people's privacy and dignity are protected when they are cared for in main theatres. Regulation 10.
- The service should ensure that board workforce reports separate vacancy rates for midwives and nurses to ensure board oversight of the true vacancy rate for midwives. Regulation 18.
- The service should ensure it continues to find effective ways to improve staffing levels across maternity. Regulation 18.
- The trust should consider offering midwives additional maternity high dependency care courses.
- The trust should consider separating the gynaecology and midwifery medical 'on-call' rota to ensure safe cover for maternity to reflect current national recommendations.
- The trust should consider improving interpreting services for women and pregnant people during childbirth.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 2 other CQC inspectors who were supported by obstetric and midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.